

**UNIVERSITY OF KWAZULU-NATAL**

**MANAGEMENT OF THE LONG TERM PSYCHOLOGICAL EFFECTS OF RAPE  
AMONG WOMEN SURVIVORS OF THE 1994 GENOCIDE IN RWANDA: A  
GROUNDED THEORY APPROACH**

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**2013**

**MANAGEMENT OF THE LONG TERM PSYCHOLOGICAL EFFECTS  
OF RAPE AMONG WOMEN SURVIVORS OF THE 1994 GENOCIDE  
IN RWANDA: A GROUNDED THEORY APPROACH**

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BY

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May 2013

**DECLARATION**

I, declare that this thesis entitled “Management of the long term psychological effects of rape among women survivors of the 1994 genocide in Rwanda: A Grounded Theory Approach” is my original work. It has not been submitted for any other degree. A complete list of references is provided with all source of information utilized or quoted in this study.

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## **DEDICATION**

This thesis is dedicated to genocide rape survivors whose testimonies have made a difference and contributed to the recognition of rape as crime against humanity.

## ACKNOWLEDGMENTS

*"I was always looking outside myself for strength and confidence, but it comes from within. It is there all the time."*

Anna Freud

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## **ABSTRACT**

In the 1994 Rwandan genocide, rape was widely used as a strategic weapon against Tutsi women. This study explored the long term psychological effects of rape experienced by these women in order to develop a middle range theory to guide the management of the lasting psychological effects of rape in the context of genocide.

A Grounded Theory approach using Strauss and Corbin's paradigm (Strauss and Corbin, 1990) was used. Data collection entailed in-depth interviews of twenty nine participants, twelve of whom were rape survivors, ten were women who had not been raped, and seven were men from their community. Open coding, axial coding and selective coding were used to analyse the data.

The results have shown that women were negatively affected, physically, psychologically and socially, by the rape. Genocide Rape Trauma emerged as a concept that defines these outcomes. It includes unbearable memories, overwhelming feelings, sense of helplessness, somatic distress, negative self-image, altered intimate relationships and social isolation. The extreme brutality, the humiliation that accompanied the experience of rape and multiple losses were reported as risk factors for the lasting psychological effects of rape. These negative outcomes were maintained by poverty, poor physical health, the burden of raising the children born of rape, hostility and stigma from their community, and lack of appropriate support and effective health care services. Facilitating the management of Genocide Rape Trauma emerged as the core category of the middle range developed theory. Recovery from Genocide Rape Trauma required formal and informal support, including psychological and medical care, sensitivity in dealing with genocide rape survivors, and advocacy. Economic empowerment was a key element, while educating the community contributed to the social integration of rape survivors and their children born of rape into their community. Women had developed coping mechanisms of their own to attain psychological relief, and had organized themselves into support groups. This study contributed to clinical practice by providing a holistic approach to taking care of rape survivors. The inclusion of such theory in the curriculum of health care professionals should contribute to the understanding of the lasting impact of rape and how to handle it in an efficient manner.

Key words: Rwanda, Genocide, women survivors, Genocide Rape Trauma, Management of the long term psychological effects of rape and Grounded theory.

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## **LIST OF ABBREVIATIONS**

<b>AIDS:</b>	Acquired Immunodeficiency Syndrome
<b>APA:</b>	American Psychiatric Association
<b>ARCT:</b>	Association Rwandaise Des Conseillers En Traumatisme
<b>ART:</b>	Antiretroviral Therapy
<b>AVEGA:</b>	Association des Veuves du Genocide d'Avril (Association of the Widows of Genocide)
<b>CAFOD:</b>	Catholic Agency For Overseas Development
<b>CBT:</b>	Cognitive-Behavioural Therapy
<b>CD4:</b>	Cluster of Differentiation
<b>CINAHL:</b>	Cumulative Index to Nursing and Allied Health
<b>CORAR:</b>	Compagnie Rwandaise D'assurances Et De Réassurance
<b>SORAS:</b>	Société Rwandaise d'Assurances
<b>DRC:</b>	Democratic Republic of Congo
<b>DSM IV-R:</b>	Diagnostic and Statistical Manual of Mental Disorders IV-R
<b>DSM-IV-TR:</b>	Diagnostic and Statistical Manual of Mental Disorders -Text Revision
<b>EMDR:</b>	Eye Movement Desensitization and Reprocessing
<b>FARG:</b>	Fonds National pour l'Assistance aux Rescapés du Génocide (Genocide Survivors Support and Assistance Fund)
<b>FDLR:</b>	Democratic Liberation Forces of Rwanda
<b>GPO:</b>	Global Professional Organization
<b>HAL:</b>	Helpful Active Listening technique
<b>HIV:</b>	Human Immunodeficiency Virus

ICTR:	International Criminal Tribunal for Rwanda
IHP:	International Hydrological Programme
IRIN:	Regional Information Networks
JEM:	Justice and Equality Movement
MAOIs:	Monoamine oxidase inhibitors
MCM:	Men community members
MFMER:	Mayo Foundation for Medical Education and Research
MINALOC:	Ministry of Local Government
MMI:	Military Medical Insurance
NGOs:	Non-Government Organizations
NISR/IDHS:	National Institute of Statistics of Rwanda/ Demographic and Health Survey
NISR:	National Institute of Statistics of Rwanda
PRI:	Penal Reform International
PTSD:	Post Traumatic Stress Disorder
RAMA:	LA Rwandaise D'Assurance Maladie
RS :	Rape survivors
RPF:	Rwandan Patriotic Front
RTLm:	Radio Television des Milles Collines
RTS:	Rape Trauma Syndrome (RTS)
RWF	Rwandan Francs
RWN:	Rwanda Women Network
SCPS:	Service de Consultations Psychosociales

SEVOTA : Solidarité pour l'Epanouissement des Veuves et des Orphelins Visant le Travail et l'Autopromotion (Network for the Development of Widows and Orphans to Promote Self-Sufficiency and Livelihoods)

SLM/A: Sudan Liberation Movement/Army

SNRIs : Serotonin Norepinephrine Reuptake Inhibitors

SSRIs: Selective Serotonin Reuptake Inhibitors

SURF: Survivors Fund

TCAs: Tricyclic antidepressants

TRC: Truth and Reconciliation Commission

UN: United Nations

UNFPA: United Nations Population Fund

VUP Umurenge: Vision 2020 Umurenge Program

WCM: Women community member

WHO: World Health Organization



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## **CHAPTER ONE: INTRODUCTION**

### **1.1 BACKGROUND TO THE STUDY**

Throughout history, women have been subjected to rape, both in peacetime and in war. Rape against women is widespread in both industrialized and developing countries. The 2002 World Health Organization report on violence and health revealed that in some countries, one in four women experience sexual violence and one third of adolescent girls report their first sexual experience as having been forced (Krug, Dahlberg, Mercy, Zwi and Iozano, 2002). Although men, too, are raped, this study will focus only on the rape of women, more specifically on women who were raped during the genocide against the Tutsi that occurred in Rwanda in 1994. Rape has historically been portrayed in victim-blaming ways that ensured the silence of the women who had been raped. Rape victims received little attention in the literature, and in most cases it was unsympathetic (Mark, 2005). However, in 1970, rape was brought to public attention as a social problem by the feminist movement (Gavey, 2005). Feminist scholars have thus contributed to a change in the understanding of rape and have drawn the attention of mental health experts to the experiences and needs of women who have been raped (Gavey, 2005).

Researchers have offered a range of explanations of the meaning and motivation of rape. According to feminists such as Koss and Harvey (1991), Brownmiller (1975), Russell (1975) and Weis and Borges (1973), rape is viewed as an act of violence and power rather than primarily a sexual act. Furthermore, rape is perceived as a function of social control to keep women in their place; in this respect it is a manifestation of gender inequality and a mechanism for the subordination of women.

Evolutionists such as Thornhill and Palmer (2000) postulated that male sexual aggression and women's sexual passivity were biologically inherent. Thus, an evolutionary perspective of rape would regard it as being inherent in men's nature, rather than a consequence of patriarchal societal structures. The evolutionists attribute rape to sexual deprivation, although they insist that this doesn't make rape excusable. Archer and Vaughan (2001) refuted these allegations and asserted that rapists are often individuals who do have a variety of other sexual outlets.

The cognitive perspective on rape emphasises the crucial role played by cognitions in men's desire to rape. Ryan (2004) suggested that rape is a chosen activity and men only rape when cognitions are in places that favour the preparation and justification of rape. The most important of these cognitions are rape-supportive beliefs, excessive sexual preoccupation, rape scripts and fantasies, and a self-definition that values hyper masculinity and the power of men to dominate women sexually.

Groth (1979) identified three patterns which motivate men to rape: power, anger and sadism. Power rapists feel insecure about their masculinity and rape becomes a way of asserting their heterosexuality and their sense of manhood. Anger rapists use rape to gain revenge for unjustified treatment. Sadistic rape, which appears to be rare, involves torture and bizarre rituals, and the aggression itself becomes eroticized.

Sociologists used to consider rape as primarily a psychopathic act, but in more recent social science research, rape has come to be seen on a continuum with other more normal behaviours, rather than as an aberrant act by a deranged man (Gavey, 2005). This author asserted that in most cases, rape is perpetrated by men who are known to the women whom they rape, such as a boyfriend, a date or a husband, rather than a stranger or psychopath. Myths about rape which claim that women are raped because they enjoy it have contributed to the occurrence of rape (Morris, 1996).

Although rape is always an exertion of sexual violence against women (Brownmiller, 1975), the meaning and motivation behind it differ in times of peace and war. According to Bracken (2003), rape in peacetime is a signifier of male power signalling that women are not equal to men and highlighting the woman's social and physical vulnerability. Most rape survivors do not relate the rape to their position as women in society and as such, they perceive it as an accidental event, and thus implicitly a preventable occurrence. On the other hand, (Bracken, 1998b) highlighted that in wartime, the raping of women is part of male communication and what counts is not the suffering of rape victims, but the effect it has on men. In these circumstances, rape is a symbolic humiliation of the male enemy who are not able to protect their women (Gottschall, 2004). Gingerich and Leaning (2004) and commented that rape is an attempt to dominate, humiliate and undermine the enemy's morale. While rape during wartime is generally used as a weapon, its significance differs from one war to another. Indicated below are just a few of many instances of rape perpetrated in modern wartime.

Zuckerman (2004) reported that in World War I, the Germans used rape as a weapon to terrorise the Belgians. In 1937, Japanese soldiers raped Chinese women when they captured Nanking, the capital city of China, as a sign of their disrespect to Chinese people (Chang, 1997). In World War II, the Russian army raped German women in Berlin as an act of revenge (Cook, 2006). In Vietnam, American soldiers used rape to force the Vietnamese population into submission (Buss, 2009). In the Darfur conflict, in which the Sudanese government and the Janjaweed militia were opposed by the Sudan Liberation Movement/Army (SLM/A) and the Justice and Equality Movement (JEM), rape was used by both sides as a war tool against women, as reported by Fatuma Limeldin, the representative of the Darfur Women's Association (Kasasira, 2010). According to Amnesty International (2010a), in the current conflict in the Democratic Republic of Congo, women are regularly raped by the government forces and members of armed groups such as the Democratic Liberation Forces of Rwanda (FDLR) and the Mai Mai militia group. In a study seeking to understand the roots of gender-based violence in the DRC by examining the experiences and motivations of perpetrators, Kelly (2010) found that some commanders explicitly support rape, perceiving women as spoils of war. In Bosnia-Herzegovina in 1990, and Rwanda in 1994, rape was used as both a military strategy and a nationalist policy (Bryjak, 2009; Saha, 2009).

In the case of genocide, rape is a means of annihilation and sometimes a prelude to death (Weitsman, 2008). In such circumstances, rape is used as a weapon. It is a political event and therefore has a systematic and officially orchestrated aspect; it is not a random act, but rather carried out as a deliberate policy (Niarchos, 1995). Along the same lines, Henry, Ward and Hirshberg (2004) stated that rape in genocide is justified as part of an overall strategy intended at the annihilation of a race or ethnic group, or for other ideological objectives.

The Rwandan genocide that took place in 1994 was the result of tension that had built up over many decades between the Tutsi and Hutu. The government of Hutu majority organized a systematic annihilation of the minority Tutsi (Zegeye, 2010). In the ensuing genocide, women were both murdered and raped. Rape was used to meet the political goal of total destruction of the Tutsi, and even Hutu women who were married to, or affiliated with, Tutsi men were targeted because they could give birth to Tutsi children (Amnesty International, 2004). In only one hundred days, 800,000-1000,000 lives were lost (Amnesty International, 2004). Although the exact number of women raped is not known, in 1996, a special reporter on Rwanda from the UN (United Nations) reported that there were 250,000 women rape

victims (Human Rights Watch, 2004) and other sources estimated that 350,000 women and girls had been raped, the majority of them being Tutsi (Bijleveld, Morssinkhof and Smeulers, 2009).

The rape of Tutsi women was a clear step in the process of the extermination of the Tutsi as a group. This was shown by the intentional involvement of men affected with HIV/AIDS in the sexual violence. The Rwandan President, Paul Kagame, (cited by Landesman (2002: 6) said: *“We knew that the government was bringing AIDS patients out of the hospitals specifically to form battalions of rapists”*. In this way women were deliberately contaminated with HIV, which was one of the weapons of choice for destroying life, while inflicting maximum pain and suffering (Donavan, 2002). Many of these women were not only raped, but were deliberately maimed by machetes, spears and other weapons, which inflicted dreadful injuries, spreading contaminated blood from one victim to another (Kayitesi, 2006).

Although the rape of Rwandan women has been well documented, there are still limited empirical studies on its psychological outcomes. The few studies that are available, however, show that rape survivors were both physically and psychologically affected by their experiences. In a society like Rwanda, where women are valued according to their roles of wives and mothers, rape has become a form of perpetual torture. Once they have been raped, girls may feel that they are unmarriageable and women may be rejected by their husbands (Mukamana and Brysiewicz, 2008). Some rape survivors who became pregnant tried to kill themselves because they had been stripped of their dignity and their place in the Rwandan community as girls or wives (Mukamwezi, 2008). Women survivors who chose to raise their children paid the price of being shunned by their few surviving relatives (Kayitesi, 2006). Most stressful of all is the situation of a woman who has contracted HIV/AIDS and does not expect to live long enough to secure the future of her children (Mukamana and Brysiewicz, 2008). These rape survivors describe themselves as living dead, having enormous problems to endure, and bereft of any hope for the future (Mukamana and Brysiewicz, 2008).

Rape has been reported as one of the traumatic events most likely to lead to Post-Traumatic Stress Disorder (PTSD) (Harvey and Pauwels, 2000). Patel (2003) argues that rape is the one of the most severe acts of violence that a woman can experience. Marsella, Friedman, Gerrity and Scurfield (1996) and Kelley, Weathers, Murphy, Eakin and Flood (2009) note that exposure to extreme stress puts the individual at risk of developing disorders which differ according to the traumatic event. Human-made trauma has been found to generate severe

post-traumatic stress, which is often more difficult to deal with than stress caused by natural disasters. Brewin (2003) points out that these reactions to trauma can have multiple psychological effects and result in impaired functioning.

In the immediate aftermath of rape, victims may produce symptoms of Post-Traumatic Stress Disorder (PTSD) which, according to the *Diagnostic and Statistical Manual of Mental Disorders Text Revision* (DSM-IV-TR), falls into three categories: intrusive symptoms, avoidance symptoms and hyperarousal symptoms. With intrusive symptoms, the victims re-experience the traumatic event and have nightmares, flashbacks and recurrent thoughts. With avoidance symptoms, rape victims avoid any stimuli related to the trauma; social withdrawal and emotional numbing are common. Hyperarousal symptoms include increased emotional arousal, exaggerated startle response and irritability (American Psychiatric Association, 2000). Post-Traumatic Stress Disorder was defined by the American Psychiatric Association (APA) in 1980, in the third edition of the DSM, as a mental disorder with symptoms of distress related to an experience generally outside the range of usual human experience, such as serious threat to life or physical integrity (Brewin, Lanius, Novac, Schnyder and Galea, 2009). Rape, combat, confinement to a concentration camp and natural disasters were in the front line of the list (Nally, 2009).

Kelly et al. (2009) stress that the nature of the traumatic event leads to a unique pattern of psychopathology. The specific traumatic stress response of victims of rape was first identified in 1974 by Ann Wolbert Burgess and Linda Holmstrom, who coined the term “Rape Trauma Syndrome” (RTS) (Chappel, Geis and Gies, 1977). In the current literature, Rape Trauma Syndrome falls under PTSD related to situations of extreme stress. In addition to psychological damage, the victims of rape experience physical problems. There is a likelihood that survivors who were injured during the attack or threatened with death by the perpetrator or who have a history of prior assault will be at high risk of experiencing the long term-effects of PTSD (Hensley, 2002).

According to scholars, people can have different reactions to extreme trauma. Marsella et al. (1996) found that survivors of extreme trauma did not necessarily develop PTSD and that while some individuals might suffer serious effects from PTSD for many years, others would be free of almost all PTSD symptoms. Hassan (2003) considers trauma as a chapter in an individual’s life, maintaining that victims react to extreme trauma in accordance with what it means for them. According to Pauwels and Harvey (2000), extreme stress may contribute to



the development of useful coping strategies, whereby people may learn from negative events and find a new appreciation of life and recognition of what really is important, with a more positive view of their own possibilities and strengths (Bulman and Timko, 1987 cited in Harvey and Pauwels, 2000). From this perspective, survivors feel more competent in dealing with adversity.

However, given the vulnerability of traumatized rape survivors, failure to receive adequate support can be devastating for them (Russell and Davis, 2007). Pharmacological, psychological and social interventions have been identified that can help trauma victims who have not managed to resolve the trauma naturally to interpret their experience and thus heal (Marsella et al., 1996). In this regard, different approaches and best practice guidelines have been produced and approach modalities are available that have been specifically designed for the reduction of PTSD symptoms commonly experienced by survivors of rape. Some modalities are individual, while others are collective. Psycho education, exposure therapy, cognitive therapy and anxiety management were the multimodal approaches empirically supported (Hensley, 2002). Other interventions with positive results are individual counselling, family therapy, group therapies, hypnotherapy, drama therapy and pharmacological treatment. Narrative therapy, described by White and Epston, has also been found to be effective in healing rape trauma (White and Epston, 1990).

Based on studies of women who experienced sexual violence, Bracken (1998b) argues that the victims' perceptions of the social cultural environment in which the rape took place is crucial for recovery. He emphasizes that unless the context of the rape is considered, it cannot be understood and treated. It appears that most interventions have been developed from a western background and from a particular cultural orientation towards the individual suffering from rape, which may limit the relevance of those interventions for non-Western communities in relation to differences of understanding, expressions of extreme stress, help-seeking methods and models of coping (Bracken, 1998a).

Marsella et al. (1996) observed that normalised post-traumatic reactions led to best outcomes from trauma, maintaining that individuals from a stable family and a safe environment with community support are less vulnerable to PTSD than others as are those who come from a culture where open discussion of trauma is encouraged, survivorship is honoured and victims are not stigmatized. These authors argued that the meaning of trauma is not universal, that there are no shared features which unite all humankind, and that one culture cannot be made

truly intelligible to another. Bracken (2002) shared this view and emphasised that traumatic experiences undergone by individuals generate different responses and meanings depending on the culture in which they live. He argued that religion and cultural beliefs may differentially influence the meaning and subjective experience of trauma and the way the people recover from trauma.

Community support is a key value in the healing process of rape survivors. According to Herman (1997), trauma experiences lead to a sense of disempowerment and disconnection from the victims' perspectives. Hence their recovery is based on empowerment and creation of new connections. The same author argues that recovery from the trauma experience cannot occur in isolation; it emerges in the context of relationships where the survivors recreate the psychological facilities which have been damaged or deformed by the traumatic experience.

Bracken (1998b) argues that modern warfare not only destroys life, but also ways of life; it targets social and cultural institutions and deliberately damages the means whereby people would recover from the suffering of war. There are various associations operating in Rwanda, such as Ibuka, AVEGA, SEVOTA, Abasa and Duhozanye, that have been created by the genocide survivors, themselves, to help them overcome their trauma and other difficulties related to the genocide. According to Hassan (2003), associations created by survivors of atrocities allow them to restore their sense of belonging and to feel normalized in that group. Herman (1997) emphasizes that solidarity among victims of atrocities such as rape provides the strongest protection against terror, despair, shame and stigma.

## **1.2 PROBLEM STATEMENT**

After the genocide in Rwanda, many rape survivors were left alone after their husbands and children had been killed and their entire communities destroyed. Rape survivors of the genocide in Rwanda experienced multiple traumatic events and most of them suffered both psychological and physical wounds which continue to have an impact on their everyday lives (Mukamana and Brysiewicz, 2008). A study conducted early in 1999 by AVEGA (cited in (Zelaya and Fellow, 2009) established that among its members, 80% of the women surveyed were suffering from PTSD. The same association conducted another study in April 2004, testing 1,200 of its 25,000 members, and found that 80% had been raped and 66% were HIV-positive (AVEGA, 2004).

Cohen, Fabri, Cai, Shi, Hoover, Binagwaho, Culhane et al. (2009) conducted a study amongst Rwandan women on the prevalence and predictors of Post-Traumatic Stress Disorder and depression in HIV-infected and at-risk women and found that PTSD was common in both HIV-positive (58%) and HIV-negative women (66%). Women with HIV had a higher prevalence of depressive symptoms than HIV-negative women (81% vs. 65 %). The HIV-positive women, who had lower CD4, cell counts and a history of genocidal rape had more PTSD symptoms. In 2009, a study on the prevalence of PTSD at national level established that 26,1% of Rwandans suffer from PTSD, 66.07% of these being women and 33.93% men (Munyandamutsa, Nkubamugisha, Gex-Fabry and Eytan, 2012). These researchers argued that more women suffer from PTSD than men because so many of them had either been raped or widowed during the genocide.

As the public health and traditional healing infrastructures failed to survive the destruction of the genocide, there are often no resources available for the survivors to rely on (Ashoka and The International Center for Attitudinal Healing, 2008).

Rwanda faces an alarming shortage of health professionals to care for people suffering the consequences of the 1994 genocide. According to National Institute of Statistics et al. (2008) in 2006 the ratio of health workers to population in Rwanda was estimated to be one doctor for 50,000 inhabitants and one nurse for 3,900. These health workers are also unequally distributed, with 75% of the doctors working in Kigali, the capital city of Rwanda, where only 15%-20% of the entire population lives, and only 17% of the nurses being in rural areas.

The gap between the availability of professional services and the health needs of the population is especially wide in the area of mental health. Figures provided by the WHO in 2005 showed a ratio of 0.3 psychiatrists and 0.3 psychologists per 100,000 inhabitants. The ratio of psychiatric nurses was 0.8 per 100,000 inhabitants (WHO, 2005). Although the figures in 2011 show a slight improvement in the ratios of some mental health professionals, the numbers are still very low; being 0,05 psychiatrists; 0.07 psychologists; 1,3 nurses; 0.12 social workers and 0.02 occupational therapists respectively per 100.000 population (WHO, 2011).

With the lack of health professionals and the insufficiency of resources, the mental health needs of the Rwandan population are not being met, and those who are vulnerable, such as rape survivors, are the most affected (Ashoka and The International Center for Attitudinal

Healing, 2008). Furthermore, there is a risk of transmitting trauma to future generations unless adequate relevant interventions are initiated (Levers, Kamanzi, Mukamana, Pells and Bhusumane, 2006).

I carried out a phenomenological study in 2004 for my Master's Degree and explored the lived experience of rape survivors following the 1994 genocide in Rwanda. The study examined how women rape survivors have been affected by their experience, and their view of womanhood. The study also explored how they have dealt with the experience. Results showed that these women had various different physical and socio-psychological problems. They were greatly concerned about their HIV-positive status and the future of their children born of rape. Despite those problems, however, some women succeeded in maintaining normal functioning. The women genocide survivors created associations in their communities which offer support to one another to resolve some of their problems (Mukamana and Brysiewicz, 2008). Hughes (2008) noted that within the communities there are skills, strengths and resources, such as supportive relationships, community capacity, committed leaders, and community-based organizations, which enable those living there to address problems and support health interventions.

The previous study highlighted the psychological effects of rape amongst women survivors of the genocide yet, to date, no research has been conducted on the management of the long term psychological effects of rape amongst women survivors. Therefore, to address this gap, this study has developed a middle range theory from the suggestions of women rape survivors and their community members to inform how the long-term psychological effects of rape could be managed.

### **1.3 PURPOSE OF THE STUDY**

The purpose of this study was to explore the long term psychological effects of rape experienced by women as a result of the 1994 genocide in order to develop a middle range theory that will guide the management of these psychological effects among women rape survivors.

### **1.4 OBJECTIVES OF THE STUDY**

- Explore what long-term psychological effects women survivors are experiencing as a result of being raped during the 1994 genocide in Rwanda;

- Explore the perceptions of community members regarding the long-term psychological effects of rape on women survivors of the 1994 genocide in Rwanda;
- Analyse the factors influencing the risk and protecting factors of long term negative psychological effects of rape amongst women survivors;
- Identify what support is available to rape survivors to help them manage their long-term psychological effects of rape; and
- Develop a theory for the management of long term psychological effects of rape in the context of post-genocide Rwanda.

### **1.5 RESEARCH QUESTIONS**

- What long term psychological effects were women rape survivors experiencing as a result of being raped during the 1994 genocide in Rwanda?
- How did community members perceive the long term psychological effects suffered by women who had been raped during the genocide?
- How did reactions of community members enhance or inhibit the management of the long term psychological effects of rape amongst women survivors?
- What factors helped the women to manage the long term psychological effects of rape and what factors put them at risk?
- What support is available to assist women in dealing with their long term psychological effects of rape?
- What theory emerged from the data to assist the management of long-term psychological effects of rape amongst women survivors?

### **1.6 SIGNIFICANCE OF THE STUDY**

There is an abundance of literature in the field of war rape purporting political and human right perspectives (Haddad, 2011; Amnesty International, 2010a; Donnah, 2003; Schiessl, 2002; Askin, 1999) and interventions to care for rape survivors in peace time are well documented (Russell and Davis, 2007; Brahm, 2004; Russell, 1975). Survivors of rape in war and genocide often experience trauma and other forms of mental health distress (Ward and

Marsh, 2006; Gingerich and Leaning, 2004). The different views of scholars in existing literature have highlighted the complexity and controversy of war related trauma. While some researchers like Pedersen (2002), Summerfield (2001) and Bracken (1998b) have suggested that the trauma of political violence should be approached as a normal psychosocial response, others have conducted research on war trauma, PTSD and other trauma-related disorders to determine and verify the effects that violent conflicts have had on the mental health of those affected (Kienzler, 2008).

However, while consideration has been given to the impact of war rape amongst victims, relatively little attention has been given to the development of theory which specifically explains the long terms psychological effects of rape on victims in the Rwandan genocide context and proposes an appropriate management thereof. This study could contribute to the body of knowledge on the long-term psychological effects of rape and how they are managed in the post-genocide context, since little is presently known in this domain. The theory that emerges from this study could guide mental professionals in the care of rape survivors. It might also inspire the Ministry of Health in Rwanda to design a specific health policy for rape survivors.

The developed theory may be included in the Rwandan curriculum for mental health nurses and other health professionals as it provides knowledge on the long term psychological effects of rape and can be used as a guide as to how those psychological effects can be managed.

## **1.7 OPERATIONAL TERMS**

### **1.7.1 Genocide**

The term genocide was coined in 1944 by the Polish-American jurist, Raphael Lemkin. He combined the Greek root *genos* (race) with the Latin root *cide* (killing) to define "genocide" as any attempt to physically or culturally annihilate an ethnic, religious or political group. In 1948, the United Nations Genocide Convention defined genocide as any of the following acts committed with intent to destroy, in whole or in part, a national, ethnical, racial or religious group, as such:

- *Killing members of the group;*
- *Causing serious bodily or mental harm to members of the group;*

- *Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;*
- *Imposing measures intended to prevent births within the group;*
- *Forcibly transferring children of the group to another group* (Madley, 2008: 303).

In this study, *genocide* refers to the events of 1994 in Rwanda, where the Rwandan government, with a majority of the Hutu group, intentionally attempted the complete destruction of the Tutsi minority.

### **1.7.2 Rape**

Rape is defined as non-consensual oral, anal or vaginal sexual penetration of a woman with use of threat or physical force, or when the victim is unable of giving consent (Brierre and Scott, 2006).

In this study, rape is defined as sexual violence committed against Rwandan women during the genocide in 1994 which was carried out under coercive circumstances by a single man or groups of men using their penises or other objects for vaginal penetration or mutilation of the women's genitals.

### **1.7.3 Women survivors**

For the purpose of this study, a woman survivor refers to any woman who survived the 1994 Rwandan genocide having been subjected to sexual violence during this period.

### **1.7.4 Long-term psychological effects of rape**

The long-term psychological effects of rape are chronic problems lasting more than six months to indefinite duration in relation to fear, anxiety, social adjustment, sexual functioning, low self-esteem and depression (Davis, Lurigio and Skogan, 1997). In this study, they also include continual suffering in thoughts and feelings related to the painful memories of rape and changed behaviours which result in the impaired functioning of the rape survivors.

### **1.7.5 Middle range theory**

Middle range theory is defined as sets of concepts or ideas which propose specific outcomes. It is based on propositions or relationship statements that are consistent with the theoretical

works from which they are derived (Smith and Liehr, 2008). According to Glaser and Strauss (Glaser and Strauss, 1999), middle range theory or substantive theory is grounded in research on one specific area and only applies to that particular area. In this study, the middle range theory is composed of interrelated concepts reflecting the long term psychological effects of rape, its influential conditions and how they have been addressed in order to facilitate the psychological management of women rape survivors of the 1994 Rwandan genocide.

#### **1.7.6 Community members**

Community members are individuals living together in defined geographic areas with common values and interests, who interact with each other and whose members are known to each other (Stanhope and Lancaster, 2000). In this study, community members refer to the men and women who were living in the same villages or towns as the women rape survivors, interacting with them and who were aware of their health and daily living conditions.

### **1.8 CONCLUSION**

This chapter has presented the background of the study and has highlighted the meaning and the motivation of rape from different scholars' points of view. It is apparent that although rape occurs in peace time as well as war time, its rationale is different. Rape as a weapon of genocide intends the annihilation of the target group. For those who survived the genocide, rape was a traumatic experience which affected the victims physically, psychologically and socially. The psychological aftermath of their rape experiences was devastating because when rape is used as a weapon of war or genocide, the sexual assault also involves the threat of death. The recovery of each woman depends on her own strength and the support she receives from her surrounding community. While for some the immediate effects of rape may resolve rapidly, for others they may remain for a long time. Different approaches have been developed to help rape survivors overcome their problems. Available information of the psychological problems of rape survivors, specifically in Rwanda, has been outlined, the purpose, objectives and research questions have been presented and the usefulness of the study has been explained.



## **1.9 THESIS OUTLINE**

This thesis is outlined as following:

**Chapter one** describes the background of the study, the problem statement, the purpose of the study and the research objectives and questions, as well as the significance of the study and the operational terms.

**Chapter two** presents the methodology and explains the research paradigm and design that were used in this study and describes the research setting and participants, as well as the data collection and data analysis process. It also includes the trustworthiness of the study, ethical considerations and data management.

**Chapter three** presents the findings using the paradigm model developed by Strauss and Corbin (Strauss and Corbin, 1990).

**Chapter four** presents the literature review of the background of the genocide against the Tutsi, post-genocide context, themes related to theories of rape, the outcomes, protecting and risk factors along with therapeutic interventions.

**Chapter five** includes the discussion of the findings.

**Chapter six** is the closing chapter. It explains the middle range theory developed, recommendations, limitation of the study, the conclusion and personal reflections.

## **CHAPTER TWO: METHODOLOGY**

### **2.1 INTRODUCTION**

This chapter describes the research methodology, the research setting and the participants. An interpretivist paradigm was adopted, and a qualitative design using a grounded theory approach guided this study. The sample selection was purposive and theoretical sampling was used. Data collection and the data analysis process are explained, as well as trustworthiness, ethical considerations and data management.

### **2.2 INTERPRETIVIST PARADIGM**

An interpretivist paradigm assumes that reality is not objectively determined, but is socially constructed through experiences and interpretations (Sarantakos, 2005). The interpretivism tradition focuses primarily on the place of subjectivity, and was developed by social scientists from Kant's idealist position, which stipulates that the world exists only in the way people think it exists (Seale, 1998). Thus, interpretivist research methods adopt the position that knowledge of reality is a social construction by human actors (Walsham, 2001). This author asserts that the interpretivist paradigm looks for culturally derived and historically situated interpretations of the social life world. Its understanding relates to the views, opinions and perceptions of people as they are experienced and expressed in everyday life (Sarantakos, 2005).

This paradigm was appropriate for this study as it allowed the understanding of the experiences and perceptions of the long-term psychological effects of rape as expressed by the rape survivors themselves and their community members. This was key to building a theory which not only reflects the real psychological effects of rape experienced by women survivors, but also proposes actions to assist them in dealing with those problems. Maree (2007) emphasizes that the aim of interpretivism research is to offer a perspective of a situation and to analyse the situation under study to provide insight into the way in which a particular group of people make sense of their situation or the phenomenon they encounter. Thus, the theory that emerged in this study might offer a perspective on how best to manage the psychological consequences of rape.

Guided by this paradigm, I was aware that the meaning I held of on rape differed from those held by the participants. Even although I shared the same culture as the research participants,

we don't have the same background, and the history of each person influences the way she/he views the world. Therefore, I placed emphasis on interaction and the exchange of ideas, and avoided imposing my own views on the participants. I thus attempted to set aside any preconceived knowledge and have made every effort to be open, sensitive and empathetic to the participants' responses.

### **2.3 QUALITATIVE DESIGN**

A research design refers to a strategic plan that specifies how the research is going to be conducted and the way in which it will answer the research questions (Terre-Blanche, 2006). A qualitative research design has been used in this study. Qualitative research is a systematic, subjective approach which allows researchers to explore the depth, richness and complexity inherent in the phenomena under study (Burns and Grove, 2009). Qualitative researchers assume that there is no objective reality, but rather that there are multiple realities constructed by human beings according to their perceptions of a phenomenon in a given context (Krauss, 2005). Accordingly, qualitative research focuses on how individuals and groups view and understand the world and construct meaning out of their experiences (Maree, 2007).

In order to discover this subjectivity or intended meaning, researchers have to empathize with the research participants and appreciate the purpose, motives and causes that underlie those meanings (Krauss, 2005). The goal of qualitative investigation is to understand the complex world of human experience and behaviour from the point of view of those involved in the situation of interest (Maree, 2007).

Therefore, in this study, I was not expected to have a pre-existing conceptualization of the long term psychological effects of rape amongst women survivors as the conceptualization should rather emerge from my interactions with the rape survivors and their community members.

### **2.4 GROUNDED THEORY APPROACH**

Grounded theory, which was followed in this study, is an approach developed for the purpose of studying social phenomena from the perspective of symbolic interactionism (Glaser and Strauss, 1999).

According to the symbolic interactionist view, individuals develop their own actions in relations to others; they take account of each other's behaviour, and interpret and respond to it (Denscombe, 2007). Thus, perceptions and actions are shaped by individual's definitions of reality and the meanings they give to it (Gerrish, 2006). Symbolic interactionism holds that people are in a continual process of interpretation and definition as they move from one situation to another (Eaves, 2001).

Grounded theory is used for the study of human interaction and focuses on particular settings to generate theory. It tells what is going on, accounts for participants' main concerns and reveals variables that may give rise to change (Glaser and Strauss, 1999). The grounded theory approach emphasizes the importance of empirical fieldwork and the need to link any explanations very closely to what happens in practical situations in the real world (Denscombe, 2007). Grounded theory is largely used by nurse researchers to study care systems as it solicits the actors' perspectives (Kearney, 2009).

The choice of using the grounded theory approach in this study was based on its emphasis on participants' perceptions and on its systematic way of collecting and analysing data. Once I had been into the field and had met the participants in their real context, guided by grounded theory, the interpretivist paradigm and qualitative design, I was able to establish how women survivors interpreted the long-term psychological effects of rape and how the communities perceived these women. At the same time, the participants in this study, who were intimately involved in the situation, offered various suggestions which they believed would assist rape survivors in managing their psychological effects related to rape.

Grounded theory, the interpretivist paradigm and qualitative design have strong compatibilities as their theoretical perspectives maintain that knowledge should emerge out of the local context and should privilege the voice of the participants, taking into account what they say, do and feel and how they make meaning of their everyday lives (Bryant and Charmaz, 2010).

## **2.5 DIFFERING VERSIONS OF GROUNDED THEORY**

There are different tendencies within grounded theory and the two versions from the originators of grounded theory are explained in this report. Grounded theory, a qualitative research approach dedicated to generating theories, was initiated by Barney Glaser and Anselm Strauss, as set out in their 1967 book, *The Discovery of Grounded Theory*.

Initially, this approach was used mostly in the field of sociology for the purpose of studying social phenomena. Since then, grounded theory has been expanded into other areas such as psychology, management and nursing (Goulding, 2002). Grounded theory uses a systematic set of data collection and analysis procedures to develop theory from the data (Bryant and Charmaz, 2010; Corbin and Strauss, 2008). Following their initial development of the methodology, Glaser and Strauss subsequently moved in somewhat different directions. This divergence reflects two tendencies that coexist in the grounded theory approach (Denscombe, 2007). Goulding (2002), therefore, advises researchers who are using grounded theory to specify if they are following the Glaser and Strauss version or the Strauss and Corbin version.

The conflict started with Strauss's publication of his book, *Qualitative Analysis for Social Scientists* (1987), followed in 1990 by *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*, which he produced in conjunction with Juliet Corbin (Strauss and Corbin, 1990). The divergence hinges mainly on the new way of coding introduced by Strauss. Strauss provides a detailed framework which attempts to help the researcher to make sense of the data and to interpret the data in a systematic way (Corbin and Strauss, 2008; Denscombe, 2007). From the raw data, the researcher starts with open coding and then moves on to axial coding and then selective coding to arrive at the concepts which form the cornerstone for the generation of the theory (Strauss and Corbin, 1990).

The innovation by Strauss and Corbin is the coding paradigm involving conditions, context, action/interactional strategies and consequences (Eaves, 2001). Glaser strongly disagreed with Strauss and Corbin's framework for analysis and saw it as a way of going against the guidelines of grounded theory by "forcing" categories and codes into the data rather than letting them naturally "emerge" (Denscombe, 2007; Glaser, 1992).

Another difference between Glaser and Strauss appears in the way they view the construction of the research process. They have differing viewpoints on the sources of the research questions, the use of literature and the process of data collection and analysis. According to Glaser, the research question may arise from the data (Glaser and Strauss, 1999), whereas Corbin and Strauss (1990) advise the researcher to develop the research question at the beginning of the study, which will help in bringing focus to bear on the phenomenon under study.

Even although both Glaser and Strauss advise the researcher not to read the literature on the areas of the study too exhaustively before commencing the research so as not to interfere with personal insights, Strauss believes that the literature may assist in the design of the study itself and in the development of the research questions. Glaser, on the other hand, argues that designing the research questions at early stage of the study may constrain the natural emergence of the theory (Glaser and Strauss, 1999).

In this study, I followed Strauss and Corbin's (1990) version of grounded theory as it offered a clearer and more systematic way for the novice researcher to begin collecting and analysing data and then move towards developing concepts with the end objective of building an explanatory theory on the management of the long term psychological effects of rape amongst women survivors of the 1994 genocide.

Grounded theory appeared to be suitable for building a theory as this study intends to do. Chinn and Kramer (1999) stated that the development of theory requires well developed conceptual meaning and sufficient structure to adequately represent the relationships within their scope. The theory process involves explaining and structuring empirical knowledge to enable scientific competence in practice.

## **2.6 RESEARCH SETTING**

The research was carried out in Rwanda, more specifically in the Kamonyi district. Rwanda is a landlocked country in Central Africa, situated in the Great Lakes region. It is bounded in the east by Tanzania, in the west by the Democratic Republic of Congo, in the south by Burundi and in the north by Uganda (MINALOC, 2010). Rwanda's landscape is mainly constituted by high hills and for this reason it is named "The Country of a Thousand Hills". The Republic of Rwanda is divided into provinces, districts, sectors, cells and villages. The population of Rwanda was estimated at 9.31 million inhabitants, with a surface area of 26,338 km<sup>2</sup> and an average density of 368 inhabitants per km<sup>2</sup>. An estimated 52.2% of the population are female and 47.2 % are male. Eighty per cent of the population live in rural areas and are engaged in agriculture (National Institute of Statistics et al., 2008).

Kamonyi District is one of the thirty districts that make up the Republic of Rwanda. It is located in the central region of the country as it is shown in figure 1 below.



**Figure 1** : A map of Rwanda (MINALOC, 2010).

Kamonyi is composed of 12 sectors: Gacurabwenge, Karama, Kayenzi, Kayumbu, Mugina, Musambira, Ngamba, Nyamiyaga, Nyarubaka, Rugalika, Rukoma and Runda. It has 59 cells and 317 villages. The number of inhabitants is 265,365 on a total surface area of 655.5 km<sup>2</sup>. The average population density is 404.8 inhabitants per km<sup>2</sup> (MINALOC, 2010).

I chose to carry out my study in the Kamonyi district because it includes both urban and rural areas. In Rwanda, the few existing mental health programmes and mental health workers are located in the cities and most of them are concentrated in Kigali, the capital city of Rwanda. Urban women, therefore, are more likely to find access to assistance than rural women (Zelaya and Fellow, 2009). In order to have a general perspective on the long-term psychological effects of rape and on its management, I felt that it was important that rape survivors from both urban and rural areas, together with members of their communities, should have an equal opportunity to express their ideas on those mentioned issues.

The members of Solidarité pour l'Epanouissement des Veuves et des Orphelins Visant le Travail et l'Auto-promotion (Network for the Development of Widows and Orphans to Promote Self-Sufficiency and Livelihoods), commonly referred to as SEVOTA, from which the initial participants were recruited, are spread across the country. They can be found in Huye in the South; Bugesera and Kirehe in the East and Musanze in the Northern Province. The main branch of SEVOTA is at Remera Rukoma, where it originated. The majority of its members live in the Kamonyi district, mostly in the sectors of Gacurabwenge and Rukoma. The participants were selected from these two sectors as Gacurabwenge is a rural area and Rukoma is an urban area. The head office of the Kamonyi District is located in Rukoma

## **2.7 RESEARCH PARTICIPANTS**

The population of this study were members of the association, SEVOTA, and their surrounding community members, located in the Kamonyi district, especially in the two sectors of Rukoma and Gacurabwenge.

SEVOTA was chosen because its members who had been raped were willing to talk freely about their experience of rape. Women members of SEVOTA contributed in documenting crimes of sexual violence during the genocide. Their testimonies at the International Criminal Tribunal for Rwanda (ICTR) created an historic legal precedent on 2 October 1998, when, for the first time in the history of war rape, a sentence was imposed for sexual violence



perpetrated in the context of civil war, and rape was recognized as an act of genocide and torture (Mukasarasi, 2007a).

SEVOTA was also chosen as it aims to help its beneficiaries; widows, orphans, women victims of rape, and their children; to organize themselves in order to analyse their own problems and those of the community and find appropriate solutions. In addition, research is one of the key activities of SEVOTA (Mukasarasi, 2007b). I, therefore, assumed that these women would be happy to volunteer to participate in the study and give relevant information which could be used in building the theory.

Members of the communities where rape survivors were living were also included in the study because their views might be important in understanding the long term psychological effects of rape and its management.

## **2.8 SAMPLE SELECTION**

According to (Burns and Grove, 2009), qualitative research is conducted to gain insights and discover meaning about a particular experience or situation. The researcher attempts to select participants who can provide extensive information about the experience or situation to be studied. This study used purposive sampling with snowball and theoretical sampling.

### **2.8.1 Purposive and snowball sampling**

Burns and Grove (2009) assert that participants who are well informed and communicative are able to share rich data in a clear and concise manner. In purposive sampling, the researcher selects specific participants who are knowledgeable about the area of study and who will thus be able to impart relevant information (Sarantakos, 2005). Polit and Beck (2008) encourage researchers to combine purposive sampling with snowballing when the topic is sensitive and it is not easy to have access to participants.

In order to obtain rich data for this study, selection was restricted to women from the SEVOTA association who had been raped during the 1994 genocide in Rwanda, as well as adult men and women over 21 years old who were living in the same community and interacting on daily basis with rape survivors.

In accordance with the process of snowball sampling, after the first participants had been interviewed, they referred me to other informants once they knew what information I was

seeking. In this manner, I got access to the best respondents about the phenomenon under study, and the women rape survivors from SEVOTA, along with men and women of their communities, contributed a great deal to this current study by giving rich and relevant information as they talked about their experiences. This information not only reflected the long term psychological effects suffered by the rape survivors, but also included propositions of how to deal with them in the form of various solutions offered by the participants.

### **2.8.2 Theoretical sampling**

Corbin and Strauss (2008) stated that theoretical sampling is a method to collect data based on concepts derived from data. The focus in theoretical sampling is on data collection rather than the choice of respondents (Sarantakos, 2005). When researchers wish to sample theoretically, they have to find places, persons and situations that provide information about the concepts they want to learn about (Corbin and Strauss, 2008). These authors added that the rationale of theoretical sampling is to collect data that will maximize opportunities to develop concepts in terms of their properties and dimensions revealing variations and making out relationships between concepts until data saturation occurs. As suggested by (Corbin and Strauss, 2008; Denscombe, 2007; Sarantakos, 2005; Glaser and Strauss, 1999), I continued to collect data for as long as the addition of data contributed to the development of properties of the codes, categories and concepts. Theoretical sampling was chosen in the present study as it responds to key criteria of data saturation in the course of theory development through grounded theory. Thus, data was collected until no more new data was coming out, a principle of saturation (Corbin and Strauss, 2008).

## **2.9 DATA COLLECTION PROCESS**

Interviews were used to purposefully collect data from the selected participants. Individuals interviews were preferred to other techniques of data collection due to the sensitivity of the topic, as recommended for a sensitive subject such as rape (Nigel, 2008). Individual, in-depth interviews, lasting between 45 minutes and one hour, were conducted, based on interview guides with open-ended questions. Kinyarwanda, the mother tongue of the participants was the language used in the interviews. Therefore the interviews guide for both rape survivors and their community members were translated from English to Kinyarwanda, (Annexures 10 and 11 are interviews guide for rape survivors in English and Kinyarwanda version, while Annexures 12 and 13 are interviews guide for their community members in two mentioned

versions). These interviews guide with open-ended questions allowed the participants to talk more widely on the issues I raised. This was used as a starting point and following questions were asked according to the concepts raised as relying only on interview guides would limit the amount and type of data to be collected (Corbin and Strauss, 2008).

I used probing questioning to get an in-depth understanding of the phenomenon under investigation and to clarify any ambiguous statements by the respondents, whose answers were developed in their own words, length and depth (Burns and Grove, 2009; Denscombe, 2007). The interviewer should be equipped with the necessary skills to collect data through in-depth interviews. I have previously collected data amongst rape survivors for my master degree's study and have also conducted therapeutic interviews on a regular basis in my profession as a mental health nurse. I, therefore, felt comfortable to conduct the in-depth interviews in this study.

With the permission of the participants, a digital voice recorder was used to record the interviews. This ensured the accuracy of data by allowing me to concentrate on the participants' storytelling and not be distracted by taking notes and missing important information.

According to Sarantakos (2005), by using the grounded theory approach, with theoretical sampling and on-going process of data collection, as is the case in this study, the researcher is required to choose the first respondent, collect relevant information and knowledge about the study, and on the basis of this decides who the next informant will be. Corbin and Strauss (2008) suggest to start data collection with a general target population and continue to sample from that group.

This study involved three groups of participants with different backgrounds from each of the two communities; women who had been raped during the genocide, women from the same community who had not been raped and men from the same community. The first group to be interviewed in the study was the women rape survivors, since they were the most well-informed on the phenomenon under study. The second group consisted of the women who had not been raped and the third was composed of men. A total of twenty-nine (29) participants were interviewed although fifty one (51) interviews were conducted. These included twelve women, who had been raped, and ten women and seven men who lived in their communities. The first twenty-nine individual interviews were for collecting data.

However, only 19 of these participants were available for the subsequent interviews to verify the transcribed data. Therefore, to accommodate those who were missing, the hard copy of their interview transcript was left in a closed envelope to be checked by them and these were later collected. The second set of interviews gave participants opportunities to make corrections and comment about the previous interviews, while at the same time allowing me to collect additional information. Lastly, a final interview was organized with each group to verify if the draft of the diagram representing the management of long term psychological effects of rape did reflect what they had told me.

Data collection lasted for a period of ten months, starting from mid March 2011 to January 2012. I found it quite easy to collect data from rape survivors I met at SEVOTA, where they were coming to attend to their usual activities. However, I found it more difficult to collect data from the community members as they were not always available as a result of having to respond to unpredicted obligations in their communities. We managed to resolve this problem by giving the participants my contact details so that they could call me once they were available. Interviews with community members took place at one of the offices of the public facilities, such as at the district, sector or health facilities.

As the issue of gender may influence the perceptions and responses related to rape survivors, men and women in the community were interviewed separately and at different times. The data collection amongst the three groups of participants is described below.

### **2.9.1 Data collection from women rape survivors**

These women all belonged to the association, SEVOTA. Prior to data collection, I visited SEVOTA's headquarters in the Kamonyi district at Remera-Rukoma and received information from the coordinator about the background of members, the different activities they carry out and the calendar of their meetings. According to the rules of SEVOTA, one of groups, Urunana, has its general assembly at Remera-Rukoma, the site of this study, on the 5<sup>th</sup> day of each month and women from the mentioned rural and urban sites attend this monthly meeting.

I therefore attended the meeting on the 5<sup>th</sup> March 2011. At its closure, the coordinator of SEVOTA introduced me and invited the women to participate in this study. Those who volunteered to participate suggested that they be interviewed at SEVOTA on the days of their weekly activities, which took place on Wednesdays and Fridays. I therefore attended on these

days to meet with the women who were willing to talk to me and who had given me appointments for interviews during the period of data collection. However, some women missed the appointments and I had to return to SEVOTA several times to meet with them.

The first time I attended one of these meetings, the women were making baskets and I was invited to join the activity. The women were surprised to learn that I couldn't make a basket as, according to their understanding, every Rwandan woman should know how to make a basket. After laughing at me, they taught me the procedure and seemed happy with my performance during the following days. Each activity began and ended with prayers, dances and songs. As stated by Corbin and Strauss (2008), this close contact with the participants allowed me to collect rich empirical data on which the theory was grounded. I observed that when the women were engaged together in different activities, such as weaving baskets or making other hand crafts, the way in which they were interacting, sharing their everyday lives, giving advice, suggesting solutions to problems arising from one of the members, and joking and laughing, showed the close relationships they had with each other. SEVOTA had become their new family, as they stated later in the interviews.

At the end of data collection with rape survivors, I informed them about the following step of my study which involved interviewing leaders of their community, men and women who had not been raped, with whom they were in close contact. I was of the opinion that these people were involved in the everyday lives of the rape victims and would, therefore, be in a position to give relevant data which would give another perspective in the understanding of the psychological consequences of rape and its management.

However, the rape survivors were uncomfortable with the idea of involving village leaders as the women were worried that their anonymity would be breached once I came to their village as they were very well known and everyone knew their history. Everyone in the village knows each other and the village leaders are expected to be informed about any issue related to the problems or the wellbeing of the village inhabitants. To respect the will of the women rape survivors, further participants were recruited from the sector level rather from the village level.

### **2.9.2 Data collection from women who had not been raped**

The Rwandan government institutions are divided in six levels starting at the bottom with the village, followed by the cell, sector, district and provinces, with the Central government at the top level (Ministry of Local Government, 2008).

From a meeting with the vice-mayor (the name given to the second administrators of district level) in charge of social affairs in the Kamonyi district, I learnt that the data needed for the study may be obtained at the sector level. The employees of the sector are well connected to the people from the village and are aware of what is going on there, as they manage the community services and are in the frontline for participatory problem analysis and solving (Ministry of Local Government, 2008).

While recruiting these participants, the rape survivors' concern of confidentiality was taken into consideration and I started meeting different people on an informal basis to find suitable participants who could provide rich information on the phenomenon under study.

Therefore, instead of interviewing the village leaders, as was stipulated in the proposal of this study, employees of the Rukoma and Gacurabwenge sectors were the first to be interviewed, followed by other members of the community who had key roles in dealing with the problems of rape survivors.

The vice-mayor mentioned above facilitated the process by giving me the contact details of women who would be able to help me with relevant information for my data collection. The inclusion criterion for those women to be part of study was that they had regular interaction with rape survivors.

### **2.9.3 Data collection from men**

The snowballing procedure facilitated the access to participants for this group as some of their names were suggested by the informants of the previous group (Polit and Beck, 2008). The interviewed men were in close contact with rape survivors, either as neighbours or because they were employed by the sector which was dealing with the problems of rape survivors.

While the research was in progress, it was suggested that key informants at the district level should be interviewed, as these employees were responsible for addressing the needs of

vulnerable citizens, which included rape survivors. The inclusion of any participant who can contribute rich information to this study was in accordance with the principles of theoretical sampling, which are flexible. There is flexibility in theoretical sampling because the analysis indicates where to collect data that will respond to questions which arise during analysis (Corbin and Strauss, 2008). The logic followed in this process was also supported by Sarantakos (2005), who stated that while using grounded theory, settings and respondents may change according to the way in which the research progresses. Therefore, the participants of this group came from the sector as well as from the district because this gave an overview on how the psychological consequences of rape are perceived and addressed by different institutions in Rwanda.

## **2.10 DATA ANALYSIS**

Analysis is a process which builds on the acquisition of data from which concepts are generated, developed and verified (Corbin and Strauss, 2008). According to Creswell (2009), there are diverse ways of analysing data and these depend on the methodology which has been used. In this study, the Strauss and Corbin paradigm model (Strauss and Corbin, 1990), was used to analyse data. This paradigm has the following six components: causal conditions, phenomenon, intervening conditions, context, actions/interactions/strategies and consequences. Causal conditions or antecedents refer to events or incidents that lead to the occurrence of the phenomenon, which is the central idea to which the set of actions is related (Strauss and Corbin, 1990). Context is defined as structural conditions that shape the nature of situations, circumstances or problems to which individuals respond by means of actions, interactions or strategies. In Strauss and Corbin's language, strategic actions are goal oriented activities to solve problems, while actions and interactions are responses made by individuals or groups to situations, problems, happenings and events. Consequences are outcomes of actions or strategies in response to the raised problems or happenings (Corbin and Strauss, 2008).

The constant comparative method was used throughout the process of data collection and analysis. This refers to the constant comparison and contrasting of the data (Maree, 2007). Denscombe (2007) stated that the constant comparative method aims to compare and contrast new codes, categories and concepts as they emerge. Concepts are ideas, thoughts or notions conceived in the mind. Words are interpretations or products of analysis that represent the idea contained in the data (Alligood, 2010). According to Corbin and Strauss (2008),

concepts are words that stand for groups or classes of objects, events and actions with similar properties; categories are high level concepts under which low level concepts with the same characteristics are grouped; and codes are key words that allow the data to be gathered.

The comparative method helped me to differentiate one category from another and to identify properties and dimensions specific to that category (Corbin and Strauss, 2008). Properties are characteristics that define and describe the category, while dimensions are variations within properties that give specificity and variety to a category (Strauss and Corbin, 1990). Furthermore, the constant comparative method helped me to refine the codes, categories and concepts by highlighting the similarities and differences that exist between codes and categories. According to Strauss and Corbin (1990), data analysis in grounded theory is primarily a continuous coding process with three phases; open coding, axial coding and selective coding. The analysis started with open coding, the first basic analytical step, without which the rest of the analysis couldn't take place (Strauss and Corbin, 1990).

### **2.10.1 Opening coding**

Open coding is the process of breaking down the data into different parts according to its meaning. This first step of analysis serves to name and categorize the phenomenon with the main purpose of conceptualizing and labelling the data (Goulding, 2002; Strauss and Corbin, 1990). In line with the principles of the grounded theory approach, data collection was carried out concurrently with data analysis (Corbin and Strauss, 2008). Therefore, the analysis of data started immediately after the first interview and the first concepts were generated. After each interview, I listened attentively to the voice recorder, transcribed the interview myself, read it through carefully and then started the coding. This process allowed me to listen to what the participants were saying and to capture what they were experiencing (Corbin and Strauss, 2008).

In addition to coding, I also took notes in order to elaborate my ideas about the data and the coded categories as my way of recording my impressions and describing the situation. These are known as memos (Creswell, 2009). Goulding (2002) argues that memos are crucial because they provide a bank of ideas when it comes time to draw the theory.

During open coding, the data was analysed line by line and each phrase was closely examined to make sure that nothing important was overlooked. This procedure facilitated the generation of concepts, which was the basis for theoretical sampling as these concepts were compared



for similarities and differences with the next data that was collected. During this initial step of data, each code was labelled by a concept representing the meaning of the data coded, which were derived from words used by the participants or from my knowledge of my professional experience as suggested by (Corbin and Strauss, 2008). Once several categories had emerged, the open coding was made by sentence, then later by paragraphs around the sorted categories. NVivo 9 and 10 software assisted in this process (see Annexure 15). Alternating data collection and data analysis allowed me to work closely with the participants and the data. By doing so, the data which first appeared meaningless to me, later became more significant as it was expressing the concern from the perspectives of the participants. As indicated by Corbin and Strauss (2008), it is the perceptions of the participants that matter and not those of the researcher.

As the analysis progressed categories and codes were integrated under common headings. Codes, categories and concepts were developed with constant reference to the fieldwork data, and this process continued until data saturation (Corbin and Strauss, 2008; Denscombe, 2007). From the descriptions emanating from the data, I moved to explaining the relationship between and across incidents, a coding technique known as axial coding, which involves the process of abstraction onto a theoretical level (Glaser and Strauss, 1999).

### **2.10.2 Axial coding**

Axial coding is a procedure which consists of putting the data which has been broken apart during open coding together again and making connections between the categories (Brown, Stevenson, Troiano and Schneider, 2002; Strauss and Corbin, 1990). When the step of axial coding was reached, I reviewed all the categories. Those that were not related to the lasting psychological effects of rape amongst women survivors, the factors that influenced these effects, both positive and negative, and suggestions on how they could be managed were ignored, while those that did were carefully checked for a potential combination. This analytical process leads to category reduction. From the long list of categories that developed from open coding, those categories which had meaningful relationships were collected together under a broader concept in ways that the relationships were shown (Brown et al., 2002).

Thus, each category, according to its meaning, was related either to the causal conditions, the phenomenon, the context, the intervening conditions, the actions, interactions or strategies or

the consequence. The Strauss paradigm model used in this study facilitated in that process as it has the advantage of making the connections between categories more visible through the conditions/consequential matrix (Alasuutari, Bickman and Brannen, 2008).

The process of coding data during axial coding required the constant examination and interpretation of data which involves the task of continually relating subcategories to categories, comparing those categories with data collected, expanding their density through their detailed properties and dimensions and exploring the variations in the phenomenon (Brown et al., 2002).

To summarize this process, analysing the data of the three groups who participated in this study was an interactive process which involved continuous use of the constant comparative method. Concepts emerged from the analysis of data collected which were compared for similarities and differences within each group and between the different groups. Thus, the concepts from the group of rape survivors were compared for similarities and differences with the concepts derived from the group of women community members. The concepts from the group of men enriched and expanded those from the two previous groups by adding new properties and dimensions. As I moved from one group to another, new ideas emerged from the data and the new concepts were sorted and added to the existing list. The course of data collection and data analysis was forwards and backwards. This process was repeated for each group until data saturation, which occurred when myself with my supervisors, who were crosschecking the process, felt that no new concepts were being generated from the data (Strauss and Corbin, 1990). The purpose of the analysis was not to compare the different perspectives of participants about the phenomenon under study, but rather to get a deep overview of information related to managing the psychological consequences of rape based on survivors' real life context and expressed through their own perspectives and the perspectives of their community members. After the completion of this process, I started looking for a core category through selective coding.

### **2.10.3 Selective coding**

After open and axial coding, the third and last stage of coding in grounded theory is selective coding. The process of selective coding is similar to the previous steps of coding, except that it is more abstract and it implies a high level of analysis in the process of integrating and refining the categories (Strauss and Corbin, 1990). This phase involved the identification of

the core category from the major categories which were interrelated, which became the basis of the theory. Glaser (1992) emphasizes the importance of the core category. This category lies at the core of the theory being developed and explains most of the variations in the pattern of behaviour. The core category tells “what the research is about” and must fit the data it stands for (Strauss and Corbin, 1990: 117). In developing the current theory, different steps proposed by Strauss and Corbin (1990) were followed. The first step consisted of writing a storyline on what the whole study was about. The storyline reads as follows:

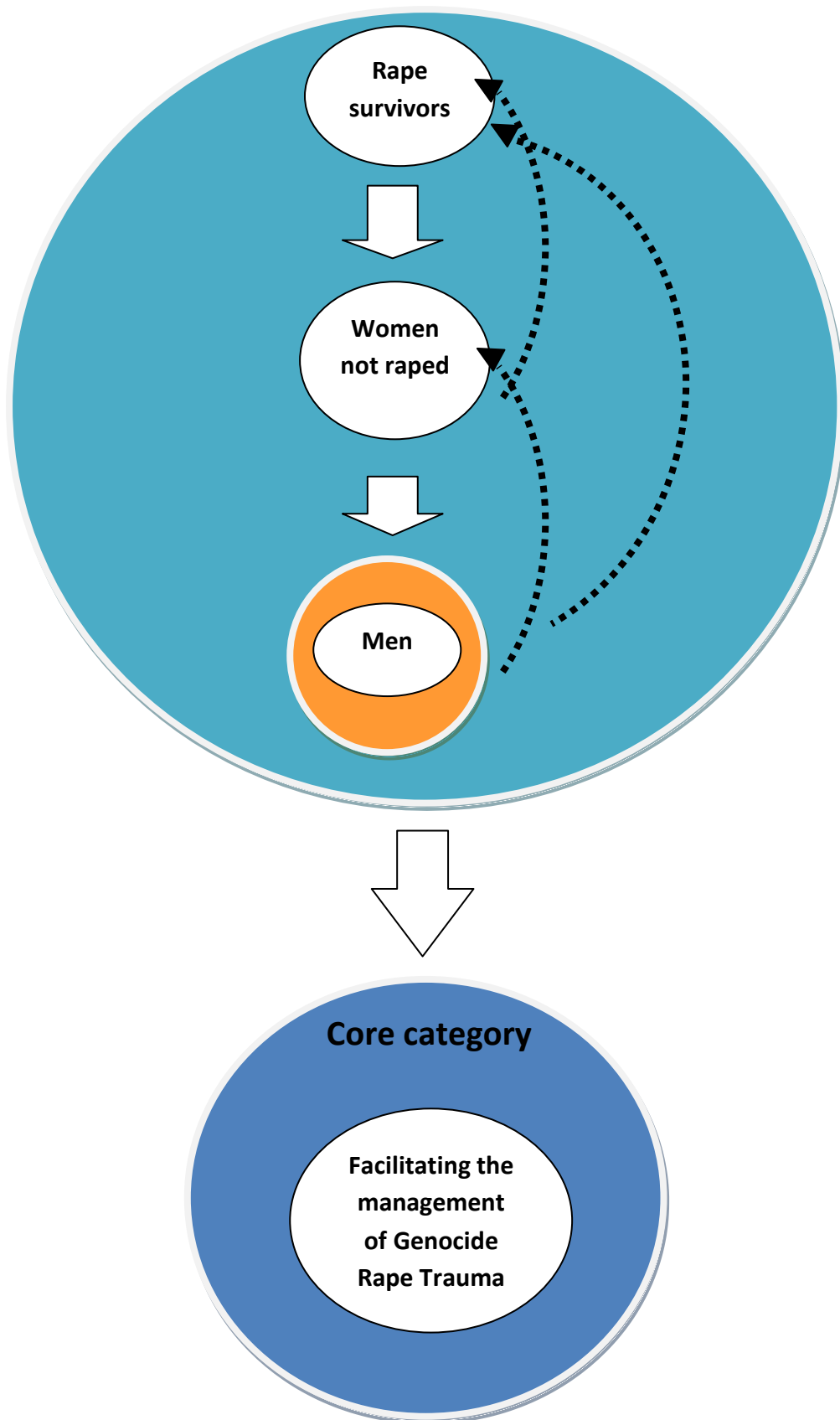
*Women have been raped under life threatening circumstances and these experiences have affected both their physical and psychological integrity. Women survivors were at high risk of developing psychological problems because of the multiple losses that accompanied their extreme experiences and the many challenges they have had to face in the aftermath of the genocide, such as the inadequacy of resources for their care. Formal support from public and private sectors are contributing to the recovery of rape survivors. While there are positive forces within the community that facilitate recovery, there are also some negative forces that hinder the recovery process. Various actions are taken by the rape survivors, themselves, both individually and collectively, and by the community and government structures, all of which are aimed to facilitate the management of lasting psychological effects of rape. “Genocide Rape Trauma” has been identified as the concept standing for the long term psychological effects of rape among women genocide survivors. “Facilitating the management of Genocide Rape Trauma” was identified as the core category.*

In choosing the name to give to the core category, I checked from the list of the existing categories to find one category that may broadly tell what the study is about, as suggested by (Strauss and Corbin, 1990). As I couldn't identify any, I went back and reread my data, reviewing all the categories. I then realized that “**Facilitating the management of Genocide Rape Trauma**” was the core category as it conveyed what the study is all about.

The second step consisted of relating the core category to its subsidiary categories in terms of causal conditions, context, intervening conditions, actions/interactions/strategies and consequences. The third step involves relating categories to the dimensional level, while the

fourth consisted of validating those relationships against the data. The final step was filling in the categories which I had noticed were poorly developed.

The diagram on figure 2 presents the process of data collection and analysis.



**Figure 2:** Diagram representing the data collection and analysis process

## **Legend for the figure 2**

The three small circles in the centre represent the data from the three groups where open coding and axial coding were taking place. The two circles within a circle represent the combination of the findings from the two groups of women. The big circle represents the findings from the three groups where the selected coding was taking place, thus generating the core category

The solid lines show the process of data analysis from one group to another, while the broken lines signify the backward movements for collecting missing information. The large straight arrow shows how data from the three groups led to the generation of the core category.

## **2.11 TRUSTWORTHINESS**

Trustworthiness is a fundamental issue for qualitative research as it ascertains the quality and value of the final findings and conclusions of qualitative research (Lincoln and Guba, 1985). These authors proposed four key criteria of trustworthiness: credibility, transferability, dependability and confirmability.

### **2.11.1 Credibility**

According to (Lincoln and Guba, 1985), credibility is one of the most important factors in establishing trustworthiness as it deals with the congruence of the findings with the reality (Merriam, 1998). Source and site triangulation, external checks with peers, researcher supervision debriefing along with member checks were suggested by Shenton (2004) as measures to ensure credibility.

Data source triangulation, as started by (Denzin, 1989), aims to use multiple data sources in a study. One way to achieve this is to interview diverse key informants about the same topic. Therefore, women rape survivors and their community members were interviewed as they had been identified as the best informants. Site triangulation was achieved by involving participants from two different sectors, Rukoma and Gacurabwenge. By applying both types of triangulation, a comprehensive view of the reality was provided based on perceptions from people with different backgrounds in different places (Shenton, 2004).

Member checks were carried out individually and in groups to validate data. I drew a graphic representation of the findings which was presented to the participants during the groups'

sessions. Participants acknowledged that what they had said was captured in the presented diagram. According to Nigel (2008), the data is valid when mutual understanding has been achieved between the interviewer and the respondents. The questions, comments and feedback from peers who crosschecked this research project also added to its integrity. My vision was further enriched during the debriefing session with my supervisors and through their discussions, as they added their experiences and observations. This was also an opportunity for me to test my developing ideas and interpretations (Shenton, 2004).

### **2.11.2 Transferability**

Transferability refers to the extent to which the findings from one study can be applied to similar situations (Merriam, 1998). Lincoln and Guba (1985) argue that it is the responsibility of the researcher to ensure that contextual information related to the fieldwork is provided to allow the reader to make such transfers. Shenton (2004) points out that the report should convey a clear explanation of the context with descriptions of the particular characteristics of the research setting where the study took place so that any reader may be convinced about the transferability of the results and conclusions to other settings.

In this study, transferability was established through thick description of the research process, where each step was detailed. The research setting was well described, and the profile of the participants and their numbers were presented. The processes of data collection and data analysis and their time frames have been explained. In addition, a deep description of the phenomenon under investigation was provided to allow a proper understanding of it. All this information was aimed to present a real picture of the context of the research and how it was conducted.

### **2.11.3 Dependability**

Polit, Beck and Hungler (2001) define dependability of qualitative data as the stability of data over time and over conditions. Lincoln and Guba (1985) maintain that dependability is the stability of the data in the study. Polit et al., (2001) asserted that dependability may be achieved through auditing. An inquiry audit, which involves the scrutiny of the data and relevant support documents by an external reviewer, is one of the techniques proposed by Polit, Beck and Hungler (2001). To achieve the required dependability for this study, a colleague mental health nurse, who is an expert in qualitative research, was consulted to check the data collection which occurred simultaneously with data analysis, as recommended

in grounded theory (Strauss and Corbin, 1990). The qualitative expert and my research supervisors monitored the data coding, as well as the interpretation of the data.

#### **2.11.4 Confirmability**

Confirmability, which goes hand in hand with credibility and dependability, refers to the objectivity or neutrality of the data; it ascertains whether the data and interpretation of the study are grounded in events rather than being purely the researcher's personal interpretations (Lincoln and Guba, 1985). The audit trial, which is the process allowing any observer to trace back each stage of the research process through the decisions made and the procedures described, was used in this study to prove its confirmability (Shenton, 2004).

A digital voice recorder was used during interviews and these were directly transferred to computer to be transcribed in MS Word. This facilitated the process of coding and analysing. The interview transcripts (see Annexure 14 for an interview sample) were available to the external audit together with the reports from the member-check group sessions and the detailed field notes. Ability to retrace the whole process of data collection and data analysis provided transparency, making the audit trial easy to follow and ensuring confirmability.

### **2.12 ETHICAL CONSIDERATIONS**

Ethics in research implies the principles of respect to the rights of participants (Nigel, 2008). Creswell (2009) argues that the researcher has the responsibility to take account of the rights, needs, desires and values of the participants. Nigel (2008) strongly recommends an ethical review prior to the research being undertaken. Ethical clearance to conduct the study was obtained from the University of KwaZulu-Natal (see Annexure 1) and from the Institutional Review Board of the Kigali Health Institute (see Annexure 3). Permission was also obtained from the Vice Mayor of the Kamonyi district (see Annexure 4), where the study took place and from the coordinator of SEVOTA (see Annexure 5). Information document and informed consent were in English and Kinyarwanda (see Annexures 6, 7, 8 and 9). Information document in Kinyarwanda was provided to the participants prior the study and informed consent in Kinyarwanda was signed by participants before they became involved in the study.

The rights of the participants have been respected, as outlined by Burns and Grove (2009). Those rights included the right to self-determination, the right to privacy, the right to



anonymity and confidentiality, the right to fair treatment and the right to protection from discomfort and harm. The risk-benefit ratio for participation in the study was considered.

### **2.12.1 Self determination**

Self-determination is the moral and legal right of individuals to have full power over their actions and the choice to decide whether or not to participate in research. It follows, therefore, that participants have the right to accurate, complete and understandable information on which to base their decision (Bless, Smith and Kagee, 2006).

Owing to the extreme sensitivity of this study, the participants were given a clear explanation of its purpose, along with all necessary information relating to the study that allowed them to voluntarily choose whether to participate or not. Once involved in the study, they were told that they could withdraw at any time without any penalty if they felt uncomfortable about continuing. It is worthy to mention that from all those who agreed to participate, no one withdrew from this study.

### **2.12.2 Right to privacy**

Participants have the freedom to decide what private information they will share with the researcher and what they will withhold. Furthermore, the researcher has no right to disclose any information that has been shared without the participants' consent. When participants are reluctant to share any information they may view personal or intimate, the researcher has to respect that decision (Fouka and Mantzourou, 2011).

Therefore, in this study, no private information was shared without the consent of the participants. Interviews were recorded with their permission and the participants were informed that an English translator and my supervisors would have access to the data.

### **2.12.3 Anonymity and confidentiality**

Anonymity and confidentiality are closely connected. According to Bless, Smith and Kagee (2006), participants' information must be protected and their identity not linked with personal responses. For the sake of confidentiality, the digital voice recorder was kept in a secret place until completion of the study, after which the interviews were deleted. Pseudonyms were used for anonymity and it was impossible to relate data back to the participants.

#### **2.12.4 Right to fair treatment**

Right to fair treatment is based on the principle of justice that stipulates that each individual should be treated fairly and receive what he/she deserves. This principle implies the fair selection and treatment of participants (Burns and Grove, 2009). Participants were selected for reasons directly related to the problems studied and agreement about my role as researcher and their role as participants was settled before the interviews.

The venue and times of the interviews were determined by the participants. Women rape survivors preferred to be interviewed at SEVOTA rather than in their own homes as they found the place calm and confidential. The interviews never went beyond the purpose for which the participants had been recruited. After the men and women community members had agreed to participate to the study, they chose a place where they felt comfortable to be interviewed and specified a time when they would be available, which I respected. The venue for each interview was calm and private to ensure the comfort of the participants.

#### **2.12.5 Right to protection from discomfort and harm and protection of vulnerable participants**

Protecting participants from any harm is a basic principle of research, and the researcher is expected to ensure their wellbeing at all times (Burns and Grove, 2009). Bless, Smith and Kagee (2006) suggest that participants who experience a high level of discomfort should either be debriefed or referred to an appropriate professional if it is felt that intervention is necessary. Fouka and Mantzorou (2011) emphasize the competence of the researcher in preventing and minimizing potential harm. Many of the participants in this study were vulnerable as they had suffered life threatening rape ordeals and their recalling the old wounds of their traumatic experiences during the interviews could have led to secondary traumatization. They were, therefore, made aware of the potential risk of painful memories related to topic under study and only those who felt comfortable with recounting the topic were involved in the study.

Before the interviews, I ensured the availability of a trauma counsellor, who could be contacted any time, if needed. As an additional precaution, I had planned to refer participants to the mental health service of the Remera-Rukoma hospital, which is 100 meters from SEVOTA, for more specialized care and follow-up in the event of both the trauma counsellor

and myself failing to assist a distressed participant. It was anticipated that I would cover any costs related to the care of the participants.

Fortunately, there were no incidents which required the help of the trauma counsellor or the mental service at the hospital. Being an experienced mental health nurse with advanced training in trauma and violence, which I undertook before my previous study on the lived experience of rape amongst women rape survivors of the 1994 genocide, I was skilled enough to identify emotional distress by being attentive to the verbal and non-verbal communication of the participants and was able to handle the situations accordingly. When some of the women rape survivors became distressed and cried while talking about painful memories, I provided the necessary emotional support and brought the interview to an end as soon as they had regained their composure.

#### **2.12.6 The risk-benefit ratio for participation in the study**

The benefits of participating in this study include the improvement in the health conditions of the participants and the acquisition of knowledge which will make a contribution to evidence based practice, while the risk involves the harm participants may encounter while participating in the research (Burns and Grove, 2009). These authors recommend that the balance of benefit and risk must be examined in a study and should only be approved when the benefits are maximized and the risk minimized.

The risk to participants in this study was the emotional distress that might result from discussing painful memories. However, my attentiveness in watching for possible distress and providing exercises of relaxation for those who were in need facilitated their psychological relief. In fact, I got the impression the interviews had a positive effect by facilitating the ventilation of participants' emotions.

The theory that emerged from this study should inform better care for rape survivors, which will benefit their psychological wellbeing. Once these women become more psychologically healthy, they will be able to contribute not only to their own development, but also to the development of their communities.

### **2.12.7 Informed consent**

The principle of informed consent is of paramount importance and goes hand in hand with self-determination. Thus, potential participants have to be provided with clear detailed information about the study, its methods, risks and benefits and should have full freedom in participating, refusing to participate or withdrawing without any adverse consequence or reprisal (American Nurses Association, 2001). Generally, informed consent is formalised in writing (Terre-Blanche, 2006).

An information document, translated into Kinyarwanda, as mentioned previously, was given to the participants who volunteered to participate in the study. This document included essential information about the researcher and the study. Potential participants were asked to read the document and make sure they understood the contents prior to giving their informed consent. Even although the participants had read the information sheet themselves before starting the interviews, I explained the content of the document once again and emphasised the fact that the participants may feel distressed as the interview may recall bad memories. I added that I would give them emotional support during the interviews, but that they had the right to stop if they found it too hard to continue.

I informed the participants of the purpose, objectives and significance of the study, as well as the ethical issues relating to it. I also informed them about the inclusion criteria and a time was given for questions and answers.

Participants were given my contact details should they want to address any concerns regarding the study. They were also given the contact details of one of my supervisors and the Director of the Kigali Health Institute Review Board, as well as the address of the Secretary of the Ethical Committee of the University of KwaZulu-Natal.

### **2.13 DATA MANAGEMENT**

The data will be kept in strictest confidence. During the study, the data was stored on a computer with a code to which only I had access. The electronic copy will be maintained by the supervisor for five years. After that period the stored data will be destroyed.

## **2.14 CONCLUSION**

This chapter presented a detailed description of the methodology used in this study. The differences between the two major approaches to grounded theory, one presented by Glaser and Strauss and the other developed by Strauss and Corbin, were explained, as well as the reason for using Strauss and Corbin's paradigm in this study. The techniques used in collecting and analyzing data were presented. The ethical issues presented took in consideration the sensitivity of the topic. Finally, the academic rigour expressed in term of the trustworthiness of the study and the management of the data were discussed.

## CHAPTER THREE: PRESENTATION AND ANALYSIS OF FINDINGS

### 3.1 INTRODUCTION

This chapter describes the women rape survivors and the members of their community who contributed to this study, their accounts are reported and analyzed in this chapter using Strauss and Corbin (1990) paradigm model. Thus, the findings are presented in terms of causal conditions, context, intervening conditions, interactions/actions and strategies and consequences. The categories and subcategories that emerged have been named by the words used by the participants or those from the literature related to the psychological effects of rape. Words acquired from the knowledge of my discipline were also used (Strauss and Corbin, 1990).

### 3.2 OVERVIEW OF THE PARTICIPANTS

The description of the women rape survivors, women not raped and men who participated in this study is presented in Table 1 below. In the interest of anonymity, the participants were given pseudonyms. The findings presented here are excerpts from interviews with rape survivors and certain members of their community, which included women who had not been raped and men. In order to identify which of these three groups the excerpts originated from the following abbreviations will appear: rape survivors (RS), women community members (WCM), and men community members (MCM).

Table 3.1 **Description of participants**

<b>Pseudonym</b>	<b>Age</b>	<b>Marital status</b>	<b>General comments</b>
<b>WOMEN RAPE SURVIVORS</b>			
Umwiza	50	Widow	She lost her husband and she has five children, four survived the genocide and the fifth one was born after the genocide. Currently she is a farmer and has completed six years of primary school. She is a very active member of SEVOTA.
Zaninka	56	Married	She completed six years of primary school. She has a small business and her husband and children survived the genocide.
Gicari	49	Widow	Her husband died with her daughter, she survived with her three children. She is educated up to primary six.
Muteteri	32	Single	She lost her father and her all siblings and she

			survived with her mother. She has a son born of rape. She completed six years of primary school and has a small business
Umutesi	44	Divorced	She is raising her five children alone after she divorced from her husband. She has a son born of rape. She has completed six years of primary school.
Umwari	29	Married	She survived with her younger brother. Her parents were murdered with her other four siblings. She got married and had three children. She is educated up to secondary school.
Kwihangana	52	Widow	She is the only survivor of her family after the killing of her husband and her seven children. She has a daughter born of rape. She has completed six years of primary school and she is a farmer.
Akimana	33	Single	She survived with her brother. She has a daughter born from rape. She has completed six years of primary school and has a small business.
Kishatse	48	Widow	She survived the genocide with her daughter, who witnessed her rape. Her husband and five children were killed by her rapist. She completed six years of primary school and she is a farmer.
Ikizanye	58	Widow	Her husband and her two children were killed during the genocide. After this she decided to have another child. She has completed six years of primary school and she is a farmer.
Gatete	50	Widow	She survived with her daughter. Her other three children were killed with her husband. She has completed six years of primary school and she is a farmer.
Rusaro	33	Married	She is the only survivor of her family. Her parents and all her siblings were killed during the genocide. She is married and has four children. She has completed six years of primary school she is a dress maker.
<b>WOMEN NOT RAPED</b>			
Jambo	28	Single	She is a health care professional working with people with mental health problems.
Claudia	30	Married	In her work place she is in charge of social affairs and in her community she plays a role in conflict resolutions. She is connected with rape survivors who are poor and who need social support from government structures. She has four children; two are orphans of the genocide.
Marine	43	Married	She is a social worker. She is in charge of gender at her work place. She became connected to rape survivors in her project which is fighting gender based

			violence.
Rosine	40	Married	She is in charge of women development in her sector. She is an advisor of rape survivors who want to set up a project regarding income generating.
Cresence	30	Married	She is a bank agent; she is also an advisor for clients who are taking a loan from the bank. She is personally committed to helping rape survivors to get over their poverty by efficiently using the loan from the bank to invest in activities which generate income.
Chance	35	Married	She is connected to rape survivors of her community through her role of conflict manager.
Margo	30	Single	She is in a leading position at her work place. She is connected to rape survivors who come to her for their problems of poverty, insecurity and who are in need of medical insurance. She has a close friend who is a rape survivor.
Gaudence	45	Married	She is a lawyer who used to be an advisor of rape survivors who were attending the Gacaca courts (Rwandan traditional courts).
Aline	28	Single	She is a health professional and at her place of work she is in charge of vulnerable people who are at risk of having mental health problems. Those include rape survivors.
Charlotte	38	Married	She is a health professional, in charge of the program of counselling for HIV voluntary testing. In her community she is mobilising the youth to support the vulnerable individuals such as rape survivors in repairing their houses and cultivating farms mainly through community work. She has two children.
<b>MEN COMMUNITY MEMBERS</b>			
Fidens	41	Married	He is a lay health worker in charge of community education against communicable diseases. He is connected to rape survivors through group prayers that he is organizing in his community.
Akim	35	Married	In his working place he is in charge of collecting taxes from the business men/women. He is connected to rape survivors who are mainly involved in small business. He has also got a friend who is married to a rape survivor.
Muvara	27	Single	He is in a leading position at his working place and he is regularly invited to the meeting of women associations who advocate for the rights for vulnerable women such as widows and rape survivors.
Alphonse	33	Married	He is a social worker in charge of vulnerable people including rape survivors. He is the person who determines the neediest people eligible to receive support in terms of food, clothes, medical insurance



			etc. In his community he is attending prayers meetings with rape survivors.
Raphael	28	Single	He is doing an administrative work and he is in charge of a youth program in his community. He has a neighbour who is rape survivor with a child born of rape.
Sebastien	35	Married	He is in charge of cooperatives in his working area. He becomes connected to rape survivors through the training he is organising for women who are interested in joining the cooperative.
Jean	35	Married	He is advising the farmers how to farm in modern way in order to increase their crops. As the majority of rape survivors are farmers they are regularly requesting his advice.

Women rape survivors who participated in this study included women who were single, married, divorced and widowed. The majority of them had lost family members. Some of the participants had a few family members who had survived the genocide, but others had been left on their own as all their family members had been killed. Four had children born of rape and others had decided to have other children after their husbands and children had been killed during the genocide. The oldest participant was 58 years old and the youngest was 29 years old. The majority of these women were poorly educated; some had completed primary school, but only one had reached secondary school and, at the time of data collection, she was still doing her studies. They didn't have access to well-paid jobs and were mostly farmers or running small businesses. To address the issue of uneducated women, the Rwandan government has made the education of girls and women a priority. This will not only contribute to the development of the women themselves, but to the country as a whole (Abbott and Rwirahira, 2010). Participants from the community were aged between 45 and 27 years old. The range age of women not raped were from 45 to 28 and for men 41 to 27. The rape victims' community members came from different educational and professional backgrounds. Some had been to primary school, some to secondary school and some had been to university. Thus, their levels of education ranged from primary six to a bachelor degree. Some were single and others married. Some were working on a volunteer basis at sector level as lay social workers or health workers. Those who were highly educated were employed by the Rukoma and Gacurabwenge sectors or by the Kamonyi district. This is in line with the policy of decentralization in Rwanda, where high levels of education are required for employees who are working in the administration at the district or sector levels (Abbott and Rwirahira, 2010).

All research objectives have been addressed by the responses from the participants.

(a) The women who had been raped described the long-term psychological effects they experienced as a result of being subjected to rape during the 1994 genocide in Rwanda and the community members expressed their perceptions of the long term psychological effects of rape amongst the women survivors;

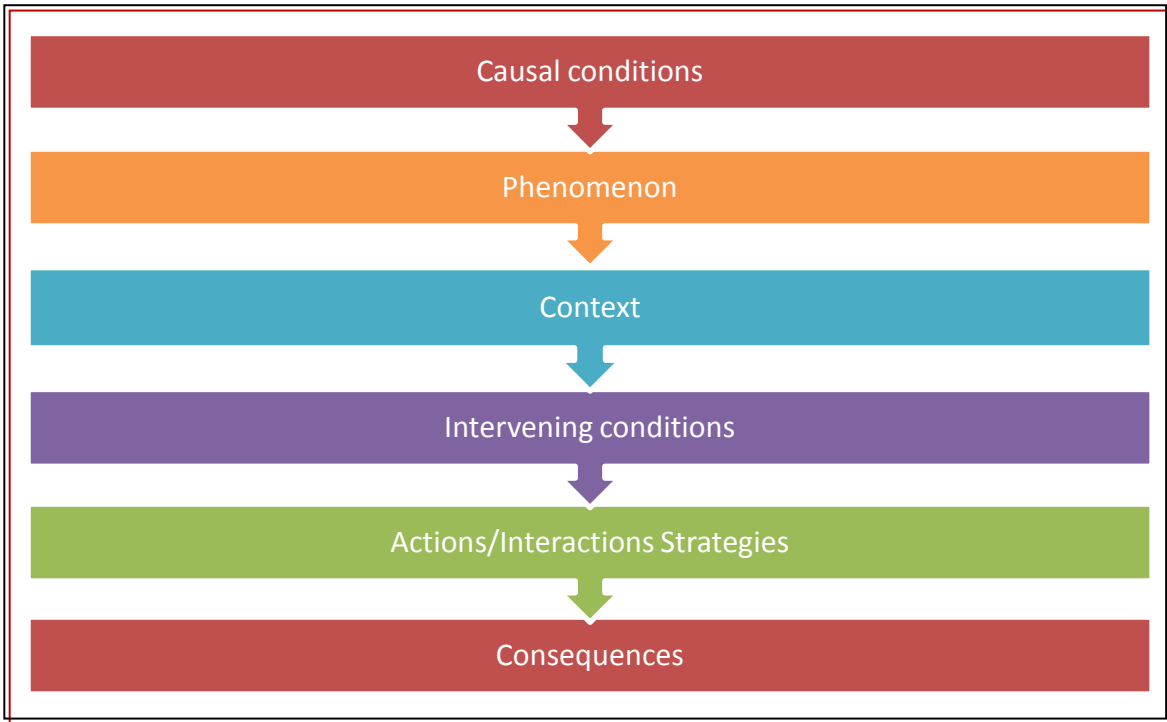
(b) The participants explained the factors which protect women survivors from the long term psychological effects of having been raped and those which put them at risk of long term psychological effects;

(c) The participants described the support that is available for rape survivors and;

(d) They described the influence this has on helping rape survivors cope with the long term psychological effects of having been raped in the 1994 genocide in Rwanda.

The results are presented in terms of Strauss and Corbin's (1990) paradigm model. Categories and concepts developed were related to (a) antecedents, which denote the occurrence and the development of conditions; which led to (b) the long term psychological effects of rape; (c) intervening conditions that facilitate or constrain the actions taken to address the long term psychological effects of rape; (d) the context within which regulations have been set up and formal support created to address the aftermath of rape; (e) actions/ interactions and strategies used by the rape survivors themselves, their communities and government structures to handle the long term psychological effect of rape; and finally (f) consequences, which result from the actions taken.

The paradigm model is presented in figure 3 below in term of interconnected blocks indicating the relationship existing between the components of the paradigm. This diagram helps the researcher to consider the data in a systematic way (Strauss and Corbin, 1990). Even although the figure 3 showing the presentation of the findings is in linear manner, the interconnection between the components that made the paradigm model is more complex. This complexity is presented in chapter six in terms of a theory which was extract from the present findings.



**Figure 3:** Diagram of paradigm model adapted from Strauss and Corbin (1990)

### 3.3 CAUSAL CONDITIONS OR ANTECEDENTS

Causal conditions are “*events, incidents, happenings that lead to the occurrence or development of a phenomenon*” (Strauss and Corbin, 1990:96). The many women who were raped during the 1994 genocide were left physically injured and psychologically scarred by their traumatic experiences. The coercive and violent environment of the genocide led to many losses which exacerbated their condition and other risk factors which appeared after the genocide also contributed strongly to the development of long term psychological effects of rape. It appears from the findings that the causal conditions of long term effects of rape are divided into two main components: what happened during the genocide and what happened after the genocide.

Thus the concepts which emerged as causal conditions of the long term psychological effects of rape that occurred during the genocide were: (a) rape with unspeakable cruelty; and (b) multiple losses. The causal conditions of the long term psychological effects of rape that occurred after the genocide were: (c) continuous challenges; and (d) secondary victimization.

### 3.3.1 Rape with unspeakable cruelty

Rape was perpetrated with atrocities that were terrible to speak of. Rapists deliberately caused great suffering to their victims, and women were subjected to the most humiliating and degrading acts of violence. The violent acts of rape inflicted on these women destroyed their physical and psychological integrity. Two sub-categories emerged from the category of unspeakable cruelty as rape survivors and community members gave their points of view. These were (a) torture and (b) humiliation. These two concepts were retained as subcategories under rape with unspeakable cruelty.

**Torture:** Rape was equated with torture due to the cruelty with which it was carried out. Women were savagely raped by individuals or gangs of rapists. If they offered any resistance they were beaten or violently assaulted. Women were not only the victims of sexual intercourse, but objects were inserted into their genital organs. Gaudence and Charlotte, community members of rape survivors, described how women were raped during the genocide.

*For some women sticks were pushed into their reproductive organs after being raped. Charlotte (WCM)*

*Women were raped with bananas trees or with sticks and other with different shape objects. Those Interahamwe (militias) used anything they found at hand since they were sure it will lead[s] to maximum pain, rape was indeed an instrument of torture. Gaudence (WCM)*

One participant described her personal experiences of such torture. Rusaro had been hiding and when she was caught by a gang of militias, they raped her and then inserted a stick into her vagina. She recounted;

*I was hiding in a swampy field and a group of Interahamwe (militias) attacked the area to search for people to kill, they found me, took me. I don't remember how many they were. They raped me, one after another.... I remember that the last one had a stick and he said rather than dirtying his penis he was going to put that stick into my genital organ.... then he did. Rusaro (RS)*

Participants recounted that women who resisted their rapists were frequently tortured to force them to submit. Some were burned, while others were badly beaten. Akim, a male

community member, talked about a rape survivor he knew who was raped after being burned with an iron:

*She (rape survivor) had a big scar on her thigh, that's where her rapists pressed a hot steam iron when she had refused to open her legs ....so they burned her thigh with the iron ....she opened her tight and then they raped her (SILENCE).*

Akim (MCM)

I had an impression that this participant was disturbed by what he was saying as his eyes were red and he was silent for a moment. Apparently he knew the woman he was talking about very well and was feeling sorry for her when recalling and recounting her story.

Women rape survivors described how they had been beaten all over their bodies by militias when they had refused to offer themselves and how they had been raped when they had no more force to resist.

*As I was resisting being raped they hit my legs, arms, head, back; no part was spared, they beat me all over the body; I surrendered and they raped me, they damaged my body. Those Interahamwe (militias) had unspeakable cruelty.*

Muteteri (RS)

*I refused to be raped by those Interahamwe (militias) and they had beaten me up until I collapsed. When I came back to my senses I found that my head had been almost smashed, and legs and body, arms were broken. I had sperm in my genital part and then I realized that I have been raped.* Gatete (RS)

The cruelty of the militias was beyond imagination as they were not only raping and beating the women, but were also deliberately mutilating them, as reported by one of the men community members.

*I know a woman who was raped by many men and after her breast was cut off, so it is obvious that such woman had suffered indeed. Sometimes I wonder how and why a human being can do such things to another human being. Even animals didn't deserve that (SILENCE).* Fidens (MCM)

Women were even raped by some of the men who were supposed to protect them. Some victims were raped repeatedly for periods ranging from a few days to three months, the entire duration of the genocide. The incidents of rape were so violent that many women came out

from their experience physically damaged. Rape was particularly destructive to those girls who were very young at the time. Umwari was 13 years old at the time of the genocide and was repeatedly raped by a neighbour throughout the three month period. The continual vicious assaults on her body resulted in damage to her pelvic organs.

*I was raped by my neighbour who was hiding me. He raped me savagely during three months so that I couldn't walk because I had difficulties moving my legs. The genocide ended when he had already damaged my bladder, I was no longer in control of urination, I had fistula.* Umwari (RS)

Women were raped in the presence of their family members, who were unable to protect them and could not bear their suffering. They pleaded with the militias to rather kill the women so as to end their suffering. Zaninka was held prisoner by militias in her own home so that she would be available to be raped by them at any time, which they did on a regular basis in the presence of her husband. He begged the rapists to end her torture.

*I remember one day when they finished raping me it was very hard to me to walk and I was crying. When my husband saw me he felt sorry and he told to my rapists: "Why do you torture her in that way. You better kill her directly rather than killing her slowly letting her [to] suffer at that level."* Zaninka (RS)

Although women fled from one region to another, there was no safe place for them and they were raped wherever they were. Akimana was trying to escape to another village when she encountered a gang of Interhamwe (militias) who captured her and imprisoned her in a room with other girls of similar age and brutally gang raped her. The other girls had been collectively raped so many times that some of them had died.

*They raped me so that I was left severely disabled... my rape is a long story, even in my village I was also raped, but what happened to me when I fled is beyond bearing...In some cases rapists arranged rooms for collective rape...When they caught me they dragged me into the room and raped me relentlessly; there were young girls of my age, we were all below 17 years, I met them there, and they were indeed on the brink of death. Later some of them died. Worse for me, when they found that I still had some energy, they gang raped me, one after another to the extent I felt I was out of breath and my back broken.* Akimana (RS)

The torture endured by these women was not only physical, but was psychological as well as some of the women were raped after they had witnessed the killing of their loved ones. One of the community members described such an incident.

*There is a woman who talked to me about how her husband got killed as well as her all children, and after they had finished killing them they told her that they will not kill her, instead they will rape her only. Now imagine witnessing all your family members being killed off and you are left alone and then you get raped.*  
Muvana (MCM)

*I didn't believe my eyes when I saw our neighbour with a machete, he killed my children and my husband in front of me, I was the last to be killed, instead he raped me.* Ikizanye (RS)

This woman was in tears when she was talking about witnessing the killing of her loved ones and then being raped. At that moment I sat closer to her put my hands on her shoulders, letting her express her painful emotions.

**Humiliation:** Rape was also used to humiliate and degrade women during the genocide. Women felt that they had lost their dignity due to the dehumanizing acts that they were subjected to. They were humiliated by the context in which they were raped and by the people who raped them. In addition to the dishonour of being raped in public, women were raped by those people who were marginalized by society, such as thieves or thugs. They were also raped by members of their community, who in normal times would have shown them respect. Cresence, one of the women community members, described how rape survivors from her community were objectified and humiliated through public rape.

*Imagine being raped, and this is known to the public, because people were there watching... and on top of that being raped by more than one person (SILENCE)... I remember when during the genocide the Interahamwe (militias) came and undressed publically all the girls. They picked the beautiful ones and started raping them and then released them when they saw others who were most [more] beautiful. They were using these girls as toys, they were playing with their bodies and rejected them when they wanted to.* Cresence (WCM)

In order to humiliate the women as much as possible, in some of the villages, the militias urged young boys of the community to rape them, although many of them were their own neighbours.

*That young boy who was supposed to be my son raped me (SILENCE)... I stayed in his house for four days.... he didn't care if I was hungry, thirsty or clean, he raped me every day and after these four days he said he is no longer interested in me and he called a gang of Interahamwe to rape me again. Umwiza (RS)*

During the genocide, women were objectified and were more vulnerable than ever. They were totally disempowered and at the mercy of any man who wanted to rape them, whatever their age or social class. The following excerpts are the accounts of men and women community members describing the humiliation of respected women who were raped by thugs.

*She (rape survivor) is a respected woman and she is keeping [on] saying that she lost her dignity... she can't imagine how an old woman like her could have been raped by thugs; she [is] still suffering from the humiliation she went through ...she can't forget it. You find that the situation is beyond bearing for her... You know.. when someone has been raped by a thug, not at least by someone with good manners although it is both bad; but when it is a hooligan it is more humiliating. Marine (WCM)*

*You know those respectful women and beautiful girls were raped by thugs on the street, some were gang raped by almost ten..... imagine a respectful married woman in an area, a woman respected by other women, being raped by a thug, a thug that spent years without washing, that's indeed humiliating, disgraceful and shocking. Jean (MCM)*

Women survivors endured unbearable humiliation being raped in front of their family members. Kishatse and her daughter survived the genocide and she recalled her experience of rape.

*What was terrible and humiliating is that my daughter was watching when they were raping me (SILENCE). Kishatse (RS)*

Gatete (RS) shared her humiliation:



*I suffered unimaginable humiliation, they raped me in the open, in front of my child when I was a mother who deserves respect and you see how mature I am, my dear, the hardship I went through is beyond bearing.*

Cresence, a community member, reported the experience of a woman from her village who had been through a similar experience:

*There is a woman who was mature at that time, she is from my area, but you could see that she was ashamed by her experience. She had children who were not killed and who are aware of her rape. They raped her in front of her children and husband. Cresence (WCM)*

There can be no doubt that rape survivors have indeed been both physically and psychologically hurt by their experiences of rape. In the chaos of genocide, many women lost everything that was meaningful and valuable to them. They not only lost their loved ones and all their property, but they also lost their dignity by losing control of their own bodies.

### 3.3.2 Multiple losses

The other category that emerged from the data was the multiple losses suffered by the women, which occurred in conjunction with their experiences of rape. During the genocide, rape was surrounded by so many losses and traumatic events that it became difficult to isolate specific incidents which have led to the long term psychological problems women are facing today. However, all participants of the study were unanimous in saying that while there is no doubt that rape survivors have been affected by the loss of their property, what has contributed the most to their psychological problems is the loss of family members in addition to their horrific experiences of rape. Therefore the subcategories became (a) loss of loved-ones and (b) loss of property.

**Loss of loved-ones:** The term genocide implies an annihilation of a specific group of human beings. During the genocide in 1994, women were targeted for rape, but their family members were decimated and their friends who tried to hide them were killed. All the rape survivors who participated in this study had lost one or more of their close or extended family members. Umwiza reported how she had been widowed by the genocide when her husband had been killed along with some of their friends.

*I am a widow, my husband died during the genocide in[at] the hands of our neighbours; he was killed in front of me with our best friends who were hiding us.*  
Umwiza (RS)

Gicari lost both her husband and her daughter.

*I am widow.... my husband has been killed during the genocide with my daughter. They were hiding in a bush and then a neighbour woman with her children came to search for fire woods, saw them and went to report them to interahamwe. They came with machetes and killed my husband with our daughter.* Gicari (RS)

Some of the rape survivors lost their entire families as well as members of their extended families.

*I am a widow. My husband and my five children were killed during the genocide. Before the genocide, I had a big family from my side and the side of my husband and in [after] the genocide the side of my husband have been killed and my side too.* Kishatse (RS)

While many of the married women were widowed during the genocide, younger girls also suffered great losses when their parents and other family members were murdered. Umwari became an orphan at a young age due to the murder of her parents. She recounted:

*Before the genocide I was living with my parents and with my six siblings. Unfortunately, four of them have been murdered during the genocide with my dad and my mum.* Umwari (RS)

Some of the rape survivors were left completely on their own because all of their relatives had been killed, as expressed in the following quotations:

*People (rape survivors) were living with their family members, and in genocide their family members got killed and they were left alone.* Rosine (WCM)

*Women were raped moreover their relatives were killed; you may find a woman victim of rape living alone after all her people was killed.* Jean (MCM)

These statements were confirmed by a rape survivor who had lost her all relatives in the 1994 genocide. Rusaro was raped when she was 15 years old and was left alone after her family members had been killed. She said:

*Before the genocide I had a large family, but now I don't have no more aunts, no uncle, and no parents. They were all killed, we were five from my mother and two from my stepmother, they all passed away, I'm the only one remaining; they were all killed, the oldest brother had two children, they all passed on during the genocide. Rusaro (RS)*

Genocide perpetrators had been roused to such a hatred of the Tutsi which pushed them to rape Tutsi women or even Hutu women who were affiliated to the Tutsi, to kill their family members and to take or destroy their property. This led to significant material losses for those who survived the genocide.

**Loss of property:** Not only did the rape survivors lose their loved ones, but they also lost what had symbolized a happy time of their lives, the homes they had shared with their loved ones who had died. Having survived, they found themselves homeless and alone, with no property or loved ones belonging to them. These losses marked a sad chapter in the history of their lives. Umwari recounted her story as follows:

*At the end of the genocide I went back home to find our house destroyed, with everything what was inside ...no one could guess that there was a nice house, I felt so sad to see that. Umwari (RS)*

Details of the genocide regarding who had killed people or stolen or destroyed property were made known at the Gacaca hearings. This is a Rwandan traditional court where perpetrators were made accountable for the crimes they had committed during the genocide in front of their community members. Muteteri was upset when she learnt that it was her neighbour who had taken everything from her parent's house.

*During Gacaca court, I was upset to learn that my neighbour is the one who took our chairs, beds, dishes, clothes and burned everything he didn't want or was unable to carry. I don't have any photos of my relatives who died. Muteteri (RS)*

Margo stays in the same village as some of the rape survivors and said how they became homeless after the genocide:

*You know after the genocide for many rape survivors ....their houses were destroyed and have nowhere to sleep. Margo (WCM)*

Women rape survivors suffered much hardship after their houses had been looted and their property stolen. Some were left with nothing, a precarious situation, and had to start everything from afresh. Gicari describes what happened to her.

*After the genocide it is like... I started my life from afresh because during the genocide they destroyed our house and they have taken all our property... I mean they took everything farming and cooking utensils, furniture, clothes; cattle even stored food...Gicari (RS)*

During the genocide, it seemed there was no limit to the spirit of destructiveness leading the perpetrators as they raped, killed and destroyed. Even the animals and crops were not spared. The majority of rape survivors who participated in this study had been farmers before the genocide, with cattle and crops, but some lost everything.

*These Interahamwe (militias) were stupid... and very bad...too bad I mean... They went to our farm and cut our bananas trees, pull out sorghum, beans and other plants which were in the farm and then came at home they took our goats, sheep and killed the cows, they cooked the meat and ate there. Kwihangana (RS)*

The destruction and cruelty of the Interahamwe (militias) ruined the lives of the women survivors as these women were not only subjected to the terror of rape and loss of loved ones during the time of the genocide, they are still having to face continuous challenges in their daily lives as a consequence because their economic livelihood had been destroyed.

### **3.3.3 Continuous challenges**

Although their experiences during the genocide put rape survivors at risk of developing psychological problems, the challenges they continue to face in their daily lives adds to their vulnerability. They have poor living conditions; they are suffering from chronic diseases, and were facing problems of raising the children born of rape. Thus the subcategories of continuous challenges were (a) material deprivation; (b) poor physical health; and (c) burden of children born of rape.

**Material deprivation:** The poverty in which rape survivors live not only prevents them from accessing specialized health-care services; it is also a factor which increases their risk of developing psychological problems. Participants of this study attributed the poverty of rape survivors to the losses they had experienced during the genocide and its aftermath. These

women lost their family members and property, as well their physical and mental health. The hardships they endured combined with their current circumstances of poverty exposes them to a high risk of developing psychological problems.

*You will find people, who had misfortune to be raped in the genocide, and their family members got killed and their properties vandalized, after the genocide they have been afflicted by poverty. It follows that they became vulnerable overreacting to anything that makes them remember the hard times they went through so that there are many chances for them to get psychological problems.*

Rosine (WCM)

*You find a woman who had a husband telling you “Was my husband still alive I wouldn’t be living in these conditions, we will working together meeting our needs”... you know someone who has been left alone without any person who could help her become easily poor and get depressed . What makes their psychological problems start; I would see poverty. Jambo (WCM)*

Poverty, therefore, is a major handicap to the process of recovery. It leads to frustration since rape survivors are deprived of fundamental needs. Women rape survivors were more psychologically affected when they were not able to respond to the needs of their family members, specifically their children. This was stated by the following participants:

*You know poverty causes despair and discontent, when you are poor and not having anything to feed your children it is a way of becoming crazy. Umwiza (RS)*

*When your child asks for something and you are unable to meet his need because of poverty you feel upset to the extent of regretting having given birth to him. So you find that you yell at your child and get angry at him. Umutesi (RS)*

Rape survivors were also concerned that their physical disabilities prevented them from generating an income. This, in turn, led to poverty, which contributed to psychological problems, as shown in the following statements:

*Many of us became poor after being disabled by rape as we were no longer able to farm, which is our main source of income. Poverty-related problems take me back to the genocide time, they make me think about future and see that it is not*

*bright, I get in despair. I get distressed when I foresee my future living conditions and on top of that poverty I am faced with, I don't get a sleep. Muteteri (RS)*

According to participants, psychological and physical problems were interrelated to poverty and influenced each other. Ikizanye explained:

*The poverty is the source of our psychological problems...When you are hungry because you are poor you start thinking that if I was healthy as I used to be before the experience of rape I will be able to work for someone and get the money to buy food but now I can't as my whole body has been broken from there I feel sad I become irritated and it becomes very difficult to sleep. Ikizanye (RS)*

The data revealed that the situation of rape survivors becomes worse when they are sick and have to spend much of their time seeking health-care services rather than working to meet their needs.

*Women rape survivors are poor because they spend much of their time at hospital for medical treatment of diseases they contracted through rape, and are not doing anything that can help them to meet their needs, some time they are relying to [on] other people and they may feel that people get tired of them and get depressed. Akim (MCM)*

Poverty and psychological problems are a vicious circle. Psychological problems can lead to poverty, while poverty adds to psychological problems.

*Some (rape survivors) have had psychological problems and don't have enough energy to work for themselves, they are withdrawn and lonely. So you understand that if they don't work they become poor, and when they are poor they are more in despair about their situation. Fidens (MCM)*

According to the participants' accounts, poverty and psychological problems are interconnected and this negatively influences the psychological wellbeing of rape survivors. Women rape survivors may not be able to overcome the problems affecting their psychological wellbeing unless they are addressed by efficient actions and strategies.

**Poor physical health:** Rape survivors have been profoundly affected by their experiences of rape. Because rape is a traumatic event which invades the body and the mind at the same

time, their physical and psychological problems are interconnected. This was expressed through the statements of the following participants.

*My psychological trauma is caused by many things, but the physical problems are the main cause. I have been disabled, all my body parts have been damaged and when I see that I'm disabled and unable to meet my needs I feel upset... look I can't even walk properly. This is due to the physical problems I am having. I can't do anything at my own. Gatete (RS)*

The physical repercussions that the participant was talking about were apparent because she was using a stick to walk. She was transported to SEVOTA for her weekly activities and for the interview for this study by a young man on a motorbike as she was no longer able to walk on her own. From her history, this participant had been badly beaten up when she was resisting being raped.

As shown by statements from participants, rape survivors were more vulnerable to health problems and were suffering from various chronic diseases. There was a high incidence of gynaecological problems, many of which have been linked to the specific circumstances of rape.

*I know a woman who was raped in horrific way and her reproductive organs were badly harmed, she used to have uterus problems always going to hospital for treatment, she was very depressed, doctors said she was suffering from uterus cancer. Charlotte (WCM)*

*I remember a girl who I talked to recently and she told me that she was raped by five men so since 1994 until today she has been suffering from her genital organs and sometimes pus comes out of her genitals and goes to hospital for treatment, the pain seems to disappear, but after some time it comes back. She seems to be desperate with her situation. Sebastian (MCM)*

*I am regularly having urinary infection and I am uncomfortable with these abundant vaginal discharges... I am really worried with this incurable disease. Gicari (RS)*

The above participant was carrying a box of antibiotics she was taking for her urinary infection. However, she said that she was not sure whether the pills would help because she had been taking them for a while.

Findings revealed that women who had been raped had a high risk of contracting HIV/AIDS. Women were not only gang raped by multiple men, they were also raped at different times by different men as they fled to regions they thought were safer, thus increasing their risk. Umutesi was infected with HIV/AIDS after being raped by different men. She testified:

*I fled from my region (south) to north region as people were saying it was more safe, but I was not lucky enough, they didn't kill me rather they raped me... (CRYING)...Imagine being raped all the way by all kinds of people those you know and those you don't know, every day I am facing the consequence of rape as it left me an indelible sign as I contracted HIV/AIDS, my life was ruined.*  
Umutesi (RS)

According to participants, men who had HVI/AIDS were deliberately raping women with the purpose of contaminating them with the disease.

*I know an Interahamwe who knew that he was having HIV/AIDS. He used to take women at his house. Instead of killing them he kept them and raped them, and after genocide they left, many of them were infected with AIDS.* Akim (MCM)

The findings of this study revealed that the suffering engendered by rape was expressed by both psychological and physical health problems. The victims of rape endured suffering of a different nature to other genocide survivors, and therefore require care that will meet their specific needs. Unfortunately, the care that they are receiving has been described by the participants as being insufficient.

***The burden of children born of rape:*** The study has shown that survivors who had children born as a consequence of their rape have mixed feelings towards these children. While a few of them have accepted these children, many consider them a burden. They were generally perceived as both a material and psychosocial burden to their mothers.

*It is a problem to give birth to a child without planning or wanting. In normal circumstances a child is born from a mutual love and is raised by both parents*



*but imagine that one born of rape..... her mother who doesn't have anyone to help her to look after the child, this one is indeed a burden. Jean (MCM)*

Umutesi, one of the rape survivors, considered her child as a burden because it was not easy for her to have a fifth child in addition to the four children she was raising on her own after she and her husband had divorced. She explains:

*My husband and I got divorced short time before the genocide; we had had four children, they are all still alive. After being raped I conceived and then gave birth to a boy. I didn't expect to have a child; I also had difficulties looking after the children ....my husband had left me with, so imagine adding on the fifth and on top of that a child who was born in those circumstances, it is really a burden. Umutesi (RS)*

The mothers find these children a burden as they are not only permanent reminders of the hardships they endured, but they neither wanted them nor have much affection for them.

*Some (rape survivors) gave birth to children in these circumstances they didn't expect or want, so they don't feel affection and commitment to look after their children; these children came as a problem and she doesn't like the child and the mother has difficulties coping with that kind of feelings and consider her child as burden. Fidens (MCM)*

The mothers found it even more difficult to raise these children born of rape when the fathers of these children had been responsible for killing all their loved ones. Muteteri explained how those members of her family who survived the genocide didn't like her child as they viewed her as a reminder of what had happened. Muteteri herself is disturbed by some of her feelings towards her child. She said:

*The man who raped me is the same father of my child, and it is the same person who killed off my relatives..... my siblings call my child a bad souvenir, even myself I view her as burden who reminds me [of] the bad time of rape I went through. There is time when I get out of control and view her as her father and feel [like] hating her.... can you imagine how is distressful [distressing] living such a life. Muteteri (RS)*

The mothers are not only troubled by the fact that their children are permanent reminders of their experience of rape, but what makes matters worse for them is that these children are also victims of the system.

What particularly upsets the women is that these children are not recognised by any of the official structures, such as FARG, that have been implemented to help genocide survivors including rape victims, and thus are not eligible for education and health care funding. Participants explained the implications of this discrimination towards those children born of rape and how it psychologically affects their mothers. Aline had personally witnessed such discrimination and shared her perceptions of what had occurred when she was involved with others in reviewing a list of genocide survivors who were due to benefit from FARG' support:

*Recently we validated a list of those who will receive support, on it there was a child born of rape and he was put off the list. His mother was upset she nearly went crazy; she was crying and she was evacuated [carried off] in people's hands and was taken to counsellors. Because people thought she was having [a] psychological crisis... (SILENCE). So you find that such scenarios increase their trauma, it is indeed difficult, we encounter such problems and it becomes beyond bearing. That case upset me and if I got means I would support those children as well as their mothers because they have been discriminated. Aline (WCM)*

Women rape survivors were mainly concerned that their children had no health insurance benefits, but they were also troubled by the fact that because they did not qualify for support, these children were not being properly educated. If their parents are receiving support from FARG, children of genocide survivors that were born before the genocide receive medical care benefits and are granted school fees until university level. As these children born of rape were born after the genocide, they are not recognized by FARG and therefore their mothers cannot claim from those funds for their healthcare or education. One of the rape survivors explained how her request was rejected by FARG authorities:

*They can't cover medical treatment and education fees for my child because FARG law concerns only people who were targeted in genocide. So those who were not yet born at that time are not concerned by the law. This discrimination*

*make me spend sleepless nights by thinking what I can do for my child. Umutesi (RS)*

Participants explained how the limited resources of rape survivors have prevented their children born of rape from acquiring an adequate education.

*So due to limited means of their mothers they don't go to school, they stay at home, some do housework to earn their living. Thus you will find that both the child and the mother live hard life, thereafter these mothers are worried and desperate for their children so that they are insecure and most of the time are unstable and gets sick. Chance (WCM)*

In addition to being worried by the discrimination facing their children, rape survivors were also confronted with various other adverse conditions which were provoking their psychological problems.

### **3.3.4 Secondary victimization**

The participants reported that rape survivors were regularly disturbed by the hostile attitude of some of their community members. Such hostility mainly emanated from those whose family members had been imprisoned for their crimes of rape. It was also revealed that rape survivors were stigmatized by members of their community. Thus, secondary victimization was further sub-categorized into; (a) hostility from family members of the rapists; and (b) stigma.

***Hostility from family members of the rapists:*** After the genocide, some rape survivors continued to live in close proximity to people who are family members of those who raped them. Those who were convicted for rape are serving life imprisonment, which raised the hostility of their family members towards the rape survivors. Hostility is displayed in the form of harassment and verbal or physical abuse. Margo and Muvura explain:

*There are rape survivors who stayed where they lived before the genocide. Over the last days they had some problems with their neighbours who went to visit their family members who are in jail. Some used to come and say "My husband was sentenced to life imprisonment because of you and you are free enjoying your malice". This may be done in privacy and the rape survivor was harassed by the*

*neighbour in that way... This may be distressful and make her (rape survivor) having psychological problems. Margo (WCM)*

*Women who were raped, and as a result of testimonies they gave at Gacaca courts the culprits were put in jail. In that case it is their family members who can harass them. It is unlikely that a family who has their relative in jail and all the time go to visit him will be in good terms with people who made him go to jail, that where the knot of the problem is; a family whose relative is in jail hasn't reached the step of accepting the fact that their person is in jail because of the crimes he committed, fewer people understand this. Muvara (MCM)*

Furthermore, people's perceptions of sexual violence differ. Some of the rapists' family members harassed rape survivors in the belief that raping a woman is not such a bad crime that it deserves a life sentence. Zaninka described her harassment:

*My neighbours are very bad to me. They are keeping saying that I am putting people in prison because they raped me. They added what's wrong with me because it is normal that women sleep with men and I didn't die from it. They don't know how even now I am having sleepless nights, suffering from that experience of rape. From the Gacaca court these men who raped me were convicted of rape and then put in prison. And their family members were not happy with the verdict. It is why they continue to persecute me. Zaninka (RS)*

Results have shown that the families of rapists were not only verbally abusing rape survivors, but were also threatening their safety and security. Participants, however, had different perceptions concerning the safety of the survivors. The rape survivors and the community members close to them felt that they were still vulnerable, the participants at a high level of local administration were of the opinion that the safety of these women had only been compromised during the Gacaca court hearings, a period which had ended in 2009 in their region.

*Well, I haven't noticed any sign of insecurity recently... What I know for sure is that during Gacaca courts, on their way back home rape survivors used to be insulted but these days I no longer witness such cases. Aline (WCM)*

*Such problems of insecurity have stopped since the end of Gacaca court in our*

*region. There were serious problems when case hearings at Gacaca courts started there were decreasing progressively until the end of hearing, now everyone is safe. Gaudence (WCM)*

These statements were contradicted by Ikizanye, a rape survivor, who has been both verbally abused and beaten up by the family members of the man who raped her. They also accused her of speaking out about the rape to get money.

*The men who raped me are in prison, their wives and children have been harassing me. You see, when we come here to the association, they think we come to collect money they say we are proud of our problems and that we have made up stories so we can get money. Last time I met them when they were going to visit their people at the prison, they blocked my way and a fight broke out between us. They beat me up and I suffered much. So due to that I get frightened and can't get a sleep so that my eyes look red in the morning. Ikizanye (RS)*

The harassment of rape survivors was also reported by those community members who interact with them on a daily basis.

*For us who live with them, who listen to their problems when they come to us every day; we have found that some are in conflicts with their neighbours because they have taken them to Gacaca courts; so you will find that they are not in good terms.... There is a woman who came to see me and she said that people throw stones at her house at night in such way that she can't get a sleep. I would tell you that their security is not ensured 100%. Jambo (WCM)*

This was confirmed by another community member who stated:

*There are also those who are intimidated and this is done by people who have cases with them, some have been victims of stone throwing; this is done at night so that it becomes difficult to have evidence for such acts, so you can't sue the person anywhere; and you will find that the woman who is victim is always frightened so that when she is in bed at night she has nightmare; she spends sleepless nights. Alphonse (MCM)*

**Stigma:** Findings indicated that rape survivors were also psychologically affected by the stigma that is associated with rape. Some people associate rape with disgrace and consider it as being the women's fault. According to the participants, some of the community members and family of rape survivors believe that they are to blame for what happened to them.

*People here are saying that during the genocide I misbehaved as I was willing to sleep with any Interahamwe (militias) who wanted to. They spend days gossiping that I don't deserve any respect. When I hear that I burst into tears, I feel a lot of grief and get sick. Akimana (RS)*

*There are neighbours who talk behind them (rape survivors) by saying that they were raped by so and so and things like ... they brought up rape upon themselves, so they felt hurt and embarrassed. Marine (WCM)*

Family members should be the primary source of support for survivors of trauma as they should care about what happened and empathise with the victims. The data indicated that rape survivors became psychologically distressed when their family members blamed them for what had happened.

*I really feel distressed when my daughter start telling me that if in the genocide I was raped it is that I wanted it because I didn't try to escape. She says that because she saw me when I was raped. Kishatse (RS)*

Data indicated although some rape survivors have been accepted by their family members, they are still being stigmatised by certain members of their community. One of the participants recounted this story:

*The husband knows about the rape of her wife and has managed to accept that situation but people with whom they are living within the same village were stigmatizing her by saying that her husband should reject her, he shouldn't be proud of the wife because a raped woman doesn't deserve the pride and that woman was distressed by those hurtful words. Akim (MCM)*

Stigma was reinforced by the fact that in many cases the women were raped by members of their community who later boasted about it, thus ridiculing the victims in their own neighbourhood.

*People who raped women disclosed it and the information was widely spread by people who were laughing at them describing in details how women were raped, and adding that they were suffering from such and such disease as a result of rape. So you find that this is shocking and frightening for rape survivors. Margo (WCM)*

As HIV/AIDS is commonly associated with rape, survivors are therefore stigmatised as suffering from that illness:

*They (rape survivors) are stigmatised and avoided by people who know them because they are viewed as people who were infected with HIV/AIDS. That makes rape survivors to feel desperate about their situation. Jean (MCM)*

Some rape survivors preferred to keep their rape experience a secret due to the stigma attached to the cases that were known. This prevented women from seeking help when they needed it. Akim explained:

*Women were reluctant to seek help by fearing stigma, because once their rape was known people will not consider them as a victim but like a person without respect, and instead of comforting them for having been raped, they say that one is finished and is about to die. Akim (MCM)*

Those who were the most stigmatised were those who had been raped at a young age as in most cases this prevented them from getting married. In Rwandan culture, marriage implies having children and if a man has any doubt about a woman's capacity to have children, he will not marry her.

*Rape survivors don't get men who ask them for marriage because they believe that their reproductive organs were damaged so they won't give birth to children. Cresence (WCM)*

Experiences of extremely violent rape that were combined with the loss of family members and belongings were highly traumatic events in the lives of the rape survivors. In addition to these, however, the rape survivors are still faced with various on-going challenges, such as poverty, ill health and children born of rape, as well as hostility from their community

members. It is little wonder that these women would be likely to develop psychological problems.

### **3.4 GENOCIDE RAPE TRAUMA AS A CONCEPTUALIZATION OF THE LONG TERM PSYCHOLOGICAL EFFECTS OF RAPE AMONG WOMEN GENOCIDE SURVIVORS**

The long term psychological effects of rape were conceptualized as “Genocide Rape Trauma”. This was identified as the phenomenon of the study as it was viewed as the object of interest, the central idea about which actions and interactions are directed at managing or handling, or to which the set of actions is related (Strauss and Corbin, 1990).

Participants viewed and defined the long term psychological effects of rape in terms of the lasting consequences of rape that are affecting the everyday lives of the women survivors. Participants recounted how rape survivors are still psychologically affected by their experiences of rape which becomes manifest in the way they interact with people. Some isolate themselves in their own homes or become aggressive to those who try to engage with them. However, they are mostly disturbed by negative feelings and painful memories in which they re-live the terrible or unbearable traumatic events that they experienced during the genocide.

The complexity of their particular circumstances is that they experienced rape in the context of genocide. Being used as a weapon of war, the manner in which these women were raped was brutal, with the intention of inflicting as much pain, suffering and humiliation as possible. However, these inhuman acts didn't occur in isolation, but were accompanied by the loss of loved ones as well as by material loss. Therefore, the traumatic memories of the rape survivors include other traumatic events which occurred concurrently with rape. The way in which the participants talked about their perceptions of the long-term effects of rape among women survivors highlighted their daily suffering.

The subcategories of Genocide Rape Trauma that emerged from the data were: (a) unbearable memories; (b) overwhelming feelings; (c) sense of helplessness; (d) somatic distress; (e) negative self-image; (f) altered intimate relationships; and (g) social isolation.

***Unbearable memories:*** Women survivors suffer from traumatic memories of their experiences of rape and the loss of their loved-ones. Once they encounter any reminder of the



traumatic event, memories start unfolding in their minds. Participants explained that the anniversary of the genocide is the worst trigger to those painful memories. Some of the women become psychologically traumatized during the week of genocide commemoration when the events are recalled through the media and official gatherings. This annual commemoration, from 7<sup>th</sup> to 13<sup>th</sup> April, has been taking place since 1995. Women who appear to be coping start complaining about intrusive thoughts during the time of commemoration, as expressed by following participants:

*When on the first week of April on Radio-Rwanda they start talking about events related to the genocide commemoration, I start feeling headache due to the memories of rape that happened to me during genocide, so I feel like drum beating inside my head. Gicari (RS)*

*Women who were raped are still having trauma (ihahamuka) Genocide remembrance plays the catalyst in occurrence of those traumas, for example if she (rape survivor) attends commemoration ceremony and hears testimonies on how people were killed and women raped, she collapses and starts crying by screaming out, rolling on the ground. Jean (MCM)*

The women are troubled by unbearable memories of their experiences of rape and of how they lost their loved ones.

*When the genocide commemoration period starts, memories of what I witnessed resurface and I scream out as I see the person who raped me, those who killed my family members and all those memories are unbearable to me. Umwari (RS)*

*Sometime during the mourning period I remember what I saw in the genocide and I view again those people raping me... they were like animals, beasts. I remember how they killed my sister. It so painful to have that kind of memories. Rusaro (RS)*

Although the genocide commemoration each year only lasts for one week in April, the genocide itself lasted one hundred days from the 7<sup>th</sup> of April 1994 until the 4<sup>th</sup> of July 1994. The anniversaries of the traumatic events, therefore, affect rape survivors not only during the commemoration week, but also during the entire one hundred day period. This is explained by one of the woman community members.

*As far as I've observed those women are having problems during the same months and dates at where they have been raped, mainly from April to July. During that period some are remembering each details of their rape and become really disturbed. Aline (WCM)*

Sebastian recounted how a rape survivor was so affected by memories on the anniversary of her rape that she isolated herself during this time.

*She told me that she was raped on 15<sup>th</sup> May; whenever that time arrived she got sick. She used to have psychotrauma (ihahamuka), and kept quiet and doesn't speak to anyone, and felt she had to go to a place where there were no people. She used to go and sit in a wood, and couldn't eat or drink anything. Sebastian (MCM)*

Traumatic memories have invaded the lives of these women rape survivors. Whether triggered by events or not, they often think about what they witnessed or went through during the genocide. Awake or asleep they are haunted by those memories.

When some rape survivors were recounting their stories, they looked haggard and were crying. As they recalled the events that had taken place, it seemed that they had been taken back to the scene of their traumatic experience.

*Day or nights I'm still haunted by images of people who raped me. I can't forget the unimaginable cruelty they inflicted on me, it is indeed unspeakable. I always remember how they raped and how they killed all my seven children and my husband (CRYING). Kwihangana (RS)*

*I am always thinking how I was raped, thinking about my children who died. Even during the nights I can't rest peacefully because I am dreaming about them. Ikizanye (RS)*

Women reacted differently to their experiences of rape. While some women seemed to cope better and adjust to a normal life, others continue to suffer for years and years from the effects of rape. A woman community member seemed surprised when she learnt that her friend, a rape survivor, still continues to suffer from her experience of rape.

*I felt sorry to learn that my friend was still affected by her experience of rape. She told me that some time she is seeing what happened to her like she was watching*

*a film, and also that she was dreaming about what they did to her and that was painful to her, she also told me that memories of rape didn't disappear for good, people always continue to have those memories for life. Chance (WCM)*

**Overwhelming feelings:** Some rape survivors have failed to get over the hard times they went through. In addition to their traumatic memories, they are distressed and frightened. They overreact to everything, are overwhelmed by their feelings and are emotionally disturbed. These women are experiencing disturbing emotions which they can hardly bear. They feel that they are losing their minds to the extent of fearing a mental breakdown. Findings have shown that rape was perceived as a permanent wound which has ruined the lives of women survivors. With such high levels of vulnerability, they are easily disturbed. Their difficult circumstances nurture psychological problems, as expressed by Raphael, one of the male community members.

*Rape survivors are in hard living conditions and are confronted to various problems when they fail to solve them; they get upset and overwhelmed by their feelings and don't know what to do. Raphael (MCM)*

This statement was confirmed by one of the rape survivors who said:

*Some time I feel very upset or feel absent-minded when I encounter problems and fail to get solutions. Muteteri (RS)*

The women rape survivors compared the indescribable discomfort engendered by their disturbing thoughts and feelings to a heavy burden that they were carrying which made them fear a mental breakdown, which they expressed as losing their mind or becoming crazy.

*Some time I have an impression that I am carrying a heavy burden plenty of bad feelings, such feelings of rage, anger. And I fear that I am becoming crazy. Kishatse (RS)*

Kishatse looked tense when she was talking about her feelings. To rape survivors, it seems that their lives are falling apart and that there is no place where they feel at peace.

*This time my life is falling apart. I am really feeling bad. When I'm in farm cultivating, I have heart palpitations and when back home I still feel insecure, and got frightened and feel like I've lost senses and about to go crazy.* Ikizanye (RS)

One of the community members, who is in close contact with a rape survivor, commented that she looked as if she had lost her mind.

*Sometimes she (rape survivor) looks like out of mind with a haggard look; it seems she is not in peace so that people may call her crazy when she isn't really crazy.* Margo (WCM)

A health professional taking care of rape survivors explained that the upsetting feelings and emotions rape survivors experience were signs of anxiety. She identified and summarized them as follows:

*Some of them have sleep problems and persistent fear. They are irritated, many times feeling frightened, upset and the like. For me I think that these women are suffering from anxiety.* Jambo (WCM)

Data revealed that the women were experiencing both upsetting and grim feelings along with negative thoughts and behaviours.

**Sense of helplessness:** The findings have shown that besides having traumatic memories and upsetting feelings, women survivors are also deeply affected by feelings of helplessness. Rape survivors feel they have no power to change the course of their lives and such negative thinking makes them feel sad, desperate and hopeless about their situation. Some went further saying that their lives were meaningless. Those negative feelings were exacerbated by the fact that some of the rape survivors have been left totally alone.

*They lost their family members and are left with no one to help them, are widows and live alone, and on top of that they were raped as result they look like sad and desperate.* Gaudence (WCM)

In the depths of despair and profound sorrow, rape survivors perceive their lives as being meaningless and feel they have no power to change the situation. Apart from being raped,

Kwihangana lost her entire family during the genocide and feels that her life is no longer worth living.

*I have no more energy to work and have no one to help me and I don't have energy to help myself... I feel deep sorrow, my entire family was murdered...I think that life has no meaning and I will always be in tears... And I stop to eat, to drink I sit in front of food and after some time I leave and say to myself other people eat so they will live but me I no longer want to live why should I waste my time on food, so I raise up and go away. Kwihangana (RS)*

These negative thoughts and feelings have impaired the capacities of rape survivors in dealing with events of everyday life. Some felt helpless and hopeless and have begun to focus on death rather than life, as perceived by one of the participants.

*It seems that those women who were raped have lost the power to control their lives... when they encounter any problems instead of thinking how to solve it they thought how to kill themselves. And have also lost hope for the future, they feel they have a few days to live. Aphonse (MCM)*

That pessimistic perception of life has led to some women rape survivors attempting to take their lives. According to participants, rape survivors saw suicide as a solution to put an end to their moral suffering, as observed by one of the community members.

*You will find that the morale of women who were raped is very low, that friend of mine, some time she felt so sad and hopeless that she can cry the all-day... saying that nothing was worse than being raped. And nothing can be done to help her to heal from such terrible wounds... She was saying that she will kill herself and then she will no longer suffer, she tried to commit suicide; fortunately she was rescued on time. Margo (WCM)*

**Somatic distress:** The somatic distress experienced by rape survivors may have its roots in the violent way women were treated by the men who raped them. Umwiza was gang raped by a group of Interahamwe (militias) and was left feeling that they had broken her body. She has not felt well since.

*That gang of Interahamwe (militias) who raped me have broken my body, and I am feeling sad. I mean when you are not feeling well in your body, it is quite impossible to feel well psychologically.* Umwiza (RS)

In spite of the long time that has passed since the women were raped, they still feel pain, both physically and psychologically, as a result of their experiences. Claudia, one of the community members in charge of rape survivors explained their vulnerability:

*Some come telling testimonies of how they were raped and the effect it has had on their lives some complain of having pain all over the body as result of heavy beatings that accompanied the rape, as result they have different physicals problems. And they seem to be worried about their health status.* Claudia (WCM)

According to the findings, many rape survivors were complaining of different pains at the same time, mostly abdomen pain, back pain and headaches.

*Some rape survivors are having abdomen pain, others have had chronic headache and back pain as result of what happened to them.* Charlotte (WCM)

*Even if I was raped long time ago, I continue to suffer from the after effects of rape, I've had persistent headache and back pain. They are very distressful.* Rusaro (RS)

Being in persistent pain has worsened the psychological problems of rape survivors.

*I know one woman who was raped she is having trauma now, and I have noticed that her situation was worsen by different health problems including persistent abdomen pain, backache and headache.* Fidens (MCM)

One of the participants, a health professional who was taking care of rape survivors, said their problems are psychosomatic. She maintained that psychological problems were the underlying cause of many of their physical problems.

*When they come to me they focus on consequences including physical problems; but when I look at it closely, they are having rather psychological problems. Some are sick for persistent urinary infections, gastritis, uterus pain that seem incurable. They persistently go for treatment and said that their diseases have resisted to drugs. It follows that they always see doctors that spend most of their*

*time at health centre. I thought they rather had psychosomatic problems. Jambo (WCM)*

**Negative self-image:** Women were dehumanised and humiliated through rape. These negative images might have been printed in their minds to the extent that they have affected their self-image. They view themselves as worthless, which denotes a low self-esteem and this was expressed mostly via negative statements when rape survivors were describing themselves or sharing their own perceptions to others. Chance, one of the community members, commented:

*They seemed to consider themselves as valueless. They are keeping saying that they have any value, because they have been naked and raped when everyone from their village was there and watching. Chance (WCM)*

That negative perception was influenced not only by their experiences of rape, but also by the way in which they were treated by others, as illustrated in the following statements:

Zaninka believed that she was worthless due to the contempt shown to her by her husband:

*I use to tell myself that I am worthless since I saw my husband very disrespectful to me. Zaninka (RS)*

Survivors who were single at the time they were raped felt even more worthless because they thought that they were no longer eligible for marriage. According to them, losing their virginity was equal to losing their value. Akim recounted his conversation with a single rape survivor in the following terms:

*That girl was saying that she is not more a worthy girl, and was wondering what she shall say to her husband if he asks her why she was not virgin, she will say that she is a rape survivor. To her she prefers not be married rather than being asked such kind of questions. She also thought that her stories of rape could trouble her husband. Akim, (MCM)*

A high value is placed on marriage in Rwanda and, according to the findings, those who were single who had children after having been raped have little chance of getting married. This has contributed largely to negative self-perceptions leading to low self-esteem. Thus, some survivors consider themselves as being “nothing”.

*It is hurtful to see that what I'm today is not what I would be in normal time. I mean if hadn't been raped and given birth to a child I would be still a girl, would have gone to school like other girls of my age, or would have got married and be living a couple life now, but today I'm nothing.* Muteteri (RS)

Rape has affected the self-image of rape survivors to such an extent that they feel that they are no longer normal and do not deserve to be loved because they do not have loving feelings themselves. Martha thought that it was little wonder that experiences of rape negatively affected the loving feelings of rape survivors.

*Such horrible experience hurts the victim to the extent of not feeling love and being loved. You can to everything you think it will show to a rape survivor that you love her... no way she will continue doubting that you love her.* Martha (WCM)

This statement was echoed by another woman community member who reported how a rape survivor had shared her feeling of being unloved by others.

*She thinks that people don't like her or don't care about her, she doubt that someone might love her as she was unlovable.* Chance (WCM)

One of the rape survivors put it into her own words:

*You know I have such impression that my inner self has changed; I feel I miss something in me, I feel I'm not as normal as I was before, because I have such strange feeling that I have no more love in me. It is like now I am an incomplete person.* Kwihangana (RS)

That negative self-image not only makes women doubt their capacity to love, but also their ability to be successful in what they do. Alphonse, one of the male community members, explained:

*They are some who lost their self-esteem. When she (rape survivor) has lost self-esteem, it means that she doesn't trust her capacities of doing things perfectly, for example if she starts a project to yield money, she doubt that her project will last, as she feels that she doesn't have capacities to perform business successfully. Or people will not buy her products.* Alphonse (MCM)



Community members who interacted with rape survivors found that they suffered from very low self-esteem and felt that they were of little value. Raphael explained:

*You may invite her (rape survivor) in a given function and expect her to help you and when she arrives you find that she is in a different mood from yours; some may reveal what happened to them by for example saying “imagine what they did to me and you know it and you are giving me a role as valuable woman”. So you find that she has this complex and sense of worthlessness. Raphael (MCM)*

**Altered intimate relationships:** Rape survivors' pleasure of sexual intimacy has been compromised due to their intense fear, pain and feelings of disgust towards the act. According to one of the community members:

*There is one thing I've seen is common to rape survivors, whether they are married or not, they have problems related to their sexual activity. Some have intense fear of having sexual intercourse, others hate sexual relations, and I may say those women are suffering from sexual dysfunction. Charlotte (WCM)*

Rusaro, one of the rape survivors, explained that she did not enjoy sexual activity because she found it painful:

*A problem I most of time have I feel I don't want have sex with my husband, when I have sexual intercourse it hurts me, I feel too much pain, I don't want him to do deep penetration because when he tries to do it I feel pain at a given part in my genital part, like if I am having a fresh wound in that area. Rusaro (RS)*

Participants associated the sexual problems that women were experiencing to the acts of rape they had been subjected to.

*Those women (rape survivors) have lost any sexual desire and they didn't enjoy having sex with their husbands, as they perceive any intercourse as rape, so a woman may refuse to have intercourse with her husband and the latter may think it is because of natural shyness when it comes to sexual matters, so the man doesn't know how that act may reactivate the trauma of the experience of rape her wife has had latently. Akim (MCM)*

The sexual dysfunction of rape survivors has often led to conflicts in which the husbands psychologically abuse their wives in the belief that they are being unfaithful or no longer love

them. Umwari was verbally abused by her husband due to her sexual dysfunction. Her husband worked in the city and only came back during the weekends.

*When he comes back home he want to have sex with me and I no longer have any sexual desire; I indeed didn't want to have sex with him. Rather than being patient with me and accepting my case, he rather started to abuse me verbally by saying "I know you have had other men", he used to say that I no longer loved him, and that I slept with other men when he left (SILENCE). Umwari (RS)*

When the women were talking about their sexual problems with their husbands they looked embarrassed, as if they were not supposed to talk about their intimacy to an outsider.

Participants explained how the sexual problems experienced by the women caused a breakdown in their relationships with men. Some women were rejected by their husbands, some became divorced and some ran away from their boyfriends.

*Rape survivors who got married are faced with unique problems of sleeping with their husbands; indeed you will find that many can no longer face having sexual activities so that their husbands always threaten to reject them. Charlotte (WCM)*

*I know one woman (rape survivor) who is in the process of divorcing; her husband was abusing her due to her refusal of sexual intercourse and liked to blame her about her rape and she got deeply hurt, she was emotionally disturbed she then decided to part company with him. Marine (WCM)*

One of the rape survivors said that she was no longer with her boyfriend as she was frightened by sexual activities.

*The experience of rape had indeed traumatised me, many years have passed now but it still haunting me, when my boyfriend told me to sleep with him I used to run away and spend the night in hiding, so I left him, today I feel little desire for men, I've lost sexual desire for good. Gicari (RS)*

While some women's relationships with their partners were collapsing, there were others who wanted to build a normal relationship with men hoping to overcome their sexual problems. Kishatse tried to have a sexual relationship with a man she trusted in order to test her feelings:

*I slept with my friend to test if I can have feeling like I used before while having sex. Unfortunately I didn't experience any pleasure, what I remember. It was a very bad experience like someone putting a knife in my vagina. From there I didn't sleep with any man anymore. Kishatse (RS)*

Having suffered degrading acts of rape, the rape survivors have altered their perceptions of sexual activity and view it as disgusting, rather than pleasurable. In addition, the feelings of hate they experience towards men have affected the way in which they interact with them. Some of the women never married as consequence of rape.

*You will find some of them who were still single aged 40 who was raped and gets disgusted, she prefers living alone because the hard times she went through have made her hate men. Jambo (WCM)*

There are others who were so affected by their experience of rape that they collapse if they see men around. Rosine reported how someone from her community, who was raped, reacts towards men:

*She was traumatized by rape, since she fears sexual activity and she hates men...when for example she meets a man who proposes to sleep with her she may collapse. Rosine (WCM)*

In some cases, rape survivors' fear of men affects them to the extent that their daily lives have been impaired. Sebastian talked about a lady who did not take advantage of support that was offered because it was given by a man.

*There is a girl (rape survivor) who recently had asked for support, we collected some items to give to people, others came to pick them but she came but refused to take them and went away. Later I learnt from her neighbours that if a man goes to her home she leaves the place, it means that when she saw that it was a man who was distributing the assistance she refused to take it because she fears men. Sebastian (MCM)*

On the other extreme, there were some rape survivors who were no longer able to control their sexual desire and were propositioning men to have sex with them. Furthermore, some have become prostitutes and sex workers. Akim explained:

*Those who were raped while they were still young many of them have been behaving badly she may come to you and say let me have sex with you, you find that she doesn't control herself; You find that she no longer cares about herself. Some have been involved in prostitution and went to the city to become sex workers. Akim (MCM)*

According to the data, the sexual problems experienced by rape survivors were mainly expressed in two extremely opposite ways. Akim continued to explain:

*I've noticed that people who were raped had a strange way to relate to men. Either they are attracted by men too much and want to sleep with them or they hate them and don't even think about involving themselves in relationship with men. Akim (MCM)*

**Social isolation:** Findings showed that women rape survivors were isolating themselves from their community members and had difficulty in interacting with them. Participants thought that these attitudes were related to their mental health problems.

*They have mental health problems; that making them being cold and withdrawn; you find that these women (rape survivors) don't like going where other people are so they will enjoy being with others and give their opinions like others, it is indeed a problem. Akim (MCM)*

Another participant shared the same observation and added that even when rape survivors were with others, they did not always enjoy their company.

*A rape survivor looks depressed; she is withdrawn and even when she is with other people she doesn't look happy, she is always shaken because of what happened to her, it seems that rape survivors don't appreciate being with others. Aline (WCM)*

Some women were not able to control their irritability, which contributed to their isolation and affected the way they interacted with their family members. Rusaro described how her experience of rape affected the way she interacted with her children.

*Being raped has affected me badly, it has negatively affected my attitudes and how I relate to people. I become easily irritated, I get irritated by a little thing in such way, I don't like my children to talk closer [close] to me, whoever talks close*

*r[close] to me I feel they are distressing me with their noise and I prefer to be alone.* Rusaro (RS)

In some cases, the withdrawn behaviour of rape survivors was perceived by their community members as strange and was sometimes mistaken for hostility or rudeness, as shown in the statement below.

*In general, when you look at them (rape survivors) you find that they are psychologically disturbed, some time they are behaving in strange way or are rude. For example yesterday I came across with a woman that I knew she was raped. When I greeted her, instead of responding she started shouting at me saying that I better leave her alone because she doesn't want to talk to anyone.* Rosine (WCM)

In other instances, women live on their own and their lack of money contributes to their social isolation:

*Well, in general their living conditions aren't good and they aren't looked after or supported. Most of them (rape survivors) live alone, so such a person doesn't have anyone to talk because her people were died. And some time when they want to go and meet their friends they may not have the money to get there. So they become isolated from others.* Fidens (WCM)

According to participants, other psychological problems suffered by rape survivors were, to some extent, reinforcing their loneliness.

*Another case I know is a rape survivor with sadness and grief who have [has] a lot of fear so she can't walk alone for fear that they may be harmed by people who killed her relatives or people may rape her. Therefore she is isolating herself at [in] her home.* Jean (MCM)

Genocide Rape Trauma represents the suffering of women who were not only raped, but also lost many of their family members during the genocide. While they survived these horrific experiences, they continue to face on-going challenges as a consequence. The combination of all these aspects has affected their physical, psychological and social wellbeing.

### 3.5 CONTEXT

Corbin and Strauss (2008) have defined context as the structural conditions that shape the nature of situations, circumstances or problems to which individuals respond by means of actions/interactions.

In Rwanda, rape survivors are living in communities in close proximity to family members of those that raped them, killed their husbands, children and other members of their families destroyed their houses and took their belongings. Some are not only struggling to get over the traumatic events, but have also been left in poverty. Health problems are still a critical concern for rape survivors. However, the Rwanda government has put regulations in place to address the aftermath of genocide which might benefit the rape survivors. Therefore, the main categories that emerged from the data with regard to context were: (a) legal action against genocide perpetrators; (b) public formal support; and (c) private formal support.

#### 3.5.1 Legal action against genocide perpetrators

The Rwandan judicial system was reviewed after the genocide and a law to judge the genocide perpetrators was established. The Rwandan initiative in the matter of genocide law has been supplemented by the international community and the International Criminal Tribunal for Rwanda (ICTR) has been created to judge genocide perpetrators. Those who committed the crime of rape were prosecuted at the Gacaca courts and the ICTR. Thus rapists' accountability at the Gacaca courts and the ICTR was identified as the subcategory of legal action against genocide perpetrators.

***Rapists' accountability at the Gacaca courts and the ICTR:*** For some women survivors, rape was the cost of their survival as those who raped them had taken their possessions and killed their husbands and children. It was vital for them, therefore, that these perpetrators were caught and made accountable for their violations.

Findings have shown that the law against rape crime has been applauded by participants.

*One most important thing is that the government has made a law that allowed [us] to put these men who raped women in prison. Raphael (MCM)*

*Those who raped women who didn't flee the country .....once caught have been sentenced and jailed for that crime committed. Jean (MCM)*

Gicari recounted how she testified at both the Gacaca court and the ICTR. She testified against those who had raped her, killed her family members and taken her belongings.

*You can't imagine how they killed our relatives with unspeakable cruelty, destroying and taking everything we had. I am glad that I got an opportunity to testify against those people at Gacaca court, and that all of them have been punished. You know people who were involved in genocide whatever the role they played, being civilian or military all of them were brought to courts for trial. Gicari (RS)*

Gicari went to testify at the ICTR at Arusha in Tanzania. She explained that although she had found it very difficult to describe the details related to her experience of rape to the court, she was proud that she had done so.

*Those people, they raped us and saying that there wouldn't be any justice... so they can do whatever they want with us... Do you know it was not easy for a mother like me to go out there and testify about how she was naked; it was shameful, very disgraceful indeed... you have to be determined to do so... But it was worth to do so, when you look at it closely you will find that it served for our cause because, whoever had chance to have significant evidence and knows the person who raped her she brought him to court, so those who were found guilty were sentenced to life imprisonment...ICTR assisted us in terms of justice, rape crime has been denounced and combated all over the world, and it has been recognized among serious war crimes (crime against humanity) and I am proud that I contributed on it. Gicari (RS)*

It required great courage and composure for rape victims to testify as they were sometimes challenged by the perpetrators to find evidence for the crimes they were being accused of. Therefore, while the hearings for other crimes were public, those related to rape crime were held in privacy and in the presence of a counsellor to prevent any emotional disturbance for rape survivors during their testimonies. Kishatse described how she was insulted by her rapist during a Gacaca hearing:

*Do you know... that man who raped me for a period of four days, he was insulting me during Gacaca court and saying that I was lying...Fortunately I was aware of that, because my counsellor has told me that the accused often denies the facts to*

*try to innocent himself [make himself innocent] that I have to be firm and calm. And that man said that he didn't rape me because culturally any woman who lost her husband and children has to perform some rituals to be cleaned before she sleeps with a man. He added that he was aware that I was not cleaned, therefore he didn't rape me. But after I argued with prompt details the judge found that I was saying the truth and that man was convicted for rape crime and was punished by life sentence. Kishatse (RS)*

To avoid being imprisoned for the rest of their lives, some of the perpetrators and their family members tried to bribe rape survivors to prevent them from testifying. Umutesi describes how she was offered a bribe for her silence, but refused it and went to testify:

*Look there are people, I've had a case with at Gacaca courts, and they wanted to bribe me so I would keep quiet about it, but I categorically refused... I indeed went and testified openly how they raped me, I gave all factual accounts without any hesitation, and you see we remember all the facts and events, as I told you it's like playing a recording. One of them from this region is in jail serving life imprisonment. Umutesi (RS)*

While the family members of the rapists perceive life imprisonment as a harsh sentence, some of the community members who were interviewed felt that the sentence was appropriate and rapists deserved it in view of what they had done to women. According to participants, crime such as rape cannot go unpunished and for that reason the Rwandan government has taken the appropriate measure of punishing rape perpetrators with life imprisonment. The following two excerpts are the opinions of two community members:

*Both perpetrators and their familymembers are complaining that the punishment they got was disproportionately severe compared to the act of raping women... to me it is fair that rapists have been handed life imprisonment, because those who raped women must be sentenced in that way, they were so cruel when they were raping women, to me they deserved life sentence. Gaudence (WCM)*

*The crime was committed and it is not good to cast a veil over it, the culprits must be punished by the law and the life sentence the rapists got was an appropriate measure taken by the Rwandan government. Marine (WCM)*



### 3.5.2 Formal public support

The Rwandan government did not only take steps to judge the genocide perpetrators; it also initiated formal support for those who survived the genocide. Women rape survivors are assisted in dealing with their daily problems by means of public funding from FARG. Thus the subcategory of formal public support was public support from FARG.

**Public support from FARG:** FARG stands for: “Funds for assisting the 1994 genocide and massacres survivors in Rwanda”. FARG is a public funding initiative undertaken by the Rwandan government to assist genocide survivors to fulfil their fundamental needs. It was established by law n0 2/98 on 22 January, 1998 (Mugabe, 2007). Its four priorities of intervention in support of survivors include education, housing, health care and creation of small income generating projects.

The rape survivors reported that they benefited mainly in terms of housing, health care and assistance for basic needs. Support for education is also offered to those who fit the criteria to pursue their studies, but such support from FARG has not been mentioned in this study. Building houses for genocide survivors who were left homeless has become a priority for the Rwandan government, which makes use of FARG funds for this purpose. Margo stated:

*You know after genocide for many rape survivors their houses were destroyed, FARG built for them on government-owned land new houses, now they live in FARG settlements of genocide survivors.* Margo (WCM)

Kwihangana is one of the rape survivors who benefited from a new house from FARG. She explained the process:

*They support me as a needy genocide survivor. You know, they requested grassroots leaders (village level) to take census of needy genocide survivors, those who don't have means to build houses and don't have shelters because their houses were destroyed during genocide; I was put on the list and now I live in a house FARG built for me.* Kwihangana (RS)

Genocide survivors, particularly those who had been raped and left disabled, suffer many health problems due to the atrocities they faced during the genocide. FARG provides for their health care by paying their medical aid (mutuelle de santé), as stated below by various participants:

*Rape survivors who reported their cases, be it diseases or disabilities have been supported by FARG for care health services. Chance (WCM)*

*Some of those women (rape survivors) are supported by FARG, mostly for their medical insurance. Muvara (MCM)*

*They get (rape survivors) medical treatment because they have medical insurance covered by FARG. Raphael (MCM)*

Ikizanye receives medical insurance from FARG. She said:

*Rape survivors who are poor like me and [are] not being able to afford for their health care are receiving a medical insurance from FARG. Ikizanye (RS)*

According to the Rwandan health care system, if people who have medical insurance from FARG get sick, they are firstly treated at the health centre, which would then refer them to a specialised hospital if necessary. If the case is too complicated to be treated in that hospital, then the sick person is referred to a suitable institution, even overseas, if necessary, for further treatment.

*When she (rape survivor) can't be fairly treated at the health centre and needs further treatment at specialised hospital like King Faycal hospital (referral Hospital), for example women who had fistula and need genital reconstruction surgery.... in such case FARG comes in; there are even case of those who get medical treatment overseas at FARG's expenses. Claudia (WCM)*

In some special cases, the help from FARG goes beyond housing and health care and becomes involved in assisting individuals with their basic daily needs. Although all human beings should be in a position to meet their basic needs of food and clothing, unfortunately there are rape survivors in Rwanda who are living in conditions of extreme poverty who are unable to fulfil such needs. Ikizanye reported how FARG is supporting the neediest from her community:

*Those old mothers... rape survivors who have lost all of their children and have been left alone are supported by FARG at regularly basis, it provides them with different assistance. Those from this area were given cattle, clothes and food. Ikizanye (RS)*

Findings have shown that women rape survivors were not only assisted by FARG, but were also assisted by various women's associations and NGOs

### **3.5.3 Formal private support**

Women's associations and NGOS from the private sector have joined the Rwandan Government in its efforts to address the problems of genocide survivors in general, but particularly those who are more vulnerable, such as rape survivors. Thus, support from women's associations and NGOs became the sub-category of formal private support.

***Support from women's associations and NGOs.*** Women in Rwanda have taken the lead in the creation of different associations to help their peers who survived the ordeals of the 1994 genocide. Findings indicated that AVEGA and SEVOTA, both women's associations, offer psychosocial support to their members and supplement each other in supporting rape survivors to overcome their problems.

AVEGA (Association des Veuves du Genocide d'Avril) is an association created by women who were widowed by the genocide in 1994. It supports widows and their children, as well as rape survivors. With its members spread across the country, AVEGA's support is mainly focused on the health and social problems of its members.

Participants of this study mentioned the support women receive from AVEGA, particularly in the areas of counselling and medical care:

*People at AVEGA, they often talk to rape survivors.... they counsel them and deal with their queries; they have been looking after them (rape survivors) for a long time. AVEGA is supporting women survivors throughout the all country. Fidens (MCM)*

The participants explained that to respond to the health needs of women survivors, AVEGA has created a department of health and trauma counselling services with trained professionals who are providing medical care and psychological counselling.

*AVEGA has professional counsellors so they know how to treat rape survivors who have psychological trauma with counselling, they also organise discussions with them and these women accept their cases; you may hear one say hadn't AVEGA supported me I would have gone crazy. Aline (WCM)*

Numerous women who were raped have become infected with HIV/AIDS. Therefore, taking care of these women has been prioritised by AVEGA.

*Very recently we received assistance from AVEGA; the support was meant for women who were raped in genocide and were infected with HIV/AIDS, it was mainly based on nutrition support. So the support reached all those who reported their cases.* Claudia (WCM)

In some cases, in order to facilitate the care provided for women with HIV/AIDS, AVEGA sends money to them via an allocated bank to pay the transport costs to get to health facilities:

*The women living with HIV/ AIDS are receiving anti-retroviral treatment at AVEGA. Not to miss their regular treatment AVEGA sent them the money.... then women come to take [the] money meant for them from Sacco BANK and went to collect their treatment.* Cresence (WCM)

In addition to AVEGA, another association, SEVOTA, has become a key component in solving some of the problems of the rape survivors who participated in this study. The findings showed that SEVOTA has been a refuge for rape survivors who were lost in the shadow of the 1994 genocide. SEVOTA brought these women together and helped them to get over their loneliness, as expressed in the following statement:

*I am thankful to the coordinator of SEVOTA who learnt about my loneliness and came to me. She reunited all women who were left alone like me. Now we got a new family.* Kishatse (RS)

SEVOTA welcomes all women who needs its services, whether they are single, divorced, widowed or married, as expressed by a woman community member,

*Well, I know that SEVOTA doesn't discriminate any one, it welcome[s] women who were raped even though they have husbands.* Jambo (WCM)

Findings have indicated that women have been both impoverished and psychologically affected by the tragic events that happened to them during the genocide. SEVOTA provides different services to the women who have joined it, which are mainly based on psychosocial support in line with each individual woman's needs.

*Here at SEVOTA we (members) are working closely with the coordinator. Each member is assisted according to the problems she reports. For example some come by saying; you see I have a problem of not having been able to go to school; for that one we put her on the list and she goes to school. Another one comes by telling you; "see me I'm sick"; for this one we put her in the category of those who need medical treatment or to see a counsellor... it real depends on the needs of each and every one. There were also those who have been given goats, cows or small loans... To tell you the truth we are lucky to have SEVOTA... (LAUGHTER). Umwiza (RS)*

Education is another area where SEVOTA is supporting rape survivors. Umwari had dropped out school due to health problems, but with the support from SEVOTA she is planning to get back to school.

*I'm getting better and feel ready to go back to school; I've already submitted my application at school, I will do hotel management and tourism SEVOTA will provide me with all needed school stuff. Umwari (RS)*

It appears from participants' statements that even although SEVOTA welcomes all women who need its services, its main emphasis is to help women who have children born of rape.

*SEVOTA support these women who were raped, specifically those who have children born of rape. Alphonse (MCM)*

Participants explained that when the needs of rape survivors go beyond SEVOTA's capacities, the organization seeks other partners to help it fulfil its responsibilities towards its members. Because of its emphasis on helping woman who have children born of rape, SEVOTA has formed a partnership with Kanyarwanda, a Rwandan human rights organization which also supports such women. SEVOTA and Kanyarwanda have joined together to create a forum to assist mothers with children born of rape.

*SEVOTA and Kanyarwanda are helping us with our children with their schooling and medical aid. Akimana (RS)*

In addition, women have benefited from the psychological support offered by these organizations to help them address the hostility they feel towards these children.

*We have a group composed with only women who have children born of rape, we are having group sessions and there we are sharing the troubled relationships we have with our children. Muteteri (RS)*

From the above statements it is apparent that although women rape survivors are finding some solace in their current situation, they are still having psychological problems related to the consequences of rape.

Apart from the initiatives of the Rwandan government and women's associations to assist rape survivors to cope with their circumstances, various other factors related to the community in which they live influence the healing process of rape survivors, either positively or negatively. These are named intervening conditions.

### **3.6 INTERVENING CONDITIONS**

Intervening conditions refer to the conditions which facilitate or constrain the action/interactional strategies taken within a specific context (Strauss and Corbin, 1990). The findings from this study indicate that the main category which facilitated the management of Genocide Rape Trauma was identified as community solidarity while the main category which hindered such actions was identified as inadequate resources for rape survivors' care.

#### **3.6.1 Community solidarity**

It became evident from the data that the factor which contributed the most to the healing process of rape survivors was that they were cared for by their community members who were sensitive to their suffering and needs. This supportive relationship was a sign of solidarity which was a powerful contribution to the management of the long term psychological effects of rape among women survivors. The sub-categories that emerged under community solidarity were; (a) supportive relationships; and (b) material support.

***Supportive relationships:*** After the genocide, many of the rape survivors were left on their own after their family members had been killed. They were reluctant to interact with their neighbours as some of them had played a part in their suffering. Positive relationships started from the initiatives of their community members who were concerned about their loneliness and decided to visit them.

*Visiting them, having conversations with them, make them to feel that they are not alone; they also realize that although there are people who did them harm there is other people who have good heart to approach them. Rosine (WCM)*

This point of view was shared by another participant who highlighted that there are people in their community who care about the rape survivors.

*You see all people are not bad, there are those who are sympathetic to rape survivors, who are aware and understand their problems, they know those who were having trauma they visit and comfort them. Akim (MCM)*

This was confirmed by one of the rape survivors:

*In our place all know about my case so they often come to my house to see how I'm doing. Last time I had trauma (ihahamuka) and a woman who is the representative of women in our village together with the head of the village in person came to visit me. And they don't do that for me only for I'm not the only one who was raped; we are many and our leaders are always closer to us and look after us well because they understand our problems. Gatete (RS)*

Displaying an understanding of the hardships suffered by rape survivors is a key element in helping them to get over their suffering. In some cases, rape survivors were in such bad health that they were not capable of seeking support or healthcare service themselves and their community members helped them to get what they needed.

*Some have mental problems and don't have anyone to help them to go for medical treatment, so you direct them where they can access doctors and you accompany them when they can't go by themselves. Jean (MCM)*

Chance, a community member, described how she reported the case of her neighbour to SEVOTA to get assistance for her:

*Last time I met a woman who couldn't move because she had been weakened by antiretroviral drugs she had taken because she couldn't afford sufficient nutritious food. I reported and explained her case at SEVOTA, and she was put on the list of those who were going to be given the needed support. Chance (WCM)*

Findings have shown that rape survivors are being cared for by the dedication of community members. Kishatse tells of her experience:

*I have such neighbour who I know they can assist me whenever I need their help. I remember one time I was seriously sick and when I awaked up I found two women surrounding my bed. They told me: “don’t worry, we are here to take care of you”. Kishatse (RS)*

Participants explained that it was the moral obligation of all community members to help rape survivors who were in difficult circumstances.

*I think it is our responsibility for each and every community member to help these women (rape survivors) who were psychologically traumatized by their experience of rape, because all of us know how vulnerable they are. Charlotte (WCM)*

**Material support:** Results have highlighted the willingness of the community members in supporting their neighbours who were raped during the genocide. While some were assisting them financially or giving them food, others were performing activities that the women were not able to carry out themselves.

The rape survivors have various health problems and, due to their poverty, do not have enough money to get to a health facility. Community members help them by providing the necessary money. Muteteri tells how she would not have been able to get to the hospital without the help of her neighbour:

*One day I was seriously suffering from back pain related to my experience of rape and I didn’t have any money to get to the hospital fortunately my neighbour gave me some money to get there. Muteteri (RS)*

Claudia explains from a community member’s perspective:

*Most of times those people (rape survivors) have limited financial means; and some time I give some money to go to hospital. I give 2000 or 3000 Rwandan francs (3 or5 \$) for transport. Claudia (WCM)*



The solidarity among community members is shown through their concern in fulfilling the basic needs of rape survivors. Those who are so poor that they have nothing to eat are assisted by their community members.

*Another thing that is good is to help her (rape survivor) to meet her basic needs; for example if you talk to her and found that she needs food you give her a bunch of banana or some kilos of potatoes; this shows her that there are people who take care of her.* Margo (WCM)

One of the participants explained that according to Rwandan culture, old people who have no family members to take care of them are looked after by their neighbours:

*In our village there is an old mother who has been raped and has been survived with no single child or family member and she is supported by her neighbours who look after her on daily basis by providing her with food water and firewood.* Fidens (MCM)

These signs of support are carried out individually or together as a community. This has shown rape survivors that the community members are concerned about their wellbeing. Akimana reported how members of her community took the initiative to help her and her mother:

*My neighbours have themselves decided to come and help us in farming activities. They do it because they are aware that my mother and I aren't physically able to cultivate.* Akimana (RS)

Data revealed that some of the villages have community work programmes which give assistance to those in need. According to one of the participants:

*If a person comes and reports her problem such as her house is leaking or that it is not well built, that problem is solved during community works where we fix it.* Charlotte (WCM)

Community solidarity is a protective factor against the occurrence of psychological problems of rape survivors as it gives them confidence to know that there are people in their communities they can rely on in hard times.

### 3.6.2 Inadequate resources for rape survivors' care

The hindering actions of the management of long term psychological effects of rape were mainly related to the absence of adequate resources in terms of human and material resources. The two sub-categories that were identified were: (a) lack of appropriate support and; (b) lack of appropriate care service delivery.

***Lack of appropriate support:*** According to the participants, the problems of rape survivors were unique and therefore different from other genocides survivors. While various forms of support had been implemented to assist genocide survivors, there was a lack of structures that specifically catered for the needs of rape survivors. This is outlined in the following statements:

*As far as I know there is no specific programme to support them (rape survivors); they are supported in the framework of general support schemes, they are supported like all genocide survivors. There has been no specific attention to them. I think it might be because they are not many or that their problems are not considered as unique. However in my opinion they need special support. Chance (WCM)*

The participants explained that the circumstances of the rape survivors were unique and deplored the absence of support which was dedicated to their plight, particularly in treating the abnormal injuries that they had sustained as a result of brutal acts of rape during the genocide.

*They (rape survivors) endured the most challenging times. Their relatives were killed and they have been left alone disabled by rape ...so imagine suffering all those things! They need support but it is not there... There is no specific assistance. Marine (WCM)*

*Besides being beaten, cut with machetes like others, on top of that she (rape survivor) was physically ruined, raped and was infected with AIDS. She has had backache and other diseases as a result, so I think her wound is more hurting than other so her medical care may differs from others as well. Aline (WCM)*

It became evident that the rape survivors did not have easy access to health care services. The women could not afford the expensive medication which was not covered by their medical insurance. One of the male community members explains:

*The first support is to look after her (rape survivor) into a particular way because she has a specific problem, for example by providing her with specialized medical treatment. But they don't get the required treatment because the drugs are expensive and they can't be covered by "mutuelle". Then they are not treated and they are continually sick. Jean (MCM)*

Rapes survivors believed that they were still suffering from the sequels of their experience of rape, but that the decisions makers in terms of health issues are not paying particular attention to resolving their health problems.

*I've realized that no efforts have been put in the area of medical treatment and yet we are still faced with diseases we contracted as result of rape we endured during the genocide; long time has passed so those in charge of health need to do something about it. Kwihangana (RS)*

Employees from the public sector who are in charge of helping genocide survivors are aware that rape survivors needed more oriented support. They explained, however, that this is not always possible due to the limited budget at their disposal and also the regulations which have put those women in the general framework.

*Some women victims of rape are very poor, with their known psychological vulnerability they might be given priority when dealing with their situation, but it is not the case. I don't know any support that is specifically meant for them. We support them like another genocide survivor. Look at the sector level we have money for support to the needy in general; but the money is very little it is not enough to provide substantial support. For example since I came here I've paid once 9,700 RWF(Rwandan Francs) (16\$) for assistance and I've been here for ten months, the problem is that the support is limited yet there is a big number of people who need it. Frankly speaking that support is almost not-existent, it is almost nothing. Akim (MCM)*

Another problem that is unique to rape survivors is having to raise children born of rape. There is no legislation in place which regulates the basic rights of these children in terms of education and medical insurance. Charlotte explained:

*With regard to their children born of women are challenged by the absence of legislation allowing the children education and medical insurance. Those children without any education are doing domestic work to earn their living. This is highly disturbing for their mothers who dreamt about a better future for their kids.*

Charlotte (WCM)

***Lack of appropriate care service delivery:*** Rape survivors are mainly treated at the health-care centres because they are widely spread throughout the country and are easier to access than the more specialized facilities in the cities. Unfortunately, these health-care centres have limited human and material resources and only deal with the common diseases.

Participants reported that the Rwandan health care system failed to adequately attend to rape survivors' health needs. This was attributed to the shortage of trained professionals at the primary health care facilities and the heavy bureaucracy related to applying for the medical insurance from FARG which was necessary for rape survivors to attend referral facilities.

*With regard to medical treatment you find that they (rape survivors) go to health centres and they get treated for banal diseases that are externally observable there is no specialized professional to treat them for the complicated disease.*

Jean (MCM)

Umwari attributes her chronic gastritis to poor care:

*I've had chronic gastritis, but when I look at it closely I attribute it to the fact that I wasn't treated appropriately with competent professionals.* Umwari (RS)

The participants indicated that the inadequacy of the referral system was another factor which made their situations difficult. Although FARG does provide rape survivors with medical aid to attend to their medical needs, this is unfortunately restricted to a limited area.

Gicari was treated at a health centre, but didn't get better. She wanted to be referred to a specialised facility for better treatment, but this was not possible as her medical insurance would not cover it.

*I requested the nurse from our health centre to refer me to advanced hospitals; but although I've been referred this hasn't changed anything because I went to a hospital that doesn't cover our area, so they refused to accept the medical insurance (mutuelle) I had, I came back without receiving any treatment and my back pain has persisted and worsened. Gicari (RS)*

This participant was not comfortable sitting down. She said that her back was so painful that she couldn't sit for a full hour. Therefore, her interview only lasted for 40 minutes and additional information was collected during the verifying interview.

Participants explained that the medical insurance they received from FARG meant that they were restricted to the health-care facilities in their areas and could not access more specialized treatment elsewhere unless they followed a long and tedious process. Aline deplored:

*The portion of the cost of treatment paid by the insurer given by FARG covers only the area in which the person lives. For example if she lives here at Kamonyi she can get treatment at Rukoma Hospital but Kabgayi doesn't accept it because she has gone beyond her area. Aline (WCM)*

In order to get access to the more specialised institutions, rape survivors must be in possession of both medical insurance and an official letter from FARG. Aline and Claudia explained the process of getting that letter:

*The one seeking medical treatment because of a disease she is suffering from, she has to get an official paper from grassroots leaders testifying that she needs support and then she writes to the sector to explain her case and then the sector officials refer the case to (FARG) because people assisted at that level are referred by grassroots leaders. Aline (WCM)*

*Once the paper from FARG was obtained the sick person has to get a referral letter from the health centre to the specialized hospital. Claudia (WCM)*

Even although it is possible to obtain an official letter from FARG which gives rape survivors access to a specialised health facility, the process is so long that some either get discouraged or don't have enough energy to follow the process through.

*I got sick. When I went to Rukoma hospital the doctor told me that my case has to be treated by a specialist at the university hospital, but I have been discouraged by the long process of getting the required documents in order to be treated at that hospital. Ikizanye (RS)*

This process of accessing adequate care is not only time consuming, it is also expensive as people have to pay transport from their villages to the specialised hospitals, which are mostly in Kigali, the capital city, and far from where they live. Therefore those who are poor and can't afford transport money will not receive the care they need.

### **3.7 ACTIONS/INTERACTIONS**

Corbin and Strauss (2008: 89) have defined actions and interactions as “*responses made by individuals or groups to situations, problems, happening and events*”. Participants perceived that there is a social implication attached to rape victims as they have been left with physical and psychological wounds and if appropriate measures are not taken their rape related problems may stand forever. Findings highlighted that women survivors were aware that their own strengths as well as outside assistance were required to deal with these wounds. Participants observed that even although the individual strengths of rape survivors are fundamental in overcoming the trauma they experience, it is difficult for them to succeed on their own and more actions from their living context and abroad are needed to support their efforts. In these circumstances, actions need to be taken that are goal oriented in order to respond adequately to their long-term psychological effects of having been raped. The categories which emerged under actions were: (a) psychological care; (b) medical care; (c) advocacy; (d) economic empowerment; (e) women's support groups; (f) education of the community; and (g) help-self strategies.

#### **3.7.1 Psychological care**

According to the findings, psychological care refers to professional health interventions, such as counselling and psycho education, which helps women survivors to appropriately address the adverse consequences of rape. The sub-categories that emerged with respect to psychological care were: (a) counselling; and (b) psycho education.

**Counselling:** Some participants suggested that professional counselling would be beneficial for rape survivors who have failed to solve their emotional problems by seeking comfort from

talking to their peers in support groups, their family members or their neighbours. They felt this was particularly relevant if their daily functioning has been affected.

*When neighbours are in good terms with rape survivors, they help them in their different problems, but there are also a need of trained professional who can provide counselling when those neighbors didn't succeed in helping those women efficiently. Rosine (WCM)*

Other participants highlighted the usefulness of counselling:

*Some women may complain of a problem of incontrollable emotions that can be healed with counselling, but when they don't get that service their problems worsen... Marine (WCM)*

*To support these rape survivors who are easily frightened the first thing is continuous counselling as I've noticed that their psychological problems never end, they seem chronic. Chance (WCM)*

Given the serious psychological problems expressed by rape survivors, it is crucial that they have access to trained, sensitive, well-informed professionals to meet their needs.

*The counsellor should have capacities and competences to help efficiently these women who are suffering from psychological problems and who coming for help. Counsellors should have empathy, be closer to women so they will listen to them and attend to their psychological needs. Marine (WCM)*

**Psycho education:** Educating rape survivors on their psychological problems was perceived by the participants as a sustainable means of providing those women with needed information and skills. If they were more knowledgeable about dealing with their psychological problems, they would cope better with those problems during some of their challenging times.

*Women rape survivors should be informed about the reason of [for] their psychological trauma so they will understand it and accept it, they need explanations and information about all that upsets them... Many of them know about trauma in one way or another, but they don't have all information about it.... you find that they start having psychological trauma when they are giving testimonies, so such a person may learn how to handle and to overcome his emotions in that kind of situations. Akim (MCM)*

The results showed that rape survivors who were members of SEVOTA had the advantage of psycho education from mental health professionals who informed them about the different causes of the psychological problems they are facing today, how they are manifested and the best ways in which to handle them.

*We learnt from professional that women like us who have been exposed to the killings of our loved ones, being raped, which was a life-threatening experience we were at risk of having psychological problems and learnt also about the signs.*

Gicari (RS)

There were rape survivors who were worried because they were not able to control their emotions and burst into tears when they talked about their experience of rape. They felt comforted to learn that tears are a normal expression of painful emotions.

*I have a friend who was concerned about the fact that when she started to speak out of her experience of rape she fell in tears [she started crying] and then started to worry about herself saying that was a sign of psychological trauma. We were taught that crying isn't bad because by shedding tears we are getting rid of our sorrow.* Akimana (RS)

During the psycho education sessions the women received from SEVOTA, they were encouraged to take care of themselves and were taught simple ways of dealing with their emotional trauma. Participants believed that this is a sustainable way of controlling their rape related psychological problems.

*We attended different sessions and we came out with interesting knowledge such as how to handle our psychological problems with relaxation techniques or by talking to a friend, joining a support group like ours and now also when we may see an experienced mental health professional.* Muteteri (RS)

### **3.7.2 Medical care**

As medical care relates to treating both physical and psychological repercussions of rape, two sub-categories were identified: (a) psychotropic medication; and (b) physical medical treatment.



**Psychotropic medication:** Findings have shown that although some rape survivors were receiving counselling, their daily functioning continued to be profoundly impaired by the negative outcomes of rape. Participants reported that medication was an alternative in such situations,

*One day I get trauma and when I came to SEVOTA.... the coordinator (counsellor) took me to a quiet place equipped with a mattress, she gave me water, comforted me by chatting with me. But after that crisis I continued feeling very sad and desperate about my situation and then she sent me to Rukoma hospital where a nurse gave me strong medication to treat my bad thoughts and feelings. Kwihangana (RS)*

*Last week I accompanied a woman who got psychotrauma (ihahamuka) to the health center .....she was crying and restless .....then the nurse gave her an injection of Valium to treat her agitation. Margo (WCM)*

However, a mental health professional explained that even although such medication had positive effects on the manifestations presented by rape survivors, it was only used in cases when counselling had failed. Jambo explained:

*Usually we don't like to give medication to women victims of rape who are having psychological trauma, we prefer counselling to medication but some time we use it when the person is not responding positively to counselling. We give antidepressant like Triptyzol but the medication varies according to the problems presented by the rape survivors. Jambo (WCM)*

Findings have shown that the more complicated cases which are in need of specialized care are referred to the Ndera psychiatric hospital. This referral facility is the only psychiatric hospital that exists in the country. It is well equipped and has various mental health specialists. Charlotte, who works at one of the health centres recounted:

*Yesterday I received a woman (rape survivor).... her neighbour who accompanied her said that since[for the pas] few days she locked herself in her house and was refusing to be in contact with others, refusing to eat saying she want[ed] to die. As I was not equipped enough to treat her case, I referred her to Rukoma district hospital but at their turn they referred her to Ndera hospital. There they have mental health nurses, psychiatrists and psychologists who know*

*how to deal with such case. At Ndera that woman was hospitalized and treated with Anafranil infusion. Charlotte (WCM)*

According to the findings, rape survivors are not only in need of psychotropic medication, they also are in need of medical treatment for their physical problems.

***Physical medical treatment:*** Rape is a complex trauma with many cases having physical repercussions. Findings from this study have shown that many of the women who were brutally raped during the genocide are suffering from bad injuries and chronic diseases as a result of their experiences. In some cases, specialised medical treatment is necessary to treat those cases. One of the woman community members suggested:

*There should be a special scheme to look after them because their problems are also special and unique. They essentially need support in terms of medical care because the problems they have mainly originated from their shaky health because most of [the] time they suffer from persistent diseases caused by [the] rape they suffered in genocide. Chance (WCM)*

According to participants, those injuries and chronic diseases were not being efficiently handled and they suggested that specialized professionals and specialized medical treatment should be available to help rape survivors overcome their health problems.

*Many of them live with HIV/AIDS while the others have had their reproductive organs hurt, and they are faced with problems resulting from being raped, so I think they need special medical treatment like surgery and ARV. Chance (WCM)*

*We are suffering from complicated disease it is why we need specialised doctors, and special medicament to treat us. Kwihangana (RS)*

HIV/AIDS was a great concern for the participants as it is one of the most devastating consequences of rape and cannot be treated without medical intervention.

*They need to get treated for the after effects of rape they face with; for those living with AIDS, those with other problems who complain of persistent abdomen pain they need careful and special medical treatment. They should have drugs or injections which may alleviate their pain. Marine (WCM)*

Findings have shown that the physical problems of rape survivors can be mistaken for psychological problems or vice versa. Thus, health professionals who are involved in the clinical assessment of rape survivors need to be comprehensive and careful so that they do not miss any details which may indicate the real problem of the women seeking care.

*Those health professionals who are in charge of rape survivors have to check carefully their health status during the process of clinical assessment to know the rationale behind the suffering expressed by rape survivors. Because some time a chronic pain may be a sign of a psychological problems but it can be also a true physical problems. It is why I urge my colleagues to check carefully on those women when they come to us seeking care. Jambo (WCM)*

The health needs of rape survivors can only be properly addressed once those in charge of the health system in Rwanda fully understand the impact of the lasting effects of rape and develop services to improve health care for rape survivors.

### **3.7.3 Advocacy**

The study highlighted the need of advocacy to make the problems of rape survivors known, as this may positively influence the community members and decision makers to collaborate to find ways to improve the wellbeing of rape survivors. The findings have shown that the psychological problems of rape survivors are compounded because their children born of rape are not eligible for support as they were born after the genocide. Policy makers should be made aware of this so that it can be taken into consideration. Thus the two sub-categories identified under advocacy were; (a) advocacy for comprehensive care for rape survivors; and (b) advocacy for basic rights for children born of rape.

***Advocacy for comprehensive care for rape survivors:*** Participants suggested that more rape survivors should be approached in order to identify their problems and find suitable solutions.

*It is high time that people approach them (rape survivors) further to find out the problems, the effects they encounter, because many years have gone and people are still faced with those consequences of rape it means that, that issue has not been addressed and solved appropriately, thus it is high time to take drastic strategies to solve the problems of rape survivors I think there is still time for action for those problems rape survivors have been facing as result of being*

*raped, one cannot say that there will be time that those problems will be over for good. We have to work on them regularly.* Cresence (WCM)

Both rape survivors and community members who participated in this study emphasised the need for advocacy to improve the lives of rape survivors, suggesting that people need to be made aware of their health, social and financial needs. Kwihangana expressed her wish of having someone who would help rape survivors find funding to start small businesses.

*I wish we have someone who advocates for us to have (palpable financing) funds for small business because we are poor and don't have any money to start our business.* Kwihangana (RS)

Besides the financial problems experienced by rape survivors, they also have difficulty in meeting their health needs. They feel that the system of health insurance that is currently in place is not tailored to their limited means and believe that changes could occur if someone pleaded their case for them.

*Our case has to be advocated for better health care services, look I have a medical aid (mutuelle) which is only admissible at health care centre it is not in a specialised hospital like King Faycal and the other problems with that medical insurance I can't get all prescribed medication there were some that are not paid by the medical insurance that I have to buy myself which is problematic because with my poverty, I don't have money to buy the prescribed drugs.* Umwari (RS)

Stakeholders have a key role to play in advocating for the needs of their community members, particularly those who are most vulnerable, so that they can contribute to the improvement of their living conditions. Some of the community leaders who participated in this research have become more sensitive to the problems that rape survivors are facing today, and have committed themselves to take a lead in the journey of advocating for their wellbeing.

*From now as stakeholder I feel concerned with the issue of rape survivors, I need to meet with them in order to know their problems, and will advocate for their case...otherwise their problems can't be solved...and there must be sensitization from the grassroots level up to higher level... for better health care.* Marine (WCM)

According to the participants, meeting the needs of rape survivors is a responsibility of the Rwandan government and relevant policies should be implemented to cater for these needs. Those who are working towards the upliftment of rape survivors have to consider their specific needs, and this requires an holistic approach.

*Rape survivors need specific assistance; I think there should be such assistance highlighted in government's policies and programmes. Above all social and financial support, counselling and medical treatment are needed. Marine (WCM)*

*As such assistance requires government budget the advocacy may be carried out by people who clearly understand the problems of rape survivors within the ability to convince the decision makers at the central government how serious the problems of rape survivors are and how it is time to take appropriate measure to solve those problems. Muvara (MCM)*

Jambo summarised the advocacy needed for rape survivors in the following terms:

*Officials in charge of social welfare should attend to them (rape survivors) closely. For health officials, to plead their causes in case their cases need further treatment; to ensure their security; and encourage them to do income generating activities and to avail funds that will support them. Jambo (WCM)*

**Advocacy for basic rights for children born of rape:** Participants were of the opinion that the advocacy of rape survivors would be more effective if it also addressed the needs of their children born of rape as results of this study have revealed how this problem is interrelated with others. These children do not have the same opportunities of education and health care as their siblings who were born before 1994 and the data has highlighted the psychological effect this discrimination has had on the mothers of these children. Although women can receive funding from FARG to support themselves and their children who survived the genocide, there is no cover for children born after the genocide, even if they were born as a consequence of rape.

*The advocacy for children born of rape may emphasize on their education and health care. I think those are basic rights for any child born of rape or not. Aline (WCM)*

Participants believed that steps should be taken to ensure that this policy of FARG is reviewed so that children who survived the genocide and children born of rape are treated equally.

*Only advocacy may change that kind of discrimination and children may have [the] right to education and health insurance... if the law of FARG today says a mother who has children who survived genocide plus a child born of rape, that child will also be considered like others, I mean... to remove the clause that discriminates against children born of rape and put a new one which is more integrative for those children. Jean (MCM)*

Participants pointed out that these children may also become psychologically disturbed as a result of this discrimination and suggested that advocacy is needed to ensure that counselling support should be made available to them.

*There also needs to be advocacy so these children benefit from counselling support. Imagine being born in such conditions where people say your father is an Interahamwe (militia) and he will be in jail for his whole life because he raped your mother. This is really disturbing, because these children felt [feel] stigmatized. Gaudence (WCM)*

Advocacy was seen by participants as a crucial channel from which issues of change could be raised. It was perceived as one way that would alert policy makers to consider the needs of both children born of rape and their mothers when developing governmental policies.

### **3.7.4 Economic empowerment**

Economic empowerment was identified as a key element in helping rape survivors to get over their status of dependence and become autonomous. This would contribute to the development of a more positive self-image in addition to improving the circumstances of their family and the community in general. The sub-category that emerged under economic empowerment was empowering rape survivors through income generating activities.

***Empowering rape survivors through income generating activities:*** The findings showed that rape survivors were demoralized by poverty. Many of them were affected by psychological problems because they were lacking the basic necessities for leading a decent life. Participants advised that the best way of empowering individuals is to respond adequately to

what type of support they need and to be helpful to them. Rape survivors needed funds to help them get involved with income generating activities which would give them enough resources to fulfil their basic needs.

*There should be funds that will help them (rape survivors) for income generating activities to meet their needs like other people rather than always giving them food; this makes them always rely on donations. Charlotte (WCM)*

Many of the women have lost their self-esteem through the frustration of having to depend on others. Generating their own support is a way of empowering the women to become more independent.

*You can't imagine how shocking it is for us to always begging when we were self-dependent before our tragedy, we don't feel proud or dignified of always begging. We need funds that will allow us to carry out small businesses like selling tomatoes and get money to meet our needs. Gicari (RS)*

Cows are considered an important source of income in rural areas of Rwanda, SEVOTA has a policy of empowering women by encouraging and supporting them in farming activities and has provided cows for some of its members.

*I got a cow from SEVOTA this has increased my income by selling milk and fertilizer to my community members. And I was been able to take care of my small family. Akimana (RS)*

Kishaste has chosen to grow vegetables. She said:

*At the moment I am part of a group which is planting Cassava; we are planning to plant tomatoes as well. Those vegetables are easily sold at our local market. Kishaste (RS)*

There a government programme in Rwanda that gives cows to people to help them overcome their poverty and participants suggested that rape survivors should be given priority in this respect.

*They (rape survivors) should be given priority in various development programmes like cow programme (Girinka); they will feel that the government*

*takes care of them; they get encouraged and manage to do some things by her as poverty will be reduced. Sebastien (MCM)*

Participants suggested that getting a loan would help survivors raise the necessary money to start a small business that could generate income. They said that many of the women do not know how to apply for a loan, but that there were community members who were helping rape survivors in the process.

*I help them to set up a project involving an activity which is generating income and get a loan. I keep on following her (rape survivor) up by providing her with advice until she gets significant income. Cresence (WCM)*

One of the community members pointed out that small business activities would not only empower rape survivors economically, but would also help to keep them busy and give them other things to think about than their disturbing thoughts. In fact, empowerment aims to enable women to control their thoughts, feelings and behaviours.

*If for example she (rape survivor) is thinking of a development project, let's say a tomato project; while planning for the project she focus on that activity, in that case the person feels that she can also do something important. Otherwise when she is not busy she keeps thinking about how she was raped she may feel she can't do anything she may feel she is no longer a normal person. Marine (WCM)*

Some rape survivors were being economically empowered by their involvement in various income generating activities which take place in women support groups.

### **3.7.5 Support groups**

The data showed that rape survivors were striving to find ways of improving their lives, despite what had happened. Gathering in group with others was described as a valuable ingredient in helping rape survivors to handle their long term psychological effects of rape. Participants viewed a support group as a safe place where rape survivors can share their testimonies with others, support each other, do activities together and have fun. Three sub-categories which emerged under women support groups were; (a) space for sharing testimonies; (b) space for activities; and (c) mutual support.



**Space for sharing testimonies:** This study has shown that rape survivors found it beneficial to share testimonies with others who have similar concerns. Apart from sharing their stories and everyday struggles, the women enjoyed the company of others, particularly those who lived alone and didn't have anyone to talk to. Ikizanye's husband and children were killed in the genocide and although she had another daughter after the genocide she does not talk to her about her painful feelings of being raped. She said:

*At home I live with my little daughter and I can't talk to her about my rape story yet I sometimes strongly feel the need to speak it out, I only talk about it when I come to the support group. Ikizanye (RS)*

It was found that in sharing their stories, rape survivors realized that they were not the only ones who had suffered, and that others had also had equally horrific experiences.

*When they (rape survivors) are together they talk about their problems and each of them feels they aren't the only one who has problems, this comforts them. Raphael (MCM)*

*Here in our group we are interacting in an open and friendly environment, while sharing our experiences one may say my case is unique and another one comes in and gives their story, when you start losing hope you hear what others are saying and you realize that your case is not unique; it is common to all of you. Gicari (RS)*

*When I'm in our support group I listen to my colleagues and when I see that there are those whose problems are worse than mine I keep quiet. I used to think that I was the only person who was mostly affected, but I found that there are others whose hardship is worse than mine. Gatete (RS)*

Support groups have become a privileged space where rape survivors are comfortable in sharing their stories of hardship as well as their hopes and dreams.

*Here I meet with other women we share our stories, our happiness and worries. We have no limit when we share, it depend on what it comes out in our mind. Zaninka (RS)*

Group members have had common experiences that enhance their sense of connection. The trust relationships that have been built among them allow constructive interactions to take place. Akimana emphasized how the trusting relationship facilitated the sharing of emotional feelings:

*In our group we trust each other, we talk about our problems, others listen to us and we listen to them; here everyone is open to another and an opportunity is provided to share our experiences, our feelings and are given due consideration. It is indeed encouraging to see that someone is open to you and listens to your problems.* Akimana (RS)

In addition to sharing testimonies, women rape survivors also carry out useful activities to promote their wellbeing within their support groups.

**Space for activities:** Findings revealed that women were involved in various activities in their support groups, such as income generating, learning and leisure activities. The community members valued the benefits of the support groups and encouraged rape survivors to join. This was expressed in the following statements:

*I often encourage them (rape survivors) to join others in associations because what they do is just to live lonely and don't get together with others. The advantage of being in associations is that they attend to economic activities. In our village, we have such group where women are weaving basket and I use to recommend to those women rape survivors to attend that group.* Rosine (WCM)

*It is important that these women (rape survivors) join others in associations because there, they have people to talk with, they were no longer alone. In these groups women are meeting weekly for their farming activities, so if one of them encounter a problem she has chances to find a solution to it thanks to talking to others.* Aline (WCM)

While community members valued support groups mainly as places to learn about generating income, rape survivors indicated that to them, there is more to a support group than a space for learning to generate income as they viewed their groups as spaces where they could learn coping skills and enjoy the company of other women. Furthermore, within these groups, rape

survivors have more access to mental health professionals when they come to teach them self-help coping skills.

*The most advantage I had by coming to SEVOTA it is that here, the coordinator is organising different trainings for us with professional who teach us, they explain to us, why until now we are having psychological problems and how they could be handled . Umwari (RS)*

Akimana explained how she learnt relaxation techniques when she came to SEVOTA:

*When you are in a group it is easy to learn, most of the time the activities of relaxation are practical and we are following the instruction given by the counsellor and when you don't get it correctly you may have a look on how other are doing and then you catch up the exercise. This is helpful because when you learn it, it is for good, because when you are at home you continue to practice at your own. Some time I tell myself if I wouldn't come to SEVOTA I would not been able to have those skills. Akimana (RS)*

The data showed that the leisure activities that took place within the support groups were much appreciated by women rape survivors as they were having a good time together. Dance was the most popular activity which took place in the support groups. Participants said that even although they enjoyed dancing to the rhythm of traditional Rwandan music, they preferred dancing to religious songs as they found comfort in the messages of hope.

*Some time we are dancing Rwandan traditional songs, but we prefer more the religious songs because they vehicle a message of hope that every one of us want and need to hear. To dance we learnt different "chorus" and then we repeat them. With "chorus" the dance is more dynamic and everyone feel involved because in the "chorus" you can put your own words what you think are giving a powerful message of hope to yourself and to your group. You clap your hands. you laugh you just pay attention of not changing the rhythm of the dance. Zaninka (RS)*

The women enjoy the time they spend dancing and laughing. Participants explained that religious songs are also used as a medium for prayer.

*The first thing we do when we meet is to worship and entrust God with our problems. When we start singing God songs we all, young and old, dance cheerfully and we end up by cheerful laughter. You know laughter is the best medicine. What is unique here is that we join our efforts in any activity we are performing together, and when we start dancing all rise up and we dance in unison. You can't imagine the cheerful climate that prevails when we are singing the famous chorus called "Our lord is powerful and listens to our prayers".*  
Muteteri (RS)

Participants believed that the cheerful climate which prevails in support groups is a cornerstone for mutual support between rape survivors.

***Mutual support:*** In their support groups, rape survivors learn from each other by sharing ways of handling the hardships that have befallen them. By doing so, they mutually contribute to reinforcing their coping skills.

*The first thing is for her (rape survivor) to be with other people who share the same problems, they exchange experiences, so one may compare themselves with others and then they learn constructive experiences. When a person joins others she knows how others are living, and understand that her problems are shared by others and learns how to develop her. When they are together they are helping each other.* Fidens (MCM)

*Here (support group) we talk to each other and get lessons and experiences from each other, you may sometimes find that what you don't consider as important is actually what matters, and when you do it serves you a lot and changes your life. It is indeed encouraging to see that people are open to each other about their cases or problems and they are willing and committed to listening to you and give you relevant advice.* Muteteri (RS)

Rape survivors affirmed that group support had tied them together by creating an important social network and a source of comfort and friendship.

*Support groups have made us united as one knot, we approach and talk to one another and have friendly and sincere exchanges, so when you've become united everyone is eager and keen on knowing about others' cases or problems, you*

*become real friends so you're always closer to one another and can seek their help if need be. Umwari (RS)*

According to the participants, the benefits of mutual support extended beyond the boundaries of the support group and reached the women in their homes.

*In our group we are in good terms with each other, all women I met here they are very kind to me, when I am at home and need their help I call them and they come to me and they know also that they can rely on me at any time. Gicari (RS)*

The mutual support, given and received, experienced by rape survivors within their groups has contributed to their wellbeing.

In view of all the advantages that support groups can offer rape survivors, some of the community member participants suggested that SEVOTA and other similar organisations which help rape survivors should approach them and urge them to join a support group.

*Women rape survivors should be in groups like the one of SEVOTA, and organisations that claim that they support people should approach them. While women are in those groups they become accessible to those people who are willing to address their problems, either by supporting them with moral or material support. It is also easier to teach them how to develop themselves when they are in a group. Muvara (MCM)*

Although women support groups play an important role in facilitating the management of the women's psychological problems, the extended community also have a part to play in the process. To react accordingly, the community needs to be educated so that it will fully understand the very real problems that rape survivors are currently facing.

### **3.7.6 Education of the community**

According to the findings, making community members aware about the role they play in preventing or provoking the psychological problems of rape survivors, and providing them with information and needed skills in supporting those women when the needs arise were found to be valuable actions that facilitate women survivors in their journey to recover from Genocide Rape Trauma. Thus, the sub-categories that emerged in relation to education of the

community were: (a) raising awareness; and (b) education of the community in basic counselling skills.

***Raising awareness:*** Findings revealed that raising awareness of rape related issues was a process that may contribute to change the negative perceptions that community members hold in regards to rape survivors.

Raising awareness will enlighten the community about the unfair circumstances that affect rape survivors' daily living. Once the community is informed, it will hopefully adopt new attitudes in dealing with rape survivors by being sensitive to their concerns and responding to their needs.

*The population should be sensitized, so they will know that in their society there are people who went through hard times. This should be done because there are some people who don't know that these people went through hard and appalling times. Some may say "what is that one complaining of; she is pretending to have problems" because they don't understand the extent of the problem. Marine (WCM)*

If people are aware of how hurtful their attitudes are towards rape survivors, it might be a step in the right direction for them to change the ways in which they interact with them.

*People have to be informed that we are not accomplice of our rape, we are rather victims. In our village we know each other; they know women who have been raped. Some time when we come across with our neighbours they say, look this one has been raped and this makes us to feel ashamed... In the community some people say such upsetting words because they don't know that is so hurtful. Kwihangana (RS)*

Grassroots leaders are responsible for addressing the problems of those living in the communities, particularly those who are vulnerable, such as rape survivors. Participants suggested that those grassroots leaders need to be sensitized about the problems of these women and learn how to approach them in a helpful way that will not worsen their situation

*There should be signs that the government employees takes care of rape survivors, and when a rape survivor has a problem they should take time to listen*

*to her; rape survivors look like vulnerable when you don't listen to their problems .....their problems worsen for [them when] they aren't psychologically stable. Raphael (MCM)*

Participants suggested that members of the community could be reached in different ways. In Rwanda, there is village gathering on the last Saturday of every month for community work where village leaders give important information to the population. Participants suggested that village leaders could use this opportunity to tell people about the current situation of rape survivors. They also suggested that radio programmes could be used to reach many people.

*The sensitization should be done through various communication channels including radio programmes, conversations held at the level of community works (umuganda), at grassroots level from the village level. Marine (WCM)*

In some of the villages, there are committees who educate people to fight against gender based violence. Participants proposed that this space may also be used to speak out about the issue of rape survivors.

*I know that at cell and village levels there is a committee of people who sensitise [the] community about fighting women and children's based violence..... during those discussions one can pass on the message of the situation of genocide rape survivors so people will get [become] aware that what was done to these women was a serious crime and that its consequences are still evident today. Aline (WCM)*

Raising awareness may also address the discrimination issues of children born of rape.

*I think we should sensitize people to change their mentalities towards the perceptions they have of those children because they were marginalised. Claudia (WCM)*

Community awareness about the unjust circumstances that affect rape survivors is a tool that can be used for changing the community members' perceptions, behaviours and attitudes towards rape survivors so that they can come up with collective solutions to the different problems that rape survivors are facing.

***Education of the community in basic counselling skills:*** Results have shown that some community members were doing a great deal to help the rape survivors by interacting with them, comforting them and helping them to overcome many of their problems. Participants believed, however, that they could be even more helpful to the women if they had some counselling skills to assist these women psychologically as only a few community members had received training in counselling to handle these cases.

Participants who were members of the community in charge of the wellbeing of rape survivors highlighted their need to be trained in counselling skills.

*Social health agents who have responsibilities to look after rape survivors should be trained in counselling. We need training because we are aware of the psychological problems these women are facing but don't know how to help them efficiently.* Marine (WCM)

*Sector staff, we need trainings in counselling because we come across with these cases of rape survivors and you find that we don't know how to deal with them professionally; this is true for village and cell levels as they were dealing also with rape survivors. I think all of us we need really training in counselling.* Alphonse (MCM)

Training in counselling skills will empower the community with expertise in providing effective support to rape survivors who are at risk of developing psychological problems. Women would then be able to seek help from those trained people or be referred to a mental health professional if their problems cannot be resolved at community level.

*At grassroots level there is a need to train people on counselling skills who these rape survivors may rely on when they are in need....if those people at the village are trained in basic counselling skills they will be able to know how to approach and talk to those women. So talking to these women they will know if they are able to help the women or if they have to refer them to a qualified professional.* Rosine (WCM)

The participants were of the opinion that the high authorities who are in charge of mental health in the country should take the lead in training people from the communities.



*The Ministry of Health has to make a plan to train people in basic counselling skills because in our community we have still those women who are having regularly trauma who need help.* Claudia (WCM)

Some participants believed that mental health professionals could provide the much needed training skills to grassroots leaders. The following participant who learnt from my introduction that I am a mental health by profession suggested that I conduct training in counselling, because it was highly needed. He said:

*You as mental health professional you have to come at grassroots and teach us how to help these women. We need to understand their problems, with training in counselling we will know how to talk to them and how to comfort them.* Fidens (MCM)

Results from this study have shown that rape survivors were more vulnerable to trauma during the period of the genocide commemorations. Therefore community members who have been trained in counselling are particularly helpful and as they complement the efforts of mental health professionals in assisting traumatised women through this difficult time. Some of the woman community members who participated in this study explained how they learnt the necessary skills to counsel rape survivors who were in psychological crisis:

*I underwent a counselling training that aimed to equip us with skills to assist those people who present [with] trauma, especially during the remembrance period..... last April I was appointed at the memorial genocide site and was helping those women who were having trauma.* Chance (WCM)

*I had training in basic counselling skills and I know how to help these women. I tell them how to behave when the genocide commemoration period is approaching and they know that they can knock at my door any time they are feeling psychologically distressed.* Gaudence (WCM)

It also follows that if community members possess the necessary skills, they will be more confident in handling the psychological problems of rape survivors. Participants also suggested that with the shortage of trained mental health professionals in Rwanda, it is crucial to provide community members with basic counselling skills to enable them to help rape survivors who are unable to help themselves.

### 3.7.7 Self-help coping strategies

The data revealed that rape survivors were aware that being able to take care of themselves is an important factor in overcoming the on-going psychological effects of rape. Their self-care strategies differ from one to another according to their respective skills and needs. Rape survivors were using both natural strategies of everyday life and skills learnt from mental health professionals in dealing with those problems. According to the participants, the most common strategies used were journal writing, praying and relaxation activities. Thus, the sub-categories became (a) journal-writing; (b) turning to God in prayer; and (c) relaxation.

**Journal-writing:** Findings have shown that some participants kept a journal to deal with their psychological problems. Umwari explained how she keeps a journal in which she records her thoughts and feeling to help her manage her painful feelings from her experience of rape. She also writes about other events that please her.

*I have a note-book where I put everything that upset[s] me. I've named my journal "Life journey after April 1994". In the journal I wrote the evil my rapist did to me, I record all my serious secrets in that notebook, even secrets I can't dare reveal, I keep these secrets in the book because I know they won't come out... But some time I write also what make[s] me happy. For example [a] few days ago I got a small job where I was helping people in building house, I got money that helps me to buy some material [for] school and gift[s] to my kids. So I was happy for[and] that is why I wrote that in my note book. Umwari (RS)*

The data revealed that various participants used diaries to record their most disturbing thoughts and feelings. Diaries were also often used by women who were too shy or embarrassed by their experiences to disclose them to anyone.

*My close neighbour is rape survivor. She didn't have any psychological problems, even in commemoration period she is fine. She told me that she has a note book who has been her counsellor, where she put everything disturbing what she felt uncomfortable to disclose to anyone...What she needs is to have just a pen, a note book and a quiet place to write what is disturbing her mind. Gaudence (WCM)*

**Turning to God in prayer:** Results have shown that some of the rape survivors found comfort in prayers as they brought their problems before God and many used prayer to help them deal with their painful thoughts and feelings.

*There are women rape survivors who have committed themselves to praying, they have committed themselves to God; they often pray so that they don't feel open to anybody because they spend most of their time on praying, that is also due to consequences they suffered in hard times they went through, they were raped, they are faced with poverty-related problems, so they take prayers as their consolation, such a person says to themselves "I won't get a solution from a neighbour but I can get it in prayers." Alphonse (MCM)*

Some of the participants of this study were strong believers who attributed their survival and their everyday living to God's power and mercy. These women, therefore, found prayer the best way to deal with their problems. Gicari believed she survived the ordeals of the genocide by the mercy of God and strongly believes in the power of prayer.

*I prayed and God rescued me; they poured poison in my mouth but I brought it up. So ever since when I feel I've got into these disturbing problems I kneel down and I pray. There is no more power[ful] arm against problems than prayers. Gicari (RS)*

Prayers bring peace and contentment into the lives of rape survivors. They become inspired with hope and courage, making their lives more meaningful and thus helping them to cope with their problems.

*I pray and read the bible, when the times are tough to me I repeat these words from the bible: "The Lord is my strength and my shield". Prayers inspire hope and courage. I use to take alcohol to solve my problems but now I stopped because I became a Christian. I have decided to put my life in God's hands. Only God has the answer to my problems. Zaninka (RS)*

While some of the survivors relied on prayer to help themselves in dealing with their problems, others found solace in relaxation activities.

**Relaxation:** The most common activities women were using for relaxation included listening to the radio or using various relaxation techniques they had learnt from mental health professionals.

Participants explained that in rural areas in Rwanda, people only have access to music through the radio. Women survivors enjoyed listening to the radio as it helped them to relax and they found it soothing to listen to soft music.

*I used to listen soft music to [the] radio.... I have found that it is way of relaxation [relaxing] my tense mind, which doesn't involve any cost. Umwiza (RS)*

*When I am alone at home and want to relax, I open my radio and start listening, but I become more relax when on the radio there is soft music and when I am listening that music I can't be invaded by my bad thoughts. Kwihangana (RS)*

Rusaro sings in a choir and this is where she has found peace.

*I have tried different ways to relax myself and I have realized that singing has been a source of relief. Music has been my treatment against bad memories. Rusaro (RS)*

Other women preferred to involve themselves in physical exercise to relax as they believe that exercise will keep them healthy.

*You can't be psychologically or physically healthy if you don't practice sport. To keep myself in good shape I use to practice some physical exercise. Mainly I like to walk. Muteteri (RS)*

In addition to these common, well- known strategies, women were also using techniques they had learnt from health professionals when they were psychologically distressed.

*When I am feeling stressed, I practice body relaxation exercises, as learnt. My preferred[method] is the breathing technique. It is an easy one .... it is about slow and deep breathing. I breathe out bad air, then I move on to breathe in fresh air, I hold my breath and then slowly exhale. Kwihangana (RS)*

According to the participants, these relaxation strategies were intended to promote wellbeing and were carried out by rape survivors either individually, in groups or with people from the support system who were concerned by their psychological problems.

### **3.8 CONSEQUENCES**

Consequences are the responses or outcomes of actions and interactions that answer the questions of what happened. Consequences might be also emotional responses to events (Corbin and Strauss, 2008). The actions and interactions that were carried out by different individuals, as reported in this study, aimed to help women survivors to recover from their Genocide Rape Trauma. Thus the ultimate expected outcome of those actions was Genocide Rape Trauma Recovery.

#### **3.8.1 Genocide Rape Trauma Recovery**

The data has shown that actions taken by rape survivors themselves, their supportive systems and health professionals were expected to yield to different consequences that are related to the recovery of women from their Genocide Rape Trauma. Those consequences were identified as sub-categories of Genocide Rape Trauma Recovery. Those were: (a) psychological relief; (b) recovery from physical illness; (c) regaining positive self-image and self-reliance; and (d) social integration.

According to Strauss and Corbin (1990), consequences may be predictable and intended, may be actual, present, potential or may happen in the future. However, there are also consequences that can result from the actions not taken and in such cases the problems that were supposed to be solved continue to persist or become worse. The findings from this study revealed that various actions have been taken that have contributed to solving some of the problems of rape survivors, but failure to take appropriate actions to address other aspects of Genocide Rape Trauma has caused it to persist. Psychological relief was achieved when rape survivors used their self-knowledge to take care of themselves or received appropriate care from health care professional. Failure to take appropriate and needed actions, such as recovery from physical illness, regain of positive self-image and self-reliance, social integration were among the consequences that will happen in the future once the actions suggested by the participants are put in place.

**Psychological relief:** Findings have shown that even although participants placed emphasis on dealing with psychological crises as they occurred in order to gain relief from the symptoms, they also highlighted the importance of preventing such occurrences. Participants, were therefore promoting a policy of preventing psychological problems in rape survivors rather than intervening only when those problems were impairing their daily functioning, as they believed that it was better to protect these vulnerable women from potential problems. Thus, they suggested that relevant organizations should train people in counselling so that they can help rape survivors to prevent their psychological problems.

*Structures in charge of psychological trauma like MINISANTE (Ministry of Health) should identify and train people from the grassroots level on how to counsel a person who was raped. I think this will prevent these women from suffering of trauma which I was seen was impairing their daily functioning.*  
Charlotte (WCM)

Findings have shown how supportive community members were using constructive conversations to help rape survivors prevent their psychological problems. Through the medium of these conversations, they encouraged the women to focus positively on their future life.

*You find that having constructive conversations with a woman who had been raped, help her to focus into the right direction; this prevents her from relapsing into her negatives thoughts. You talk to her about interesting activities that's what would contribute to her welfare, you seek to know her plans for the future and you encourage her to go ahead. This helps her to focus on building her better life rather than on [her] painful past.* Rosine (WCM)

The compassion of concerned neighbours has helped women survivors to share the pain caused by their experiences of rape and given them relief from their different psychological problems.

*Rape survivors have respite from the pain caused by their experience when they reveal what happened to them to those neighbours who were sympathetic and they trust. Their understanding helped rape survivors to overcome their distress and sadness.* Sebastien (WCM)

In some cases, however, the women felt they could not trust their neighbours and preferred to write their embarrassing problems in a journal or share them with their peers in the support group.

*Because I feel embarrassed to talk openly about my sexual problems, I make sure that I am in a quiet place then I write down those disturbing thoughts ....afterwards I feel relieved. Umwari (RS)*

*I have embarrassing problems because they are related to my sexuality and I can't trust my neighbours and talk to them about those issues. What I do is to keep those problems to me and wait until I get an opportunity to meet other women in our support group ....we sit together and talk about our problems, that's when I speak them out and feel somehow relieved. Rusaro (RS)*

Trained professionals have helped rape survivors to manage their psychological symptoms better by teaching them how to identify signs of oncoming trauma. Such self-knowledge alerts these women to the onset of psychological problems and they are then able to prevent the relapse on time.

*Since I have learnt from professional how to identify the alerts signs of my trauma, now I know how to prevent me to relapse. Because when I am feeling tense and not being able to concentrate to any activity at home, then I know that I have to go out for a walk otherwise I relapse. Once outside, I meet people, greet and chat with them, this help me to get away from my bad thoughts and help me to feel relax enabling me to attend to my activity. Umutesi (RS)*

Some of the rape survivors who had been overwhelmed and desperate about their traumatic memories have found relief and renewed hope through praying. Participants viewed prayer as a source of strength and hope and the findings showed that it was a powerful instrument in assisting rape survivors to overcome their problems.

*When all those genocide memories overfill my head, I feel desperate and see the future darker than the present. As I know my Jesus is my only hope, I immerse myself into prayers and God relieves me of that entire burden, He put more light and hope in my life. Akimana (RS)*

According to the findings, it is not only the rape survivors who have acknowledged the power of prayer, but their community members have become aware of how much it has helped them and have started organising prayer sessions in their homes to help them regain hope.

*In our community we have set up a programme where we hold praying sessions at homes of rape survivors in order to help them overcome their loneliness. And we have noticed that with our prayers they have regained hope and stability.*  
Fidens (MCM)

According to participants, rape survivors who were seriously affected by their psychological problems needed help from a mental health professional to overcome their situation. One of the community members explained how a rape survivor who had been depressed regained hope and confidence after being supported by a counsellor.

*I know a woman who was raped and become depressed, but she has managed to overcome that problem because she had chance to benefit from counselling, and her case was understood and dealt efficiently that assisted her to regain hope and confidence and seems to cope better with any distressful problem relate to her rape.* Aline (WCM)

Women survivors who felt confident were coping better with their lives. Confidence was viewed by participants as an essential element which was nurturing the wellbeing of rape survivors.

*I was not feeling well. With the loss of my dignity [that] I underwent I felt that my life has lost its sense and wanted no more to live and went to a counsellor. She helped me a lot as later I felt confident and courageous in myself to cope with problems I was faced with.* Kwihangana (RS)

However, in some cases where the problems were severe, hospitalisation was required to provide the necessary medical treatment.

*During the mourning period my trauma becomes worse. As I remember those bad things [that] happened to me..... I got trauma and I had to go to Ndera hospital (psychiatric hospital) for treatment. The doctors gave me pills until I recover[ed] from my traumas and I then I go back home.* Gatete (RS)



*Severe cases are referred for specialized care. I referred a woman rape survivor to Ndera hospital, due to its suicide attempts, after a couple of weeks after she has been hospitalized at Ndera and have received anafranil in infusion; she got recovery and then was send back home. Jambo (WCM)*

**Recovery from physical illness:** Results have highlighted the need of relevant health care services to treat the physical illnesses of rape survivors as many of them experienced psychological problems as a result of their physical diseases. Participants expressed that it is important for the psychological wellbeing rape survivors that their physical problems are treated and cured.

*Now I have [a] hearing disability and I haven't got any treatment for that specific disease, yet it may be cured. I went to different health facilities (hospital), but the disease hasn't been cured, I still live with it. Muteteri (RS)*

*They need medical checking so they will know exactly the problems they have. Marine (WCM)*

Rape survivors believe that their cases are complicated and therefore need to be treated by specialised health professionals.

*Availability of specialized health professional is necessary because they will look into our specific problems and ascertain diseases we've been suffering from, and then will treat us accordingly. Kwihangana (RS)*

Participants believed that the Ministry of Health would implement change if it was aware of the inadequate care available to rape survivors as the Ministry of Health is responsible for allocating health professionals to different health care facilities and equipping the facilities with the necessary materials. One of the participants was of the opinion that research was a way of advocating the cause of rape survivors by making the Ministry of Health aware of the limited health care services available to them.

*So I think people like you who do research should show with your results.... that care services of rape survivors are needed because they have diseases related to genital organs that were hurt..... you should plead their causes to the people from*

*the Ministry of Health who will take needed measures on health care issues so rape survivors will get treated and cured.* Rosine (WCM)

One of the factors that is hindering the treatment of rape survivors is the long process of the referral system from a health centre to a specialised hospital. Participants believed that if the referral system was made easier, they would have a better chance of receiving the required treatment.

*It would be more easily for us if we can have straight access to these specialized hospitals rather than passing through the health centre, this will facilitate [us] to be treated on time by qualified professionals and [to] get healthy.* Umwari (RS)

**Regaining positive self-image and self-reliance:** Results have revealed that rape survivors lost their dignity through their humiliating rape experiences and some women felt that they had also lost their value as a woman in Rwandan society. Their dignity was even more affected when they become socially dependent due to the poverty they suffered having lost not only all their property, but also their loved ones with whom they were working together as a family to fulfil their needs.

The fact that their rapists have been judged and imprisoned has had a positive contribution in restoring the dignity of rape survivors. Umutesi explains how she felt when the man who raped her was convicted at the Gacaca court for rape crime and was put in jail.

*Although his imprisonment has not wiped off the wounds he afflicted to me and cannot make me forget the cruelty he did to me, it has shown me that Gacaca officials have considered my hardship and handed him due sentence. Justice is so important because you feel your dignity has been restored, and you also feel your pain relieved.* Umutesi (RS)

During the genocide, rapists were treating women as objects rather than as human beings with rights. They thought they could do whatever they wanted with them without any further consequences. Justice has restored their humanity and self-esteem.

*By the way they believed that they could do whatever they wanted to us be it killing us, raping us and that would go unnoticed, especially because they had reduced us to nothing...We felt that we have no rights. So I've been encouraged*

*by the fact that justice has been done to me. It is so exceptional to feel again that you are someone valuable and judge may spend hours to your case....Of course his imprisonment doesn't suppress what he did to me, but at least he paid for his crime. Umwari (RS)*

Although such justice played a big part in restoring the dignity and self-esteem of the rape survivors, this will only be fully regained once they are able to overcome their dependency on others. This study has shown that dependency as a result of poverty was undermining the recovery process of rape survivors. Women rape survivors viewed self-reliance as the solution to that problem. Participants believed that if they could get funding to start a small business, they could end their dependency and become self-reliant and regain the respect of others in their community. Participants explained that this would increase their self-esteem.

*Some time I feel diminished on depending to others, but if I get funds from sponsors this will allow me to be able to implement a project that will give me sufficient income and would help me to develop socially and economically ending over my dependency. Consequently I will be again a valuable woman respected in my community. Kwihangana (RS)*

*Rape survivors were viewed no more worthy women by their neighbours because they were dependent. I am convinced that if these women get funds they will run their own business improving both their living conditions and for their families. This will allow them to be considered as valuable person who are contributing to the wealth of their family. Cresence (WCM)*

Findings revealed that economic development was viewed as a source of better wellbeing. Participants believed that women rape survivors would have more access to funds from sponsors if they grouped themselves into associations

*If they group themselves in cooperatives or associations, they will get funds for their project easily because sponsors trust more associations than individuals. Those funds will help them in their economic development, to save for better future and overcome poverty which is undermining their self esteem. You know more rape survivors will be self reliant more they will feel self-worth. Alphonse (MCM)*

**Social integration:** According to participants, social integration will be achieved once rape survivors and their children are accepted and integrated into their community. Safety was highlighted by the participants as a fundamental condition for that social integration.

Findings have shown that the rape survivors have felt safer since their rapists have been imprisoned. Some of them had been living in fear for many years, but felt more secure once the judgements had been passed.

*Since my rapist was sentenced to life imprisonment, I've felt secure. But before he went to jail I used to get frightened by him because he could come any time and kill me to destroy evidence. I am feeling so safe...I will never meet him again.*

Umwari (RS)

On the other hand, however, the findings have shown that the safety of rape survivors is threatened in some instances by rapist's family members. This requires the appropriate measures by relevant authorities to ensure their security. One of the community member participants suggested:

*Both neighbours and authorities should assist them (rape survivors) with regard to their security. Thus they will feel safe as other member of their community.*

Jambo (WCM)

Participants observed that insecurity went hand in hand with discrimination and they believed that community awareness was the best way to fight against the insecurity and discrimination that rape survivors are currently facing.

*With the community awareness people will be informed how insecurity and discrimination are distressful to rape survivor, in that case people will understand that those women who had misfortune to be raped can't be discriminated and threatened instead they would be approached and integrated in the community.* Aline (WCM)

They also felt that community awareness will help people to consider the children born of rape as equal to other children in the community. The findings have shown that women have been psychologically affected by the discrimination shown towards these children and it

follows, therefore, that if these children are accepted into the community it will contribute to the psychological wellbeing of their mothers.

*There should be community awareness so people will take these children as others from their community. This will decrease the distress of their mothers as they suffer from the exclusion of their children. Claudia (WCM)*

Furthermore, the participants suggested that a law protecting these children against discrimination should be adopted. This would help these children to benefit from their basic rights to education and health care.

*Those children indeed need attention so they will enjoy the same rights to health care and education as other children. There need to be a specific law that protects them from discrimination. Aline (WCM)*

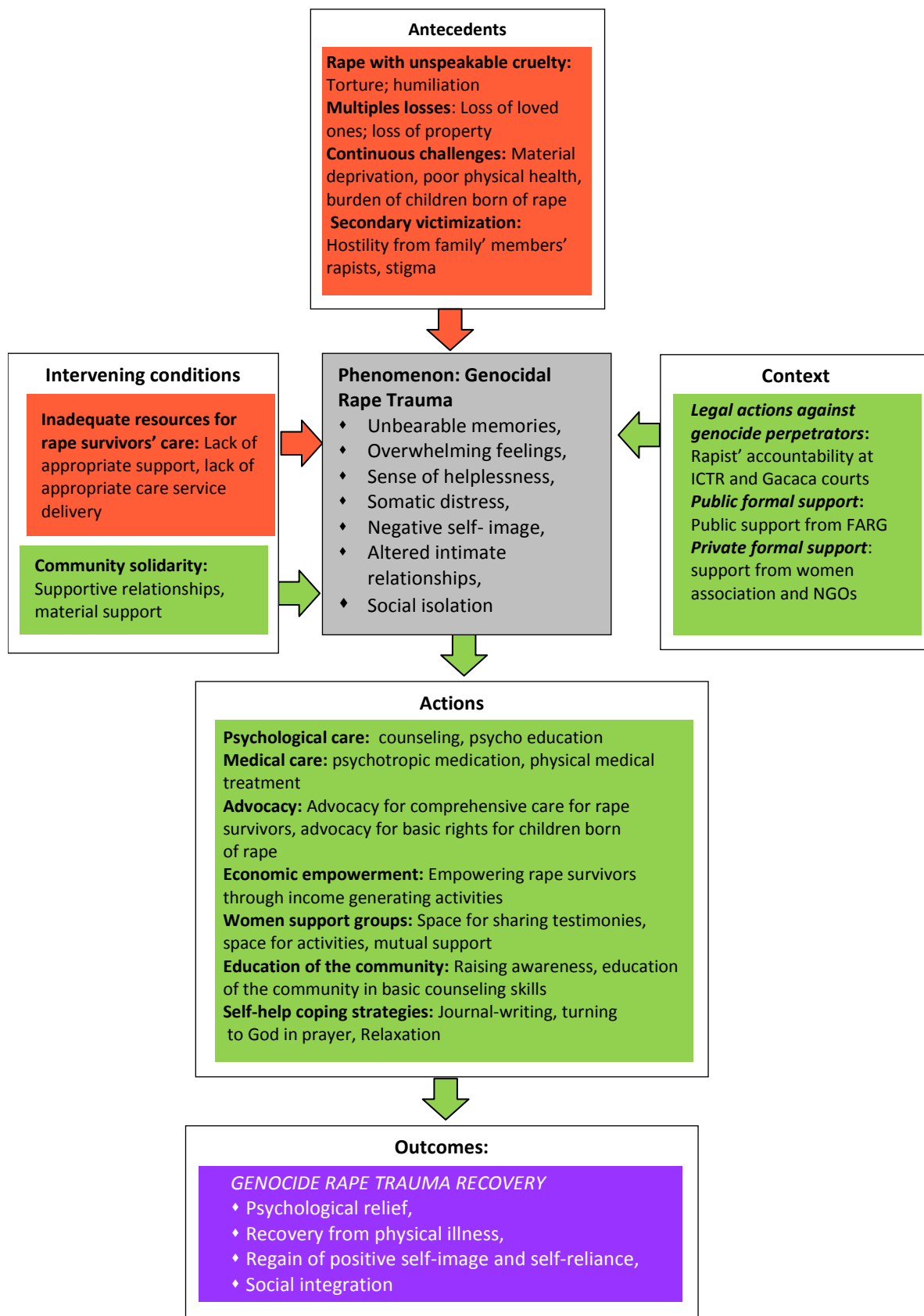
Participants viewed children born of rape as a consequence of the genocide and believed that they should receive the same benefits as genocide survivors. One of the community members explained:

*With regard to children who were born because of rape, it appears that they are a direct consequence of genocide, so they need to be supported as those who survived the genocide especially for their health care and their education. When those children will be healthy and educated and completes their studies they will become useful to them and to others. Then both mothers and children will have hope and confidence for better lives. Chance (WCM)*

### **3.9 CONCLUSION**

The presentation of the results highlighted the long term psychological effects of genocide rape and the reasons survivors are still experiencing such lasting effects of their ordeal. It also described how this has impaired their day to day functioning and identified factors that could influence their recovery process. Adequate health care service delivery and the development of specific policies and programmes to ensure the wellbeing of these women have been suggested as crucial steps in helping them to recover from Genocide Rape Trauma. However, although the main goal of each action would be recovery from Genocide Rape Trauma, this has yet to be achieved. In fact, total recovery may not always be a realistic goal, and

interventions should be conceptualised in terms of ongoing support to ensure the maximum possible physical and psychological healing and social reintegration. The findings of this study are schematically represented in figure 4. The content highlighted in red indicated those conditions what contributed to the development of Genocide Rape Trauma and are connected to it with a red arrow, while those in green represent the factors contributing to its management. They are connected to Genocide Rape Trauma by also a green arrow. Genocide Rape Trauma the phenomenon of the study is in grey while the Genocide Rape Trauma Recovery which represents the outcomes is in purple.



**Figure 4:** Schematic representation of findings.

## **CHAPTER FOUR: LITERATURE REVIEW**

### **4.1 INTRODUCTION**

The literature review is a cornerstone of any research study as it informs on the methodology to be used and also provides ways of interpreting and analysing data (Burns and Grove, 2009). Even although in grounded theory there is no formal interdiction of referring to literature before commencing the study, (Glaser and Strauss, 1999) suggest that the researcher should avoid becoming immersed in the literature so as to guard against importing preconceptions and expectations into the field which are borrowed from the work of others. According to these authors, the researcher should read the literature on the relevant areas of study once the data analysis stage has been reached (Glaser and Strauss, 1999).

Corbin and Strauss (2008), on the other hand, advise the researcher to read the literature in order to shape the study and develop the research questions. Therefore, in line with Strauss and Corbin (1990), the literature review was carried out in three phases. The first phase served to build the background to the study. The main intention was to be aware of the existing literature which allowed the identification of the gaps in existing knowledge and provided a rationale for commencement of a grounded theory study (Burns and Grove, 2009). The second phase of the literature review was carried out after the categories had emerged in order to enhance the theoretical sensitivity. This phase also served to determine whether there were similarities or differences between the present findings and previous literature on a similar phenomenon (Strauss and Corbin, 1990). The third phase consisted of reviewing new literature while discussing the results and refining the emerged theory. The literature is therefore reviewed throughout the whole study and each phase has its specific purpose (Strauss and Corbin, 1990). This extensive reading was carried out to inform the development and the explanation of a middle range theory for the management of long term psychological effects of rape among women rape survivors of the 1994 genocide in Rwanda.

This chapter presents the historical background of the 1994 genocide in Rwanda, an overview of the theories on the use of rape as a weapon in armed conflicts and the use of rape as an aspect of genocide in Rwanda. The theories on the post trauma reactions are described as well as the long term negative psychological outcomes of rape in times of both peace and war. The rationale of reviewing the material of rape in peace time, which was not the focus of this research, was suggested by the fact that rape in war time was an extreme extension of rape in



peace time (Heit, 2009). The risk and protecting factors of the outcomes of rape as well as therapeutic interventions were reviewed. Finally the post genocide support for women rape survivors, and for the whole of the Rwandan society, is outlined.

On-line databases used for this search included Academic search complete, CINAHL, Healthsource: Nursing/Academic Edition, PUB MED/ MEDLINE, PsycInfo, psycArticles, Wiley, Science Direct, Google, Google Scholar and Index to legal periodicals. Key search terms were *Rwanda, genocide/war, rape or sexual assault, consequences and interventions relating to rape trauma and theory.*

#### **4.2 BACKGROUND TO THE 1994 GENOCIDE IN RWANDA**

Rwanda was colonized by both Germans and Belgians. The 1994 genocide in Rwanda in which the Hutu government of Rwanda and its extremist allies aimed at the extermination of the Tutsi was the result of its historical legacy of colonialism and post-colonial politics (Mamdani, 2001). Zegeye (2010) argued that the genocide was a manifestation of historical social injustices and tensions between the Hutu and Tutsi that had not been correctly addressed by Rwandan politicians after the colonial period.

In 1885, at the conference of Berlin, the European governments had divided the African continent and Rwanda was given to Germany (Melvern, 2000). The German colonizers arrived in Rwanda in 1894 and found a feudal society composed of people of different social classes known as the Tutsi, Hutu and Twa. While the Rwandese shared some customs, had common religious and philosophical beliefs and spoke the same language “Kinyarwanda” (Green, 2002; Melvern, 2000; Prunier, 1995), those classes were indicative of the individual’s economic status. The Tutsi were cow herders and as cows were considered a sign of wealth, the Tutsi were considered as high class. The lower class Hutu were cultivators and the Twa lived as hunters in the forest. A person might shift from one group to another by a change in economic status. Germany, however, started the division by turning the social classes into ethnic groups, and this was reinforced by the Belgians (Prunier, 1995).

Rwanda became a Belgian colony in 1916 after World War I, when, in collaboration with the Allies, the German army was defeated (Semujanga, 2003 ). In accordance with the practice of colonization, the administrators selected a group to be privileged and educated in order to serve as intermediaries between the governor and the governed, and the Belgians chose the Tutsi (Budeli and Vambe, 2010). Their choice was based on physical characteristics. The

Belgians determined that the Hutu with a short build and dark skin were an inferior Bantu people and the smaller Twa were at the bottom of the social hierarchy, while the Tutsi, who were taller and thinner, with a light skin and a more European look, were considered as superior. Thus, the Tutsi were granted more power, educational opportunities, and social and economic privileges than the Hutu or Twa (Mamdani, 2001). In 1936, after they had organized a national census, the Belgians introduced an identity card which classified every Rwandan as Hutu, Tutsi or Twa (Semujanga, 2003 ). From then until 1994, every Rwandan citizen was required to carry those identity cards everywhere.

In 1959, because of their feelings of oppression, the Hutu revolted, seized power from the Tutsi, took their land and killed approximately 20.000 of them. The surviving Tutsi went into exile in neighbouring countries such as Burundi, Congo and Tanzania, with the majority going to Uganda (Power, 2002). In 1962, the Hutu won a referendum organized by the United Nations and Belgian granted independence to Rwanda. Gregoire Kayibanda, a Hutu, was elected as the first president (Shaw, 2003). In 1973, Juvenal Habyarimana organized a coup and took power from Gregoire Kayibanda. However, under both regimes the Tutsi inside the country were discriminated against and subjected to periodic killing and ethnic cleansing (Dallaire, 2003) and exiled Tutsi were not permitted to return (Rettig, 2008; Melvern, 2000).

Three decades later, in 1990, a second generation of the exiled Tutsi formed an organized army, the Rwandan Patriotic Front (RPF), and tried to come back to Rwanda by force, attacking the regime of Habyarimana (Prunier, 1995). This was the beginning of a civil war that lasted three years. During this time the French government provided weapons and training to the Rwandan troops while the RPF was supported by Uganda (Melvern, 2004).

In 1993, the Arusha accords signed in Tanzania agreed on power sharing between the Rwandan government and the RPF, and a United Nations force was called to keep peace during the transition to an elected government (Power, 2002). Hutu extremists opposed the accords and started plotting the extermination of Tutsi and moderate Hutu. The armed forces and political parties began the training of militias; the majority of them being recruited from streets boys, rag-pickers, car washers and homeless unemployed. Despite their lowly origins, the militias had authority to take revenge on powerful people who were perceived to be on the wrong side, and they could steal, kill and rape with minimal justification (Prunier, 1995).

An anti-Tutsi campaign began using the Rwandan government radio station and RTLM (Radio Television des Mille Collines) and Hutu also circulated propaganda via written press. Governmental officials and military leaders were describing Tutsi as arrogant, advantaged immigrants, devils, who were the enemy of the people, and oppressors, who were responsible for all that was wrong in the country (Dutton, 2007; Human Rights Watch, 1996). The discourse of hate recalled the period of division under colonialism where Tutsi were more privileged than Hutu and this ancient situation was exploited in the preparation and execution of the 1994 genocide when extremist leaders encouraged the Hutu to take their revenge against the Tutsi. Those Hutu who believed that they had been the victims of history and were resentful of their previous subordinate status become determined to eliminate their oppressors. Tutsi were viewed as enemies and along with some of the Hutu, who were seen as traitors, become the target of the attack (Semelin, 2007). The planners of the genocide used propaganda to amplify the religious, racial and ethnic differences between the groups (Dutton, 2007). According to Baum (2008) all forms of hatred can be used to inflame the population for murder once the enemy has been socially identified and the attack becomes legitimate when everyone knows who the enemy is.

On 6 April 1994, the governing president of Rwanda, Juvenal Habyarimana, was killed in a plane crash while returning from a peace conference in Tanzania. People close to the president accused the RPF of the shooting. The death of Habyarimana, was then used as the pretext to initiate the Tutsi genocide that had been planned a long time previously (Human Rights Watch, 1996).

April 7<sup>th</sup> 1994 was the official start of the genocide and the aim was to kill every Tutsi in the country. Hutu civilians were told via the radio to wipe out the Tutsi as they were the enemy of the state who had killed their president (Rwafa, 2010). All those who were carrying Tutsi ID cards were targeted (Budeli and Vambe, 2010). The position of Twa during the genocide was less visible because they were very few in number (Desforges, 1999).

The whole population was mobilized to hunt and kill the Tutsi. People killed their neighbours, looted and destroyed their houses and some were even told that they could appropriate the land of the Tutsis they killed (Rwafa, 2010). However, the Interahamwe (militias) were the most active in the killing throughout the country, using guns and slashing machetes (Prunier, 1995). The brutality that characterized the genocide was unprecedented and forty-eight methods of torture were used against the victims. People were buried alive,

quartered, impaled or roasted to death, organs were cut out, the wombs of pregnant mothers were cut and opened, all of which led to incredible human suffering (Mamdani, 2001). According to this author, Tutsi women were particularly targeted and labelled as cockroaches, as they had the ability to reproduce other Tutsi. This labelling was intended to dehumanize the Tutsi as a group and enabled ordinary people to murder without compassion and empathy as they assumed they were squashing an infestation and not killing another human being (Baum, 2008; Dutton, 2007).

Daily warnings and reports of genocide addressed to the United Nations by the commander in charge of the UN peace force were ignored. France, Belgium and the United States sent troops to Rwanda to evacuate their citizens, leaving behind the millions of Rwandese who were being murdered (Melvern, 2000). The international community showed no interest in stopping the genocide in Rwanda (Power, 2002). The genocide against Tutsi ended on 4 July when the RPF rebels led by General Paul Kagame captured the capital city, Kigali, and ousted the extremist government (Rwafa, 2010). In one hundred days, an estimated one million Tutsi men, women and children and moderate Hutus were murdered, and an estimated 250,000 women were raped, the majority of them being Tutsi (Melvern, 2000).

#### **4.3 RAPE AS A WEAPON IN ARMED CONFLICTS**

The use of rape against Rwandan women, particularly the Tutsi women, was, unfortunately, not a unique phenomenon. Sexual violence against women is an abhorrent social phenomenon that prevails in armed conflicts. Since the beginning of time, women have been subjected to rape in time of war (Kivlahan and Ewigman, 2010). However, the systematic use of rape as a strategy of war was not documented until World war I (Heit, 2009).

Today, various sources have documented the phenomenon of wartime rape and theories have been developed to explain it. However, theorists have failed to find a consensual theory which can provide a full explanation of wartime rape, probably because it is such a complex human phenomenon and little human behaviour can be explained by a single theory. The most reported theories in the literature are feminist theory, biosocial theory, cultural pathology theory, strategic rape theory and genocidal rape theory.

### **4.3.1 Feminist theory**

Feminist theory places emphasis on the inequality of power and viewed rape in times of both war and peace as being motivated by the desire of a man to exercise his dominance over a woman (Brownmiller, 1975). Kivlahan and Ewigman (2010) pointed out that rape is related to the lack of attention to the safety and respect of women in both war and peacetime contexts. Factors such as geographical, cultural, religious, political, legal, as well as the personal military behaviours influence the use of rape in war (Kivlahan and Ewigman, 2010). Early civilisations perceived a woman as the property of a man and rape was not perceived as a crime against the woman or girl herself, but rather against the man to whom she “belonged”, be he a father or husband (Seniavskii and Seniavskaia, 2010). In such patriarchal societies, in the war situation, rape was not so much a crime of physical and sexual violence as a symbol of a combatant’s victory over his opponent (Heit, 2009). Blackburn and Thomas (1998) explained that once the ancient Greeks and Romans had conquered a city, they enslaved and raped the women as a sign of victory over their enemy.

According to Barstow (2000), the current sexual violence against women in war is an expression of male power, where women’s bodies become a tool to be used by men as an end to political and military means. In line with the feminist theory, (Heit, 2009) declared that if patriarchal and subjective attitudes are exhibited towards women in peace time, they will be treated accordingly in armed conflicts. Therefore acts of violence become automatic in wartime as they represent a continuum of the usual oppression faced by women.

### **4.3.2 Biosocial theory**

The biosocial theorists are of the opinion that men possess instincts of sexual aggression that are restrained under normal conditions, but which come out in a chaotic wartime situation (Gottschall, 2004). The influence of the environment on whether a behaviour is aggressive or not was emphasized by (Thornhill and Palmer, 2000). Therefore, wartime is seen as remarkable illustration of a time when environmental conditions are favourable to coercive sex, as internal and external inhibitions are momentarily removed in these contexts (Henry et al., 2004). These authors highlighted the increase of rape in wartime as result of the acceptance of interpersonal violence, which is legitimated by institutionalized military violence. Furthermore, the anonymity and confusion which prevail in times of war overcomes self-control and the usually inhibited impulse to engage in sexually aggressive behaviour

(Winton, 2011). In addition, the consequent punishment which is usually an inhibiting influence of aggressive behaviour, is considerably lower in a war context, which is mainly characterized by relative anarchy and lawlessness (Dutton, 2007).

### **4.3.3 Cultural pathology theory**

Cultural pathology theory attributes the occurrence of rape to a nation's history in assessing what factors incite soldiers to rape women in wartime. The way people behaved prior to conflicts influences the way they will behave in times of conflict. Maladaptive behaviours they have towards women, in general, and to their sexuality, in particular, will influence the way they will interact with women in times of conflict. Chang (1997) linked the rape of Nanking in 1937 when Japanese soldiers committed atrocities on Chinese women to the brutality of military training and profound contempt for women in Japanese military culture.

MacKinnon (1994) explained Serb rapes of Muslim and Croatian women in early 1990 as a consequence of the widespread availability of pornography prior the war. She suggested that pornography was an important preparation for sexual atrocities as it normalized the dehumanization of women and the pleasure of men while they were inflicting sexual assaults on women. According to (Dutton, 2007), an historical base of lowered self-esteem with a threatened egotism may be a leading factor contributing to sexual violence. Rape implies a sense of power from a man's perspective, thus, a frustrated man might resort to sexual violence as a way of rehabilitating his self-esteem. He evokes the case of the 1994 genocide in Rwanda where there was an historical belief that Hutu had an inferior status vis-à-vis the Tutsi.

### **4.3.4 Strategic rape theory**

The strategic rape theory was reported by activists, researchers, international journalists and commissions as being the most appropriate in explaining the occurrence of rape in wartime. Gottschall (2004) argues that rape is used in the same manner as bullets and bombs in armed conflicts for military purposes. Rape creates fear, shame and demoralizes the women victims, their family and their communities, and by so doing facilitates the defeat of the enemy group.

According to Barstow (2000), in conflict situations, rape is used as a weapon to achieve the intended goal. For example, when the gain of territory is at the origin of the conflict, rape become more effective than murder, which was illustrated by the war in Bosnia in 1991-1995

(Hayden, 2000). Loncar, Medved, Jovanovic and Hotujac (2006) state that before the expansion of the war in Bosnia, rape was used to spread fear among the target ethnic group in order to make them flee and so that land could be taken. They added that many people were incited to flee during the time of occupation through fear brought about by public mass rapes. The rationale behind this process is to evacuate the population and undermine their possibility of joining up and fighting back (Hayden, 2000).

#### **4.3.5 Genocidal rape theory**

With genocide being the most devastating form of war (McCann and Pearlman, 1990), rape is used to inflict terror on a population, or as way of ethnic cleansing (Hargreaves, 2002). In such circumstances soldiers don't spare anyone as they rape all women, from young girls to the elderly, inflicting deliberate physical and psychological pain (Kivlahan and Ewigman, 2010). Thereafter, women may die from their injuries or become pregnant by the enemy. Forced pregnancy of a targeted group was viewed as a genocidal act because once pregnant, those women cannot carry the babies of the men of their own ethnic group (Fisher, 1996).

Dutton (2007) stated that in military rapes, sexual opportunity and desire to humiliate and annihilate the victim seem to be at play. Raping women in front of their family members suggests that knowledge of a human social taboo against family sex is part of the consciousness of the military rapist. Its purpose is to generate humiliation in the victim and her family. Allen (1996) stated that in World War II, even although Germans were prohibited from raping Jews so as not to contaminate their Aryan blood, they raped Jewish women to achieve total humiliation and consequently destruction of the Jewish race, whom they considered inferior.

In a society where the chastity of women is honoured, rape victims may be abandoned by shamed husbands and families, which affects the ability of the culture to replenish itself through sexual reproduction (Gottschall, 2004). Rape, therefore, becomes a paramount genocidal act as it serves to annihilate a people and its culture (Hayden, 2000; Allen, 1996).

Even although the above mentioned theories differ from each other, they share the similarity of viewing rape in war as not being incidental, but rather being functional, as it serves the interest of the conflict's purpose.

#### **4.4 RAPE AS WEAPON OF GENOCIDE IN RWANDA**

During the 1994 genocide, Tutsi men and boys were targeted to be killed (Jones, 2002), while the women and girls were spared to be raped. Genocide perpetrators also raped Hutu women who were members of the political opposition parties, married to Tutsi men or were protecting Tutsi. Even although, in some circumstances, the lawlessness and disorder which prevailed in the genocide led to indiscriminate sexual assaults against both Tutsi and Hutu women, Tutsi women remained the target group (Human Rights Watch, 2004).

In accordance with strategic rape and other genocide rape theories, the rape of Tutsi women in Rwanda during the genocide in 1994 did not happen by chance. It was a well-planned strategy, used as a weapon to destroy not only Tutsi women, but the Tutsi as a group (Desforges, 1999). This author noticed that prior to the genocide, the Rwandan government specifically put in place a campaign of hatred against Tutsi women, which made their subsequent rape possible. Propaganda of hate against Tutsi women was diffused through the media, where these women were portrayed as being beautiful, but inaccessible to Hutu men. Therefore, raping a Tutsi woman during the genocide was associated with “tasting” (Green, 2002). To refer to the cultural pathology theory that relates the occurrence of mass rape to the previous context, the myth of the sexuality of Tutsi women who were regarded as being sexually sweeter than Hutu women, contributed largely to multiples rapes as militias ‘tasted’ those women. At the same time, because their attraction and beauty was stereotyped in the Hutu extremist newspaper named “Kangura”(Rwafa, 2010), Tutsi women were accused of being enemy infiltrators using their sexual charms to access influential Hutu men (Human Rights Watch, 1996). Intermarriage between Hutu men and Tutsi women was condemned by Hutu extremists, who viewed the offspring from mixed couples as racially impure. Being socially at the permeable boundary between the two ethnic groups made these women more vulnerable to rape (Green, 2002). According to the view of extremist ideology, Tutsi women used their sexuality as a tool to dominate the Hutu group, therefore rape was an effective method to shame and defeat the Tutsi population (Human Rights Watch, 2004). On the other hand, rape was a form of revenge against those women they would not have had access to in the past and thus it was also an act of revenge toward their entire community (Mukamana and Brysiewicz, 2008).

Various atrocities to which the women were subjected have been well documented. Rape was carried out by soldiers from the Rwandan Armed Forces, militias (Interahamwe), as well as



by ordinary civilians. Women were subjected to sexual violence as they were raped by individuals and gangs. Sexual enslavement and forced marriages were frequent and, in some cases, resulted in pregnancy (Mukamana and Brysiewicz, 2008; Mukamwezi, 2008; African Rights, 2004; Amnesty International, 2004; Green, 2002; Sharlach, 1999; Human Rights Watch, 1996).

Dallaire (2003) and the (Human Rights Watch, 1996) reported that Tutsi women were raped, mutilated, murdered and had objects such as guns and sticks inserted into their vaginas and their corpses. Dutton (2007) qualified that forensic psychologists or psychiatrists usually attributed sexual sadism in civilian contexts to trait pathologies, but in wars and genocides, a form of sadism appears that is generated by a short term psychological state and by a toxic environment.

Many of the women were taken from their homes or from churches or bushes, where they had been hiding, and were publicly raped and forced to watch other women being raped (Zraly, Rubin-Smith and Betancourt, 2011; Mukamana and Brysiewicz, 2008; African Rights, 2004). As humiliation was the rule, women were stripped naked and exposed to public mockery (Green, 2002). Moreover, women witnessed the torture and death of their families members and the destruction of their homes and a number of them were killed after they had been sexually abused (Human Rights Watch, 2004).

As a policy of genocide, military and civilian authorities encouraged the systematic rape of Tutsi woman (Power, 2002). That campaign of terror did not spare even the very young or the very old and it was estimated that the victims were aged from two years up to over fifty years old. Pregnant women and those who had just given birth were raped and the rape of vulnerable groups such as these ended with medical complications or death (Green, 2002). Sharlach (2000) indicates that rape become a powerful instrument of genocide when soldiers or militias used it as tactic to cause either death or psychological and physical harm to women victims. This author continued by saying that rape toward specific target-groups in modern conflicts has taken the form of a systematic tool or strategic weapon of war and terrorization.

#### **4.5 UNDERSTANDING RAPE TRAUMA REACTIONS**

A variety of theories have been developed to provide an understanding of how a traumatic experience disturbs multiple aspects of an individual's life. However, no single theory has yet been comprehensive enough to fit that purpose. To inform this work, theories that appeared to

be relevant to the presented findings are described; these are the biological model from Van der Kolk; the information processing model from Horowitz, shattered assumptions from Janoff-Bulman and learned helplessness by Seligman. Even though those theories were not developed specifically for post rape trauma, they facilitate the comprehension of the traumatic reactions that are manifested by women victims of rape.

#### **4.5.1 Biological theory**

Traumatic events affect both body and mind. When an individual is faced with danger, that person becomes alert, and the sympathetic nervous system is aroused with an intense production of adrenalin. This prepares the individual for fight or flight from the danger. When those two options are not possible, then the individual becomes overwhelmed. An alteration of consciousness becomes an alternative (Herman, 1997), which is a state of detached calm where terror, rage, and pain are dissolved. Perceptions and sensations are numbed, and there is a perception that any struggle might be futile. This numbness results from the production of endogenous opioids by the central nervous system. These have similar effects to opiates such as morphine in affecting pain perception. Later, the individual may use alcohol or narcotic drugs to alter the sensation of pain (Rothschild, 2000).

A psychiatrist named Van der Kolk developed a biological model to explain post trauma reactions from an animal experiment. He found that human beings react similarly to traumatic events as animals do as both had alterations in their nervous systems that produced an important variety of secretions of neurotransmitters (Van der Kolk, 1994). This model has been criticized as humans differ from animals in term of genetic background and on the meaning they attribute to the traumatic event (Kirmayer, Lemelson and Barad, 2007). However it continues to be referred to as it provide basic comprehension on the physiological perturbation of the nervous system related to traumatic events and their treatment.

In line with the biological model, (Rothschild, 2000) states that the extreme stimulation of the central nervous system results in permanent neuronal discharge which is repeated once the individual is confronted to any stimuli related to the original trauma. Thus, the body keeps the memory of traumatic events, because the traumatic memory is retained at physiological level (Van der Kolk, 1994). According to Horowitz (1986), when the event was not fully integrated into the cognitive schema, the individual continues to re-experience the event

when put in similar conditions. Rape was perceived as an individual devastating experience which is very hard to assimilate (Cohen and Roth, 1987).

The impairment in appropriately evaluating the sensory stimuli leads to a high level of physiological arousal (Rothschild, 2000). With the chronic arousal engendered by the persistent emotional distress along with persistent physiological arousal, the immune system is busy in the fight-flight cycle instead of protecting the body against diseases. Thus, this permanent perturbation of the neurotransmitter exposes traumatized people to various psychological and physical diseases such as anxiety disorders, depression along with cardiovascular disease, headaches, gastrointestinal problems, to name few (Kalayjian, Moore and Aberson, 2010).

#### **4.5.2 Information processing model**

This theory has been developed by Mardi Horowitz (1975), who explains how the trauma impacts on the cognitive schema by disturbing the control, the regulation and the process of information. This model is built on the three following propositions which state that active memory storage has an intrinsic tendency toward repeated representation of its contents; this tendency will continue indefinitely until the storage of the particular content in active memory is terminated; and termination of contents in active memory occurs when cognitive processing has been completed (Horowitz, 1975). Pearlman (2003) identified five aspects of the memory which include verbal memory (cognitive narratives); imagery (pictures in the mind); affect (emotions experienced); somatic memory (physical sensation); and interpersonal trauma (active in interpersonal relationships). Those traumatic memories are encoded in form of fragments in relation to those five aspects and until they are successfully integrated into existing cognitive schemas, they relentlessly continue to invade the memory of the victim. According to Horowitz's theory, the fragmented images are disruptive and may emerge when the person is asleep or when she/he is in a situation which recalls the traumatic event (Horowitz, 1975). Many normal situations become reminders to victims of rape, such as having sex with their partners or simply being in situation involving interaction with men. This make them at a high risk of having flashbacks (Cohen and Roth, 1987). Flashbacks and nightmares are expressions of the cognitive schemas integrations failure (Pearlman, 2003; McCann and Pearlman, 1990).

In addition, Horowitz (1986) has described the denial and emotional numbing that follow the experience of intrusive thoughts as the mechanisms used against overwhelming emotions. The course of trauma often alternates between denial and intrusion until it is resolved, and this cognitive process is only achieved when there is no longer denial and the traumatic event can be recalled. This may explain the presence of hyper arousal, intrusive and constructive symptoms among traumatized individual such as victims of rape.

#### **4.5.3 Shattered assumptions theory**

Individuals are affected by traumatic events in accordance to the meanings attributed to them. These meanings are based on three fundamental assumptions as proposed by Bonnie Janoff-Bulman, who states that for most people, the world is benevolent, is meaningful and the self is worthy (Janoff-Bulman, 1992).

Those fundamental beliefs provide the vehicle for the expectations that individuals have of themselves and their environment, as they guide their interactions and allow them to function efficiently (McCann and Pearlman, 1990). At the centre of individual assumption there is a trust in invulnerability that is grounded in early childhood from secure and protected relationships with caregivers (Erikson, 1980). Since their early years, individuals believe in the benevolence of a world where people are good and caring, and events are predictable and social justice prevails. They view themselves worthy and expect positives outcomes from their interactions with others (Janoff-Bulman and Frieze, 1983). The maintenance of such assumptions contribute to the individual psychological equilibrium (Janoff-Bulman, 1992). Once confronted with a traumatic event those assumptions are shattered, and the victim becomes even more stressed when the trauma is from another human being, as in the case of rape (Herman, 1997). She states that sexual violence inspires intense fear, helplessness and loss of control, and that the weakness experienced by the victim leaves her with a sense of shame, humiliation and loss of self-respect. This results in disintegration of the cognitive system. Therefore the meaning that the person holds regarding herself and the world is challenged and she loses trust in herself and others (Janoff-Bulman, 1992). This author pointed out that a rape attack leaves the victim with sense of self-criticism and vulnerability that devalues her as an individual and she views the world as no longer safe, but rather malevolent, uncontrollable and hostile. People are perceived as a source of threat. If the sense of vulnerability persists it may lead to anxiety disorders and a decrease of self-esteem.

#### **4.5.4 Learned helplessness theory**

According to Seligman (1975), who proposed the learned helplessness theory, helplessness is a conditioned behaviour where individuals who have been subjected to an extreme situation without any chance of escape may continue to behave helplessly even when it is over.

Ron (2004) indicated that rape involves dominance. The perpetrator takes advantage of the vulnerability of the unwilling victim, who is forced physically or psychologically to submit. The helplessness that was endured may continue to affect the victim if she is not strong enough to overcome the situation or receive adequate support.

Later, that learned helplessness contributes to a sense of worthlessness and interferes in decision making, as the victims doubt the controllability of events and the positive outcomes of their acts (Henry, 2005). That diminished self-esteem is significantly associated with passivity, cognitive distortion and a state of hopelessness as the victims falsely believe that they have no power to make changes in their life (Jones, 2008).

Loneliness appears as another psychological problem related to learned helplessness and affects individual's interactions with their relatives and friends because they have the pessimistic view of being incapable of doing anything, which is associated with a lack of trust in themselves and other people. This is closely tied to the shattering of fundamental beliefs described by Janoff-Bulman. In the long term, learned helplessness may result in anxiety disorders, depression and also in physical health problems as victims do not take care of themselves, thinking that it is useless (Chang and Sanna, 2007).

Although the theories described above overlap each other, each of them attempted to explain the principal reactions occurring after a traumatic event in general and what has been extended to cases of rape. The psychological consequences of rape are described in the following section.

#### **4.6 PSYCHOLOGICAL CONSEQUENCE OF RAPE**

Rape has been identified as one of the most stressful events that an individual can experience as it is sudden, unexpected and challenges the individual's coping capacities. It disrupts the psychological functioning of the victim (McCann and Pearlman, 1990). Hilberman (1976) considers rape much greater than an invasion of an orifice; it is the ultimate violation of one's

inner self as it invades the most private space of a person, together with loss of autonomy and control. Even although some rape victims may surmount that traumatic event, researchers have shown that for the majority, the suffering goes beyond the instant of the act itself, impacting the individual's life for a long period, even for an entire life (Ricchiardi, 2011).

The psychological consequences of rape have received the attention of scholars since the 1970s. The accumulated empirical studies have invariably shown the serious negative effects of rape on the victims' psychological wellbeing in the short and long term, whether the assaults took place in times of peace or war (Zinzow, Resnick, McCauley, Amstadter, Ruggiero and Kilpatrick, 2012; Bryjak, 2009; Gingerich and Leaning, 2004; Clum, Calhoun and Kimerling, 2000; Lonsway and Fitzgerald, 1995; Atkeson and Calhoun, 1982; Brownmiller, 1975; Burgess and Holmstrom, 1974).

The pioneers in documenting the aftermath of rape were Ann Wolbert Burgess and Linda Holmstrom. Having observed women victims of rape, these authors noticed that the stress related to rape was acute for some women, while for others it was chronic or delayed. These various reactions were conceptualized as "Rape Trauma Syndrome" (Burgess, 1983; Chappel et al., 1977).

Rape Trauma Syndrome was divided into two phases. The first or acute phase, which may last from days to weeks was characterised by the immediate reaction such as emotional shock numbness and disbelief followed by or alternating with anxiety. During the second phase or organization, the victims tried to resume with their traumatic experience, but may feel depressed, experience flashbacks or nightmares and this phase may last from a month to years (Burgess, 1983). Burgess and Holmstrom (1974) outlined four major criteria of Rape Trauma Syndrome according to the following observations:

- Rape was perceived as an event that causes extreme stress that went beyond the abilities of the victims in dealing with it
- Victims had intrusive images where they were re-experiencing the event and some were viewing their assailant everywhere. Furthermore they had upsetting dreams and nightmares. Those nightmares were in three categories: (a) reproduction of the incident of rape and the state of helplessness; (b) symbolic dreams involving a theme of rape; and (c) mastery dreams where the victim overpowers the assailant. The disappearance of the replication and symbolic dreams are signs of recovery.

- Psychic numbing, with reduced involvement to the environment. Victims became withdrawn from their family and their participation in activities was reduced
- The four criteria stipulate that there be two of the following of the six symptoms that were not existing before the rape such as (a) hyper alertness, (b) difficulty in sleeping, (c) self-blame and guilt, (d) increased reactions to events that recall rape, (e) problems of memory and poor concentration, and (f) avoiding the trigger event. Rape Trauma Syndrome is currently recognized as a type of Post-Traumatic Stress Disorder (PTSD) as a specific response to coercive sexual act (Keogh, 2007).

According to the Diagnostic and Statistical Manual of Mental Disorders IV-R (DSM IV-R), the criteria of PTSD are similar to those identified above in Rape Trauma Syndrome. However, the first criterion for PTSD extends beyond the individual exposed to traumatic events to also include their witnesses. It stipulates that any person who is witness to extreme violence such as disasters, accidents or atrocities involving others may also develop PTSD. The second criterion implies that the traumatic event is continually experienced, the third invokes the persistence of avoidance behaviour, while the fourth is an increased arousal (APA, 2000).

Herman (1997) had grouped those post trauma reactions or symptoms of PTSD in three main categories; hyper arousal symptoms, intrusive symptoms and constrictive symptoms. Hyper arousal symptoms are mainly characterised by emotional distress and permanent physiological arousal related to the intense fear and threat of annihilation experienced during the moments of the traumatic event. Hyper alertness, irritability and poor sleeping are some of the manifestations of hyper arousal symptoms. Intrusive symptoms are experiences of traumatic events related to the eruption of the encoded moment of trauma in the consciousness. They are experienced by flashbacks and nightmares which are coupled with such intense fear and emotional distress that it is as if the event was recurring in the moment and not in the past. Constrictive symptoms are avoidance behaviours that aim to protect the individual from overwhelming situations. Therefore individuals restrict their interactions with others and reduce their daily activities to prevent any risk of harm.

Later studies conducted with women rape survivors confirmed that the majority of them were suffering from PTSD after they had been sexually assaulted (Clum et al., 2000; Acierno, Resnick, Kilpatrick, Saunders and Best, 1999; Kilpatrick, Acierno, Resnick, Saunders and Best, 1997; Koss, 1993; McCahill, Meyer and Fischman, 1979). Recently Zinzow, Resnick,

McCauley, Amstadter, Ruggiero and Kilpatrick (2012) reported that between 17% and 65% of women victims of rape develop PTSD.

Besides the immediate effects of rape, adverse long-term psychological consequences were also observed, which varied greatly from one victim to another. It became apparent that different factors play a role in the maintenance or recovery from rape psychological trauma such as women's characteristics, social support, socioeconomic status, severity of the assault, the relationship with the assailant and the victim's previous history of sexual violence (Cohen and Roth, 1987; Littleton and Radecki Breitkopf, 2006).

Cohen and Roth (1987) studied a group of women eight years after they had been subjected to sexual violence and found that those who failed to overcome their trauma were suffering from chronic PTSD, continually experiencing intrusive thoughts, nightmares, sexual dysfunction, impaired social relationships and difficulties in carrying out daily activities.

Substance abuse was often associated with chronic PTSD as these were frequently used by victims to alleviate intrusive thoughts and solve sleep disturbance problems (Kilpatrick, Ruggiero, Acierno, Saunders, Resnick and Best, 2003). Anxiety disorders such as obsession-compulsion, phobic anxiety, paranoid ideation and eating disorders were identified as lasting effects of rape, contributing to a poor health status (Zinzow et al., 2012; Cogle, Resnick and Kilpatrick, 2011; Faravelli, Giugni, Salvatori and Ricca, 2004). Furthermore, evidence suggests that in complicated cases where long term rape survivors suffer from psychiatric disorders with high co-morbidity of PTSD and depression, major depression is associated to suicidal behaviours (Zinzow et al., 2012; Cogle et al., 2011; Bryant-Davis, Ullman, Tsong and Gobin, 2011b; Kilpatrick et al., 2003).

In war, women are vulnerable to diverse traumatic experiences which include sexual violence, permanent fear of death, starvation, and loss of family members and propriety (Shanks and Schull, 2000). Extreme situations in times of war expose women without inadequate support to a high risk of developing mental disorders such as obsessive compulsive disorder, dissociative disorders, eating disorders, panic attacks, self-inflicted injuries and suicide attempts (Clifford, 2008). Complex PTSD, which was manifested by difficulties in emotional regulation, disturbed relationships, alteration in attention with poor memory, shattered assumptions along with somatisation, were often reported among rape survivors as a result of those repeated and multiple traumas. Somatisation was viewed as an



expression of psychological pain expressed through physical disease such as headaches, pain back, gastro intestinal diseases, muscular problems, as well as cardiopulmonary symptoms (Wasco, 2003).

Few empirical studies conducted among women survivors of war, however, have shown that the effects of rape have persisted for many years. Lueger-Schuster et al (2012) carried out a study among Austrian women who had been victims of rape during World War II six decades later to assess the impact of that sexual violence on their mental health. They found a high prevalence of PTSD. The elderly women indicated that the physical memories of the traumatic event were still vivid and PTSD symptoms were triggered during genital examinations or hygienic care of their genital organs. In addition, those women reported signs of depression, high levels of distress with phobic fear and social isolation.

A similar study conducted by Kuwert, Klauer, Eichhorn, Grundke, Dudeck, Schomerus and Freyberger (2010) among German women who survived the mass rape committed by the soldiers in 1945 during World War II, revealed that almost half of the women survivors were experiencing a significant posttraumatic symptomatology related to the wartime rapes. Accordingly, 19% of the respondents reported significant current posttraumatic stress symptoms indicating a possible Post Traumatic Stress Disorder, and 30% fulfilled the criteria of a current partial Post Traumatic Stress Disorder.

The result from a group of Croatian researchers (Loncar et al., 2006) who studied the psychological consequences of rape on women during the from the 1991-1995 war in Croatia, Bosnia and Herzegovina were more explicit. The findings showed a strong correlation between war rape and various psychiatric disorders, mainly depression, social phobia and chronic PTSD, with high co-morbidity between them. The women also reported suicide attempts as a result of unwanted pregnancies which were perceived as a humiliating trauma. The study took place from April 1992 to December 1995 and the women involved had a history of rape occurring at least 2.4 months and above prior to the study.

Sixteen years later (Hasanović and Čatić, 2012) provided figures showing a high rate of psychological problems expressed by women rape survivors of this previously mentioned war (Croatia, Bosnia and Herzegovina). These included anxiety disorder 98.9%; PTSD 94.7%; somatic symptoms 78.9%; depression 76.8%; anxiety co-morbid with insomnia 57.9%;

severe depression 55.8%; social dysfunction 55.8%; and substance abuse, including cigarette smoking 55.8% and alcohol abuse 8.4%.

In Rwanda, there are not yet such studies focusing specifically on the lasting effects of rape. However, studies on the long term impact of genocide on the mental health of the Rwandan population have shown a high magnitude of mental disorders (Schaal, Dusingizemungu, Jacob and Elbert, 2011; Pham, Weinstein and Longman, 2004; Palmer, 2002). Fourteen years after the genocide the level of PTSD was estimated at 26,1% in the general population. Those with PTSD often displayed signs of depression (68%) and the percentage of substance dependence co-morbid to PTSD was 7,6 % (Munyandamutsa et al., 2012). Another study conducted thirteen years after the genocide among women widows and orphans of the genocide has shown that 29% of the orphans met the criteria of PTSD, depression was estimated at 34%, anxiety disorders at 42% and 39% were also suicidal. With respect to the widows, 41% met the criteria of PTSD and 48% suffered from depression, 59% displayed anxiety symptoms and 38% of them were classified as suicidal (Schaal et al., 2011). Even although those figures did not only relate to rape survivors, we may assume that rape survivors may not be exempt of suffering from such problems once rape is known to be risk factor of mental health problems.

The psychological vulnerability of rape survivors appeared in an exploratory study on their lived experiences. This study was conducted ten years after the genocide and has shown that those women suffered loss of identity, social isolation, loss of hope for the future and survival guilt (Mukamana and Brysiewicz, 2008).

In 2005, eleven years after the genocide and widespread rape of Rwandan women, a study was conducted by (Cohen et al., 2009) that aimed to measure prevalence and predictors of Post Traumatic Stress Disorder and depression in HIV-infected and at-risk Rwandan women. The results showed that PTSD and depressive symptoms were high in women who tested both positively and negatively. Almost all the women (4/5) infected with HIV had depressive symptoms with a highest score among those with a CD4 count less than 200.

Although the literature on the long term psychological effects of rape among women in war time is not as extensive as the studies of the effects of rape in peace time, the existing studies show the differences and similarities of both. While there appear to be similarities in the clinical manifestations, the differences are the intensity, severity and diversity of the

symptoms of wartime rape. Just as there are few studies of the long term effects of war time rape in general, there are even fewer studies of the effects of wartime rape on Rwandan women. However, the majority of the psychological effects that have been shown to be evident in women after non-wartime rape must also be present in women after wartime rape, and perhaps even more so. There is obviously a profound need for major psychological studies to be made of the long term psychological consequences of the genocidal rapes of Rwanda of 1994 in order to provide support for those who were victims.

#### **4.7 RISK FACTORS TO THE LONG TERM PSYCHOLOGICAL EFFECTS OF RAPE**

Different factors are interconnected in the occurrence and maintenance of the psychological effects of rape. Rape is a wound which affects the mind, the soul and the body of the victims. The circumstances in which rape happened, the individuals characteristics and physical health status of the victims, whether children were born as a consequence of the rape, as well as living in a context of deprivation and social stigma, all have a great influence on the lasting psychological effects of rape (Wasco, 2003).

##### **4.7.1 Sexual assault characteristics**

The degree of violence used during a sexual assault and the relationship between the assailant and the victim have specific consequences on the health of rape victims. Extreme cruelty by the perpetrator during the attack has been associated with severe and the long term negative psychological outcome (Ullman, Filipas, Townsend and Starzynski, 2007a). During times of war, women have been raped multiple times by multiple perpetrators and have often been held as sex slaves for long time. As rape has been used as a weapon to destroy the enemy communities, women have been subjected to sexual attacks carried out with guns, bottles or branches. Victims have been beaten and in most cases their genitalia has been mutilated (Chiwengo, 2008). Those kinds of violence inflict unbearable pain and victims are left terrified (Clifford, 2008). The cruelty and brutality which accompanied the sexual assaults were found to be predictors of lasting mental health problems such as PTSD, depression and anxiety disorders (Hagen and Yohani, 2010; Campbell, Dworkin and Cabral, 2009b; Clifford, 2008).

In addition, in times of war, women have not only been raped by the military forces, but also by their neighbours and, in some of the worst cases, women have been forced to commit

incest. Those who have been raped by someone known to them, particularly families members, blame themselves and suffer intense shame and guilt at having survived such humiliation rather than having been killed (Amnesty International, 2004). Such tumultuous feelings affect victims for long periods of time and result in various negative mental health disorders (Ayele, 2011; Clifford, 2008).

#### **4.7.2 Individual characteristics**

Scholars are consistent in saying that individuals who are personally vulnerable, have limited coping mechanisms and are living in unsupportive environments were at high risk of developing persistent mental disorders after being raped (Campbell et al., 2009b; Herman, 1997).

According to Ullman et al. (2007b) and Cogle et al. (2011), women who have had a history of child abuse or other trauma are at high risk of developing psychiatric disorders once they are exposed to sexual victimization. Those authors explained that younger women are more likely to be affected than adult women because they are not psychologically mature and their coping mechanisms are not yet developed enough to handle severe stressors. On other hand, elderly women were also badly affected due to the apprehension of stigma related to the rape experience (Ayele, 2011; Hagen and Yohani, 2010).

Mental health disorders prior rape were considered as risk factors to high levels of persistent PTSD among victims of rape (Herman, 1997). According to this source, a low level of education was also estimated as one of risk factors to long term psychological effects of rape. This is related to the fact that women who have not been educated have limited capacities in searching for useful information about the health care services.

#### **4.7.3 Poor physical health**

It was established that women who have been physically injured as a result of rape can develop chronic diseases which contribute to poor physical health. This poor physical health status was associated with a permanent psychological distress, being at the occurrence and perpetuation of mental health disorders especially PTSD, depression or anxiety disorders (Hagen and Yohani, 2010; Wasco, 2003).

Almost all women who have been raped in wartime will have been affected by their experience one way or another. The brutality of war rape and the use of objects or instruments to carry out the assaults have left some of the women permanently damaged with some women having rectal or vaginal tearing and fistulas (Clifford, 2008). Many women had their bones broken or were severely wounded as punishment for resisting their rapists (Amnesty International, 2010b). In such cases, therefore, the psychological trauma these women experience is exacerbated by physical problems and the scars they bear from their physical injuries are a permanent reminder of their ordeal. This is further exacerbated by the inaccessibility of resources or inadequacy of services rendered to rape victims (Amstadter, McCauley, Ruggiero, Resnick and Kilpatrick, 2011).

In a war context, women who have been raped rarely have the benefit of medical care for their injuries. In most cases, apart from the available medical aid not being appropriate, women prefer to keep the details of their rape secret due to fear of stigma and therefore don't seek help. This delay in receiving adequate treatment exposes them to later complications, mainly in their reproductive health (Amnesty International, 2010b; Moszynski, 2004). Infertility due to the damage caused to their reproductive organs was frequent among war rape victims (Clifford, 2008). Sexually transmitted diseases which were complicated by chronic gynaecological infections were predisposing rape survivors to cervical cancer. HIV/AIDS is the most common sexually transmitted disease in current war time rape (Hagen and Yohani, 2010; Clifford, 2008).

In addition to the bodily injuries that illustrate the extent of the violence they were subjected to, Rwandan rape survivors were also affected to a large extent with HIV/AIDS (SURF, 2012; Zraly et al., 2011; Blizzard, 2006). According to Amnesty International (2004), it was estimated that 70% of women rape survivors were affected by HIV/AIDS. This high rate of infected women was related to the deliberate use of HIV/AIDS as weapon of genocide (Donavan, 2002; Landesman, 2002; Desforges, 1999). This deadly disease continues to prevail in the lives of rape survivors. In a campaign carried out by AVEGA of voluntary testing for HIV amongst its member survivors of rape, it was found that out of 11,874 members tested, 1,561 were HIV positive (AVEGA, 2010). Various studies have shown that in Rwanda, HIV/AIDS is strongly associated with psychiatric disorders and a high rate of depression. A study conducted with women living with HIV/AIDS found that 59% of them were suffering from PTSD while 81% were showing symptoms of depression (Cohen et al.,

2009). Another study conducted in one of the primary health care centres in Rwanda, which involved people from different backgrounds, both male and female, found that 41% of those who were HIV positive were suffering from depression (Umubyeyi, 2010).

#### **4.7.4 Children of rape**

Children born of rape are the most visible and strongest reminder of the experience of rape. Women who bear children of rape are in permanent emotional tumult from the beginning of pregnancy, whether they choose abortion, adoption or decide to raise the child (Clifford, 2008). In Rwanda, it has been estimated that between 2,000 to 5,000 children were born as the result of rape (Godard, Munyandamutsa, Mutarabayire-Schafer and Rutembesa, 2012). These children are an embodiment of the pain and anguish endured by their mothers during the genocide (Blizzard, 2006). Those mothers who kept their children are psychologically troubled by the controversial feelings of hate and love, and furthermore feel guilty about the negative feelings they harbour towards their own offspring (Keienburg, 2012b; Landesman, 2002). It often happens that children born of rape are rejected by their family as well as the community (Mukamana and Brysiewicz, 2008). This is translated through the names given to those children like “children of bad memories” or “unwanted children”(Clifford, 2008: 7).

The responsibility of raising those children is left to the mother who has to cover all expenses related to the child’s basic needs, such as food, health care and schooling (Keienburg, 2012b). Many of the women are extremely poor and while they receive social assistance from FARG, which is a fund supporting genocide survivors, unfortunately those children are not eligible for support as they were born after the genocide and are not considered as being victims of genocide violence (Keienburg, 2012b). Thus, those children become a social burden for their impoverished mothers.

Furthermore, throughout the world, children born of rape suffer from discrimination, which impacts negatively their psychological wellbeing. This suffering affects the psychological wellbeing of their mothers to a large extent as their wellness is interconnected (Rimmer, 2006).

#### **4.7.5 Social stigma**

The reactions of the surrounding environment of rape survivors can either facilitate or hinder their recovery. The acceptance or rejection of women rape victims depends on the perception

of the women's sexuality. Women are more stigmatized in a culture where they are not perceived as being the owner of their own sexuality and body. This is most prevalent in cultures with taboos on sex, where women are valued by their chastity and virginity. In such societies, rape equals disgrace and dishonour, not only for the victim, but also for her family (Wehbi, 2002). This extended shame leads family members to shun or abandon rape victims who are perceived as unfaithful, traitors and unclean. They are blamed and accounted responsible of what happened to them and then rejected (Messina-Dysert, 2012). This author explains that those hostile attitudes leave the women feeling ashamed and guilty for their assaults.

In case of war or genocide, social stigmatization is amplified and perpetuated by the fact that rape is mostly public and the entire community know the women who have been sexually victimized (Clifford, 2008).

Stigma isolates victims of rape and leads to the rupture of valuable ties between women and their social support network. Stigmatized women often feel frustrated and abandoned as they believe that their harm and suffering has not been acknowledged. This considerably undermines their psychological wellbeing (Messina-Dysert, 2012). Stigma which results in social isolation for rape survivors has been consistently qualified by researchers as one of most contributing factors to mental psychological problems (Messina-Dysert, 2012; Ayele, 2011; Mukamana and Brysiewicz, 2008; Ullman et al., 2007b). Munyandamutsa, Nkubamugisha, Gex-Fabry and Eytan (2012), who conducted a study on the prevalence of PTSD in Rwanda, considered marginalization or stigmatization as an additional risk factor for persistent PTSD amongst genocide survivors.

Many women rape survivors are not only affected by stigma, but also have to endure poverty.

#### **4.7.6 Poverty**

Poverty is a human experience with different sorts of deprivation. Even though it is mostly linked to lack of income or material resources, poverty also implies the deprivation of basic needs to which each individual has right. Those are mainly related to education, health and housing (Turró and Krause, 2009).

Poverty has been reported to be a major consequence of war and a risk factor to the occurrence and persistence of psychological problems among the population in post conflict

contexts (Clifford, 2008). The fragile economic status in Rwanda has been affected by the genocide. The country has limited natural and mineral resources which directly affects the source of income for its citizens. Land is the major source of income and the majority of Rwandese rely on agriculture for their survival (Mugabe, 2007). The poorest in Rwanda are those who are landless and many single women are living in poverty (Abbott and Rwirahira, 2010). This may be explained by the fact that until recently, Rwanda was a patriarchal society where men were considered the breadwinner of the household and women did not have the right to inherit land. However, things have changed with the increased number of women in Parliament, where they represent 56% in the lower chamber and 35% at the senate, and women now have equals rights as men (Ministry Of Gender and Family promotion, 2010). It is believed that the gained rights to families' inheritance and other rights will ameliorate the living conditions of Rwandan women. Meanwhile, the average of single women living under the poverty line is higher than 47%, compared to the national average which is 45% (NISR, 2012). Those women living in extreme poverty were reported as having PTSD (Munyandamutsa et al., 2012).

The lack of competences and skills in performing activities other than low paid farming work expose Rwandese women to chronic hunger, which considerably affects their psychological wellbeing (Zraly et al., 2011). The opportunities for new job creation are limited by the low education of the Rwandan population. Only 13% of men and 11% of women have attended secondary education, with 1,6% of men and 1% of women attaining higher education (National Institute of Statistics of Rwanda, Ministry of Health and Macro International Inc, 2009).

In the post genocide context, even although the majority of Rwandese are considered as being psychologically affected by poverty, it is the women rape survivors who are the most affected (Keienburg, 2012b; Zraly et al., 2011). In addition to losing their family members and possessions as other survivors did, rape victims carry the psychological and physical injuries of their traumatic experience (Hagen and Yohani, 2010). Such health restrictions make rape victims vulnerable to poverty as it prevents women from working in order to earn a fair standard of living. Furthermore, many of those rape survivors are unable to work as they spend much of their time seeking care for their health problems (Ullman et al., 2007b). Poor living conditions are highly associated with psychological distress as it place women in situations of hopelessness for the future, which is translated into depression, or in the



consummation of illicit drugs as women try to cope with their stressful living conditions (Bryant-Davis, Ullman, Tsong, Tillman and Smith, 2010).

Rape victims who have been impoverished by the conflict have little access to adequate mental health services due to their limited resources and the absence of appropriate therapeutic interventions exacerbate and perpetuate their psychological problems (Brouwer and Chu, 2012a; Ayele, 2011). It can be seen, therefore, that the consequences of rape have led to an interconnected cycle of poverty and psychological problems which, by reinforcing each other, make it a long term problem (Hagen and Yohani, 2010).

#### **4.8 FACTORS PROTECTING AGAINST THE LONG TERM PSYCHOLOGICAL EFFECTS OF RAPE**

Protecting factors against the long terms psychological effects of rape are a combination of women's internal resources as well as various external factors (Littleton, 2010). Those presented here are social support, women's coping strategies, their religious beliefs and self-help groups.

##### **4.8.1 Social support**

Studies have shown that the outcome of trauma depends not only on individual coping abilities, it also greatly depends on the comfort, reassurance and feelings of safety from others (Littleton, 2010; Goldenberg, 2009; Walsh, 2007). In the aftermath of war and genocide, the connection and support of being with others is needed more than ever. Survivors may only cope with their loss once they are able to recreate a new social network and regain their sense of belonging (Goldenberg, 2009).

Fazio and Fazio (2005) argue that social support influences adjustment after stressful life events. Community connections with fair relationships where people can feel that they are accepted and cared for are powerful elements in healing from psychological wounds. For victims of rape, the informal support of family members, friends and neighbours with an empathetic understanding was viewed as being more efficient than an environment in which the victims are distracted from their experience or overprotected (Littleton, 2010; Walsh, 2007).

Letting the victims talk freely about their rape according to their own perspective decreases their sense of shame and makes them feel that they are believed and that their pain is

acknowledged. This attitude serves as a deterrent of the lasting effect of the traumatic experience (Ahrens, Cabral and Abeling, 2009). In some cases, the members of the community don't only facilitate emotional expression, but also challenge the victim's maladaptive coping by encouraging the victim to take control over her trauma and her recovery (Littleton, 2010).

However, the way the rape survivors interpret the support they are receiving from their community influences the outcomes of their psychological trauma. Support is only healing if it is perceived positively by rape victims (Ahrens and Aldana, 2012). A trusted relationship, therefore, in which the victim feels that the others are reliable, prevents feelings of insecurity, helplessness and meaninglessness. This is especially important in cases of rape, which violate human connections. Trust and security have to be restored to allow victims to start their journey to recovery (Skinner, 2009; Smith and Kelly, 2001). Social support is particularly helpful in contexts where traditional mental health services are not available or victims do not feel comfortable in seeking their assistance and prefer to rely on their usual support system (Bradley, Schwartz and Kaslow, 2005).

For social support to be helpful, victims have to operate at a different level. Besides the emotional support which comes at the frontline as immediate support after the rape, other needs of the victims have to be taken into consideration. Efficient support provides tangible aid such information regarding relevant health services or other areas of interest expressed by victims, as well as material support (Littleton, 2010; Ahrens et al., 2009). Provision of material support is most relevant in times of war where rape victims have been deprived of their livelihood (Amnesty International, 2010b). Comprehensive social support constitutes an essential protector for the well-being of rape survivors. Women feel valued when their experience of rape is acknowledged by their community and their additional needs met. Under those conditions they are able to regain their sense of self-worth and safety, which are the cornerstone of rape trauma recovery (Bryant-Davis et al., 2011b). In Rwanda, many rape survivors are supported by their neighbours, essentially in farming activities (Handicap International, 2009).

The validation of a traumatic experience in a supportive context is an acknowledged way of preventing and treating trauma related disorders. However there were some women who may not benefit from the social support offered by their living environment because they view their suffering as unique.

#### 4.8.2 Women's coping strategies

There are several coping mechanisms used by women in order to cope with adversity. While some individuals are vulnerable to stress, others manage to recover more quickly from the suffering of extreme situations. These women are said to be resilient. Resilience is described as the inner capability of individuals to bounce back from adversity. Resilient people have a high capacity of problem solving and view their traumatic experience as part of normal life (Wadsworth, 2010; Harvey, 2007).

Traumatic reactions after rape are mediated by women's coping strategies and the way in which they perceive the effect of rape. Those women who have a high level of self-efficacy or confidence believe in their capacity to control the outcomes of rape, which facilitates their recovery even although they viewed their experience as being very traumatic (Sarkar and Sarkar, 2005; Regehr, Cadell and Jansen, 1999).

Positive self-assessment and women's socialisation fostered their coping abilities. Positive rape victims do not blame themselves or feel responsible for the rape. Rather, they view it as crime against their person for which the perpetrator has to be accountable (WHO, 2007). Through socialization those women embrace values of strength and perseverance in hardship and are thus better equipped to cope with their sexual assault (Bryant-Davis et al., 2010). Rape victims who have coped better are those who have had the benefit of social support and who have engaged themselves in actions which reduce negative thoughts and foster positive thinking, such as religious activities and self-help groups.

#### **4.8.3 Religious beliefs**

Researchers have shown that religion is a common coping mechanism in times of adversity. Rape survivors who have faith in their religion have more positive mental health outcomes (Bryant-Davis et al., 2011b; Chang, Skinner and Boehmer, 2001). Religion was found to be an important factor in the recovery of traumatic events as it fosters and promotes resilience (Hourani, Williams, Forman-Hoffman, Lane, Weimer and Bray, 2012). Religion is expressed in different ways, such prayers, meditative practices or ritual ceremonies. The common goal, however, is an expression of faith in seeking and obtaining strength from God (Bradley et al., 2005). The unspeakable things that one human can do to another can be brought into the presence of God in any manner fitting the desire of the believer, such as dancing, crying or shouting. Those moments are source of emotional release and comfort (Harris, Erbes,

Engdahl, Olson, Winskowski and McMahon, 2008). Rape is a traumatic experience which shatters the victim's belief in the benevolence of the world and the people in it and instils helplessness and despair (Janoff-Bulman, 1992). Faith helps to transcend such suffering by providing meaning and purpose to life and serving as a source of hope (Yick, 2008; Gall, Basque, Damasceno-Scott and Vardy, 2007). Hope, in its turn, helps traumatized individuals to dream of a better future and thus protects them against negative feelings (Bryant-Davis et al., 2010).

#### **4.8.4 Self-help groups**

Self-help groups are made up of individuals who are experiencing similar problems who, on a voluntary basis, choose to come together in order to solve their problems (Coatsworth-Puspoky, Forchuk and Ward-Griffin, 2006). The members of self-help groups are usually vulnerable people with health conditions or social issues. Some are physically or mentally disabled, or suffer from chronic and mental illnesses. Others are survivors of different type of violence, or are socially marginalised (Coatsworth-Puspoky et al., 2006).

The cultural context of the self-group may influence its direction. Whereas in many contexts the priority is mainly focussed on helping people to cope with their personal problems, in those where the empowerment of vulnerable people are valued, the self-help group may act for social change (Mok, 2004). An example is given by Hatzidimitriadou (2002), who states that a number of self-help groups in North America have advocacy goals which aim to influence legislation and impact public attitudes.

The reason for attending self-help group varies from one individual to another. While the lack of social support and isolation were reported as a major motif in joining a self-help group, the mere fact of being with others who have had a common experience was identified as being very attractive (Munn-Giddings and McVicar, 2006). The uniqueness of a self-help group resides in the way members of the group are able to mirror each other's experience, which allows each member to feel heard and valued. This was highlighted by an holocaust survivor, who assumed that no one could understand her painful experience except those one who had been through it (Goldenberg, 2009).

Herman (1997) states that victims of human atrocities, particularly survivors of sexual violence, often feel alienated by their experience and it is through a group of people with whom they share a common experience that they can fully feel themselves again. The

expression of their torment and the understating offered by peers dissolves the shame and feelings of dehumanization, thus preventing psychological disturbance.

A self-help group provides a sense of connection and belonging, it is a safe space for building true relationships and freely sharing one's personal life experience, where strengths and weaknesses in coping with one's own problematic situations are openly expressed (Schutt and Rogers, 2009). The disclosures of the victims are facilitated by the active listening of peers and mutual respect prevails in such a group (Anderson-Butcher, Khairallah and Race-Bigelow, 2004). This not only allows emotional release from the encounter, but also gives members the opportunity of learning coping skills from those who have suffered similar ordeals (Adame and Leitner, 2008). This experiential knowledge is the basis of the efficiency of a self-help group as it contributes to the empowerment of the individual and to the group as a whole as members learn how to be in control of their living situation (Schutt and Rogers, 2009).

Participation in a self-help group may also have another rewarding character. Individuals may initially attend a self-help group because they are hardly coping with their own situation, but might find that they have not only found solace themselves, but have also had a positive impact on the life of others (Anderson-Butcher et al., 2004).

The benefit of involvement in a self-help group was highlighted in study conducted in Hong Kong among different type of self-help groups. The findings showed that 95% of members become more positive by joining the group, 92,6/% became more hopeful, 93,7% were more confident in solving their problems, while 93,3 were more sociable (Mok, 2004). Munn-Giddings and Borkman (2005) confirmed that self-help groups improved the self-esteem and self-confidence of members as they gained mutual support and shared coping strategies, thus expanding their view of the world.

With the above evidence, there can be no doubt that self-help groups are a key protecting factor against psychological distress. However, it was found that some rape survivors continued to suffer severely in the aftermath of their rape in spite of attending a self-help group. Such women are in need of specialised interventions from a health professional.

## **4.9 THERAPEUTIC INTERVENTIONS**

Specialized help from a health professional is indicated for those women who have failed to recover from their rape trauma despite their own efforts and those of their community. Psychological and pharmacological approaches are used in the treatment of those women. While one approach may be sufficient for recovery, there may be some cases in which clients do not respond to only one approach and clinicians are encouraged to recourse to both approaches to increase therapeutic outcomes (Hetrick, Purcell, Garner and Parslow, 2010).

### **4.9.1 Pharmacological approach**

Research has shown that situations of extreme violence such as rape yields to the perturbation of a number of neurotransmitters of the central nervous system. Such disturbances are the origin for short or long term psychological and physical conditions. The most prevalent is PTSD, which has a high comorbidity with other medical and psychiatric conditions (Kalayjian et al., 2010). Medications used for the treatment of those conditions intend the equilibrium of the neurotransmitters (Sharpless and Barber, 2011).

Traumatized individuals often report physical pain, which may be a sign of emotional distress. It is therefore important to clarify the connection between those kinds of distress and how they will be affected by the treatment. A comprehensive functional analysis of a client's problems is required prior any treatment plan (Campbell, 2007). Medication options have to be clearly discussed with clients for successful compliance required for better improvement (Jeffreys, Capehart and Friedman, 2012).

Extensive reviews on random control trials in assessing the most effective treatment in addressing the outcomes of trauma reactions have recommended the use of antidepressants (Ipser and Stein, 2012; Hetrick et al., 2010). Those antidepressants are ranked in two lines according to their effectiveness. Adrenergic-inhibiting agents are also used in the treatment of traumatic reactions as an alternative to antidepressants (Berger, 2009). Even though sedative-hypnotics and benzodiazepines are not well recommended, they are also used for anxiety and problems of insomnia (Bastien, 2010).

#### **First line anti-depressants**

In the first line, there is new generation of antidepressants known as selective serotonin reuptake inhibitors (SSRIs) and Serotonin norepinephrine reuptake inhibitors (SNRIs).

### ***Selective serotonin reuptake inhibitors (SSRIs)***

These agents are indicated in PTSD and other anxiety disorders. The principal properties of SSRIs is that they affect the serotonin system and are thought to be effective due to their effect on the altered serotonergic receptors in the amygdala and other sectors of the fear circuit. The most well-known of the SSRI drugs are Sertraline, Fluoxetine, Fluvoxamine and Paroxetine (Jeffreys et al., 2012). According to this source, Sertraline and Paroxetine are the most recommended in treating PTSD. In a study conducted on evidence based pharmacotherapy for mood and anxiety disorders with concurrent alcoholism, it was shown that Sertraline (Zoloft) was effective in treating patients having both PTSD and alcohol dependence (Brady, 2008). Trial on the use of Fluoxetine has shown its effectiveness in treating and preventing relapse of PTSD symptoms (Martenyi and Soldatenkova, 2006).

### ***Serotonin norepinephrine reuptake inhibitors (SNRIs)***

The most efficient of the SNRIs were Venlafaxine and Duloxetine. With its dual reuptake inhibitors of Serotonin and Norepinephrine, Duloxetine has been found to be effective in improving the clinical symptomatology of comorbid PTSD and mood disorders along with significant reductions of nightmares (Carter and McCormack, 2009). Venlafaxine, on its side, had proved its efficacy in treating the core symptoms of PTSD, which are intrusive, hyperarousal and avoidance symptoms (Ipser and Stein, 2012). Despite the therapeutic benefit of SSRI and SNRI, they have disturbing side effects, such as sexual dysfunction with delayed orgasm. Gastrointestinal disturbance was also reported, mainly at the beginning of treatment (Jeffreys et al., 2012). These authors suggest that those side effects have to be addressed so as not to hinder compliance.

### **Second line antidepressants**

The second line comprise the old generation of antidepressants. They include tricyclic antidepressants such as Imipramine (Tofranil), Amitriptyline (Tryptizol), Anafranil (Clomipramine) and monoamine oxidase inhibitors like Phenelzine (Nardil); they also include the adrenergic antagonists such as Mirtazapine and Nefazodone (Sharpless and Barber, 2011). If the first line of medication is not found to be effective, the alternative option is to use the second one. For example, Mirtazapine may be used to replace SSRIs in case of depression as it has a noradrenergic stimulation and demonstrates more activating effects with less sexual side effects. Nefazodone, with its properties to block reuptake of serotonin

as well as postsynaptic receptor it reduces hyper arousal symptoms, sleep disturbance and anxiety. However it has to be seriously monitored due to its hepatotoxicity (Freeman, 2006).

In recent times, with a random control trial, TCAs and MAOIs were no longer recommended for depression and anxiety disorders due the lower therapeutic index and high rate of side effects. TCAs proved to be hepatotoxic and MAOIs led to hypotension (Jeffreys et al., 2012).

In Rwanda even though SNRIs and SSRIs are also used, TCAs and MAOs continue to be used, mainly for patients who not able to afford the cost of the first line antidepressants (Nkubili, 2012).

### **Adrenergic-inhibiting agents**

Those drugs are indicated for patients with hyper arousal and intrusive symptoms as they have the properties to decrease the central noradrenergic activity responsible of such symptoms. They are indicated in sleep disturbance as they do not have sedating side effects and carry no risk of addiction. The most adrenergic-inhibiting agents known are Prazosin, Propranolol, Guanfacine, and Clonidine. Prazosin is an  $\alpha$ 1-adrenergic receptor antagonist, it has been identified as having the best result in treating posttraumatic sleep disturbances (Nappi, Drummond and Hall, 2012). Due to its hypotension side effect, a regular monitoring is required for clients under Prazosin (Raskind, Peskind, Hoff, Hart, Holmes, Warren, Shofer et al., 2007). Propranolol is a non-selective  $\beta$ -adrenergic blocker and it has been studied for treatment and prevention of PTSD (Hetrick et al., 2010). Thus, Propranolol is suggested immediately after rape as it alleviates the vivid and intense emotions related to rape and by doing so prevents the development of PTSD (Hurley, 2010).

### **Sedative-hypnotics and benzodiazepines**

As benzodiazepines have an advantage in decreasing anxiety, they are regularly prescribed for patients with PTSD (Bastien, 2010). Both benzodiazepines and sedative-hypnotics are frequently used to address sleep disturbance. However, patients with difficulties in sleeping in trial of benzodiazepines and sedatives-hypnotics did not show any pre and post difference in quality of sleep while using those medications (Nappi et al., 2012). These authors argue that benzodiazepines and sedative-hypnotics should not be used because they are not only ineffective, but they also lead to addiction.



Despite the paucity of literature of specific research on medical treatment of rape trauma, a study carried out by (Rothbaum, Ninan and Thomas, 1996) focusing only on sexual assaults victims has shown the effectiveness of Sertraline among rape survivors with chronic PTSD.

Overall, the literature provided limited information on medical treatment of physical conditions that are directly affected by rape. I may assume, therefore, that the physical treatments are inherent to the physical manifestations presented. However, the use of anti-retroviral for rape survivors infected by HIV aids is well documented (Cohen et al., 2009; Kim, Mokwena, Ntlemo, Dwane, Noholoza, Abramsky and Marinda, 2007).

Beside pharmacotherapy, psychotherapy was identified as an important element in addressing the lasting effects of rape.

#### **4.9.2 Psychotherapeutic approach**

Many psychotherapeutic approaches are used with trauma survivors. The most known, however, are EMDR, narrative therapy, cognitive behavioural therapy and supportive counselling. The use of these approaches depends on the professional background of the practitioner or on the preference of the client (Vickerman and Margolin, 2009). Cognitive behavioural therapy and supportive counselling were the most empirically studied and have been proved to be successful in dealing with the aftermath of rape. Therefore; they are the only ones that are described in this section.

The effectiveness of cognitive behavioural therapy and supportive counselling was reported in depression, chronic and complex PTSD and in other anxiety disorders. Both approaches improved the assertiveness, self-concept and self-esteem of rape survivors who underwent treatment (Vickerman and Margolin, 2009). Cognitive behavioural therapy and supportive counselling may be used individually or in a group. However, in general, individual therapy is indicated in a time of crisis for the stabilization of the client. Group therapy reinforces the benefit of individual therapy and for some clients they are concurrent. While group therapy is indicated for clients who are socially isolated, it is also useful in a context where there is a shortage of professionals, as in Rwanda (Kaminer and Eagle, 2010).

#### **Cognitive-behavioural therapy**

This approaches combines both cognitive and behavioural therapy. Cognitive therapy is based on the fact that symptoms are the result of misinterpretations about the occurrence of

the traumatic events and the difficulty of their integration in the cognitive system. With cognitive therapy, clients learn how their distorted thoughts lead to the symptoms they are having and how they may change those cognitions for a better functioning (Resick, Williams, Suvak, Monson and Gradus, 2012; Cahill, Rothbaum, Resick and Follette, 2009). According to Cahill et al (2009), behavioural therapy, on the other hand, assumes that symptoms related to trauma reactions result from operant conditioned responses to the traumatic situation. Therefore the treatment consists of reducing the anxious, emotional conditioned responses by affecting the fear reactions associated to the reminder of the traumatic situation. Thus, joining cognitive to behavioural therapy provides a significant vehicle for the alleviation of symptoms that dominate the lives of rape survivors (McFarlane and Yehuda, 2000; Leiner, Kearns, Jackson, Astin and Rothbaum, 2012; Cahill et al., 2009; Yehuda, 2002). The techniques used in the cognitive behavioural therapy (CBT) approach are basically anxiety management, psycho-education, exposure and cognitive restructuring. Those techniques are sometimes modified according to the skills of the clinicians or in order to fit the needs and the context of the clients. However, the main principle that CBT changes dysfunctional thoughts, emotions and behaviour remains unchanged. CBT is a prescriptive approach which is conducted in accordance with a specific goal in a determined period of time and following certain procedures. The number of sessions varies between nine and sixteen (Kaminer and Eagle, 2010).

### **Anxiety management**

Different techniques have been utilized to help traumatised individual get over their anxiety. Breathing retraining is one of the tools used in managing anxiety. It was established that anxiety leads to rapid breathing which results in a diminution of carbon dioxide in the blood and an increased alkalinity which can cause physical discomfort. Therefore, learning to breathe slowly, deeply and with separated breaths augment the level of the oxygen in the body, making the individual feel calmer and gain a sense of wellbeing (Jaycox, Zoellner and Foa, 2002). This way of breathing has an advantage of being natural and easy to learn. In addition, it has been found to be a powerful instrument for relaxation (Katherine, 2012). Other activities also help one to relax, such as physical exercises, having fun by involving oneself in leisure activities, listening to music or simply walking (Sanderson, 2010). Mindfulness is also considered an important remedy for anxiety. It consists of concentrating one's thoughts on the present moment, keeping away negative thoughts, such as blaming oneself about what happened or worrying about the future (Robinson, Segal, Segal and

Smith, 2012). Anxiety management may be carried out both in and outside sessions. Some techniques in managing anxiety are natural, while others have to be learnt through the sessions of psycho education.

### **Psycho-education**

Psycho-education plays an important role in CBT as it informs the patient about the process of the treatment, and it explains the benefits and the side effects of the treatment. With comprehensive assessment, the symptoms are identified and personal strengths and available external resources are highlighted to be used as coping mechanisms in the treatment (Kaminer and Eagle, 2010). Furthermore, psycho education explains and normalizes the symptoms related to rape trauma syndrome and therefore the gain of knowledge helps the victims to stabilize their own trauma reactions (Schnurr, Friedman, Engel, Foa, Shea, Chow and Bernardy, 2007). Rape survivors learn about different reactions to their experience of rape. Even although psycho-education focuses more on the common outcomes of rape such as PTSD and depression, the therapist considers the individual's uniqueness to the trauma and therefore concentrates the discussion on the reaction of the specific survivor. In this manner, rape survivors learn that a sense of guilt; shame; low self-esteem; and negative feelings, such as sadness, helplessness and hopelessness are common reactions to rape trauma (Jaycox et al., 2002).

With psycho education rape survivors are also taught the skills in managing their anxiety, such as different methods of relaxation, positive self-talk and other distraction techniques (Vickerman and Margolin, 2009).

### **Exposure**

The maintenance of trauma reaction is explained by the presence of trauma memories in active memory and any reminder provokes its reactivation, which is accompanied by anxiety. Thus traumatized individual have a tendency to avoid situations that will remind them of what happened and by so doing they hinder the processing of the traumatic memories and perpetuate the trauma symptoms (Leiner et al., 2012). Exposure involves activating the traumatic memories in an organized way so as to alter their pathogenic component. The client, therefore, may be confronted with the feared situation in an imagined or concrete way (Schnurr et al., 2007). There are variants of exposure; self-exposure, prolonged exposure or systematic desensitization. While the different kinds of exposures differ in terms of their

procedures, they share the same goal of targeting anxiety (Nisha, Zak, Auerbach, Casey, Chowdhuri, Karippot, Maganti et al., 2010).

All of the above kinds of exposure address specific fears and maladaptive behaviours developed after an assault. The main objective is to decrease anxiety related to the reminding situation. To be successful, the exposure requires a safe environment, the stabilisation of the client and an empathic and supportive relationship with the therapist (Cahill et al., 2009). The sessions may be written and read outside the session or recorded and played back to the client between sessions. That kind of homework helps the survivor to regain the control (Kaminer and Eagle, 2010).

The outcome of the exposure is the validation of the non-threatening characteristics of the feared element, decreased anxiety and adaptive behaviour in the face of the trauma-related situation (Jaycox et al., 2002). Exposure was reported as having positive long term benefits among women with PTSD and co-morbid depression and anxiety disorders (Resick et al., 2012).

### **Cognitive restructuring**

In some cases, after their experience of rape, survivors have changed their assumptions about themselves and the world (Janoff-Bulman, 1992). They may assume that the world is unsafe and they will be unable to cope with the stress related to their experience. In addition, they fail to accommodate information related to the rape into their pre-existing belief and memory schemas (Jaycox et al., 2002). Cognitive restructuring therefore is based on the modification of such assumptions and distorted cognitions. This treatment facilitates information processing, and traumatic memories are integrated with others adaptive memories (Wheeler, 2007). This author argues that exploration of the held beliefs is imperative in order to work on them accordingly. The view of the self and the world are central determinations of emotions and behaviours, and by changing one's thoughts, emotions and behaviours are changed accordingly (Cahill et al., 2009). Cognitive restructuring may be carried out through writing assignments in which the rape survivor describes her experience and her perceptions of its meaning. Multiple readings of her account help her to incorporate a new understanding of her experience which is acceptable to her and thus more easily integrated into her beliefs and memories (Resick et al., 2012). Conversation is used for those who are illiterate, Schulz, Marovic-Johnson and Huber (2006) reported how sessions of conversations enabled a rape survivor of the Bosnia and Herezgovina war to challenge her negative thoughts, to cope

emotionally and to improve her symptoms of PTSD. Along with the successful process of the rape trauma memories, cognitive restructuring contributed to an increase in her sense of safety, trust, power, self-esteem and intimacy. Middleton and Craig (2012) indicated that the results of cognitive restructuring were promising in improving the problems of substance abuse reducing the symptoms of PTSD, depression and related cognitions among American women veterans of war.

Cognitive restructuring focuses on the change of the cognitive schema which results in a change of behaviours. Survivors who would like to get the meaning of their traumatic experience, however, should be directed to supportive counselling.

### **Supportive counselling**

In supportive counselling, the trust relationship between the counsellor and the client is key in recovering from psychological trauma. Rape is a matter of dominance and power on the part of the perpetrator, and the ensuing terror for the victim leads to loss of control, a sense of isolation and the loss of one's self esteem. It has been established that one of the most devastating outcomes of rape is the loss of trust in oneself and in others (Herman, 1997). Thus, supportive counselling accompanies the victims of sexual violence in the process of developing a new self and reconnection with others. It provides the means to understand the traumatic experience, to integrate it and operate inner changes for personal growth (Sanderson, 2010). According to Carl Rogers, the founder of the supportive counselling, such growth requires a safe and nurturing environment with an empathetic and congruent counsellor who has an unconditional positive regard towards the client (Rogers, 1995).

### **Unconditional positive regard**

Unconditional positive regard implies counsellor-acceptance and a non-judgmental attitude. Women with a history of sexual violence often blame themselves and are also subjected to the rejection of others. With a counsellor who listens to them without contempt, they feel motivated to freely express their disturbing thoughts, emotions and behaviours related to their experience without fear of being judged (Sanderson, 2010).

Supportive counselling is a person-centered approach which focuses on autonomy and encourages the individual to self-actualization. It is believed that each individual has internal resources that once mobilized, will facilitate the process recovery (Quinn, 2008). By accepting the individual's weaknesses and believing in her personal capacities, clients are

encouraged to set the goals towards their recovery process. This attitude is pivotal in the recovery of rape survivors because it contributes to restoring their sense of power to control their lives which has been lost with their experience of rape (Edwards and Lambie, 2009). To be more effective, this unconditional positive regard has to be supplemented by an empathic understanding.

### **Empathic understanding**

Empathic understanding refers to the capabilities of the counsellor to perceive the experiences of their clients. This is facilitated by attentive verbal and nonverbal communication during the time of interaction. It is only from an accurate understanding of the clients thoughts, feelings and behaviours that the experiences of the clients are valued (Mulhauser, 2011). Empathic understanding is an important aspect of the healing process for women who have been sexually assaulted. Through a supportive relationship women learn to re-establish safe relationships that have been distorted by their experience (Edwards and Lambie, 2009).

### **Congruence**

According to Mulhauser (2011), congruence refers to the consistence of a counsellor on her/his way of being. Being present and transparent in the relationship is sign of congruence. To achieve such an attitude, counsellors are encouraged to proceed with their own self growth in order to facilitate the growth of their clients (Adame and Leitner, 2008).

Women who have been sexually victimized are confronted with the incongruence of their self-identity moving from their abused self to the self they want to achieve. These women will find a congruent counsellor more reliable as he/she will facilitate the mourning and the grief of the lost self to the creation of a new accepted self. The ultimate objective of supportive counselling is only achieved once the survivors have regained the sense of their safety, have successfully mourned their lost self and have reconnected with others (Herman, 1997).

## **4.10 ADDRESSING THE AFTERMATH OF GENOCIDE**

This section will broadly describe how the outcomes of genocide have been addressed in the Rwandan context, with an emphasis on the measures taken to specifically address the aftermath of rape. As rape is considered as crime with health and social impacts, this section will review the justice system, the health care system and the social support system.

#### **4.10.1 The judicial system**

In the matter of justice, every government is required to protect its citizen to guarantee their security, rights to life and to prosecute any kind of abuse (Amnesty International, 2004). Paradoxically, during the 1994 genocide, the Rwandan government encouraged the worst violations of human rights, such as sexual violence against women, the killing of hundreds of thousands of individuals along with the destruction of property (Desforges, 1999).

After the genocide, in line with international law, the international community and the new Rwandan government that was in place had an obligation to punish the perpetrators. The United National Security Council qualified the crimes perpetrated in Rwanda as crimes against humanity (Amnesty International, 2004). Thus, in November 1994 an International Criminal Tribunal for Rwanda (ICTR) was established to judge such crimes. Its mandate aimed to prosecute those responsible for organizing the genocide, those who led it and those who committed sexual violence and rape against women (Haddad, 2011). The Rwandan justice system also had an obligation to prosecute such cases.

#### **Justice for rape survivors at the ICTR**

Rape and sexual violence being recognized as an outrage to human rights violation was an important step for Rwandan women survivors, as those who had ruined their lives would be brought to justice. Although the ICTR was responsible for prosecuting the perpetrators of rape, it took three years for the indictment of the first case. This was related to the fact that rape was not part of the general prosecutorial strategy of the tribunal (Haddad, 2011). However, when the ICTR started with the prosecution of rape, the definition of rape was not quite the same as how rape was defined in international law (Eboe-Osuji, 2007). The trial chamber defined rape as:

*“Physical invasion of a sexual nature, committed on a person under circumstances, which are coercive”.*

It stated that

*“coercive circumstances do not need to be evidenced by a show of physical force. Intimidation, extortion and other forms of duress which prey on fear or desperation could be coercion”.*

This definition is stated under the judgment, Case No. ICTR-96-4-T, 2 September 1998, (ICTR, 1998).

An emphasis, therefore, was placed on the violent context that accompanies sexual violence rather than on the act itself.

Akayesu, the first person to be convicted of rape at the ICTR was not physically involved in raping women himself, but had ordered a group of militias to commit mass rape against Tutsi women who had sought sanctuary in the locales of commune Taba which was under his authority (ICTR, 1998). The decision of the ICTR was consistent with the 1949 Geneva convention stipulating that accountability of sexual violence, including rape, may be prosecuted under international law for acts of genocide, war crimes or crimes against humanity (Amnesty International, 2004). The trial of Akayesu was the first time the court recognized rape as an act of genocide under international law. By doing so, the ICTR did not only contribute to the historical contribution in the prosecution of wartime rape, it also extended the definition of rape beyond a forced physical contact (Askin, 1999).

Despite this great achievement of the ICTR, it has been criticized for its failure in confidentiality and witness protection, which resulted in stigmatization, hostility from family members and reprisals when victims went back to Rwanda. Additionally, it was also reported that the victims of rape had not been handled sensitively during the investigation and that women were often traumatized during their testimonies by intrusive questions from the judges (Human Rights Watch, 2004). Henry (2010) argues that being victim and witness at the same time was a challenging task for the victims of rape as providing details of the incident to prove their credibility was emotionally an overwhelming experience for them as it recalled very painful memories. This author sustains that public disclosure to the courtroom is extremely traumatizing for women because of the taboo related to sexual intimacy.

The slow process of prosecuting rape cases was also noted as a weakness of the ICTR. According to Haddad (2011), although it was expected that the trials would be concluded in July 2008, available figures at the time showed that of the 42 indictments in total, 20 (48%) cases had been completed and 22 (52%) were awaiting judgment. There had been 5 (25%) convictions (not overturned on appeal); 13(65%) unsuccessful (not guilty verdict, pleaded out to charges other than rape, and convictions overturned on appeal); and 2 (1%) other outcomes (transfer to federal courts). According to the Security Council, this tribunal was supposed to complete all investigations in 2004, all trials in 2008 and all appeals by the end of 2010 (Human Rights Watch, 2004). This definitive closure has been postponed in 2014 (Oosterveld, 2010).



According to the literature reviewed, I believe that, regardless of the reported shortcomings of the ICTR, it has contributed greatly to the psychological rehabilitation of Rwandan women rape survivors by acknowledging the harm done to them and prosecuting the perpetrators. In addition, rape has been recognized for the first time as an act of genocide, and thus included in the international law under crime against humanity.

### **Justice for rape survivors under the Rwandan justice system**

Rape was considered a crime in Rwanda before the events of the genocide. According to Rwandese penal code, article 360, rape was defined as forced sexual penetration by a man of a woman without her consent, and was punished by five to ten years of imprisonment. If rape resulted in death, the perpetrator was sentenced to capital punishment (Amnesty International, 2002). The 1996 organic law on genocide stipulates that people who committed acts of sexual torture could be punished by capital punishment, without any possibility of sentence reduction (Amnesty International, 2002). There is no death penalty currently in Rwanda and the maximum sentence is life imprisonment.

The genocide left Rwanda with a devastated justice system which had suffered massive losses in material and human resources. It was estimated that after the genocide, the country was left with only 20 lawyers out of the 700 judges and magistrates who had been there prior the genocide. Some had been killed while others had fled the country (Schabas, 2005). The other major challenge the country was facing was the justice system having to judge crimes related to the genocide that didn't fall under the jurisdiction of the existing penal code.

In spite of these challenges, however, the Rwandan government was determined to combat impunity and make everyone who had committed crimes accountable, whether they were ordinary civilians, military, militias or members of state (Amnesty International, 2002). According to this source, later in 1996, an organic law N0 8/96 of August 30, 1996 on genocide was established. The genocide offenders were divided in four different categories. The first category included those who had committed grave offences, such as genocide organizers and planners, civilians and military authorities who had encouraged and led the genocide and other individuals who had committed systematic murders and sexual violence. The second category included those who committed or attempted homicide. The third category covered those who perpetrated serious attacks on their victims without any intention to kill them and the fourth category involved crimes against property. The legislation allowed offenders from the last three categories (categories 2-4) a reduction of penalties or even

release from prison if they gave a full confession, pleaded guilty and expressed remorse (Rettig, 2008). This system, therefore, attracted a great number of pleas which exceeded the capacity of the judicial system.

In 2001, Gacaca law was adopted by the Transitional Assembly of Rwanda as an alternative method of formal justice under the organic law 40/ 2000 of January 2001 (Schabas, 2005). In the same year, a law on community work scheme in lieu of imprisonment was introduced to supplement Gacaca law (Ballabola, 2001). Before colonisation, Gacaca was a traditional public court orchestrated by honourable local leaders and elders with the aim of solving conflicts which arose from property or family issues. This custom tribunal was replaced by the European justice system after Rwanda had been colonised by Germany and Belgium. It was, however, revived after 1994 to solve the problem of the limited number of lawyers and to speed up the numerous pending trials from the conventional courts. The structure of the ancient Gacaca was reviewed in order to address the more extreme matter of genocide related charges and to respond to the needs of the population in term of justice (Schabas, 2005).

The updated Gacaca courts were composed by judges who were lay people of integrity (Inyangamugayo) elected by the community (PRI, 2010b). While some viewed the system as a relevant and innovative solution to deal with the crimes that happened to their community (Cobban, 2002; Drumbl, 2000), others severely criticised the process, arguing that Gacaca jurisdiction was in contradiction with international standards (Wells, 2005; Donnah, 2003; Daly, 2000). Furthermore, Penal Reform International, an international non-governmental organisation, documented the Gacaca process during a period of eight years and noted that Gacaca judges did not have a legal background and that there was no counsel for defendants during the trials (PRI, 2010a).

According to the Rwandan government, the crime of genocide was committed in the open and involved the majority of the population. The rationale of judgment being held publically was that everyone in the community knew what had happened and therefore any lies would be contradicted by those who knew the truth. Moreover, it was perceived that mass involvement in solving the problems would lead the population to rehabilitation (Schabas, 2005). Officials of Rwandan government argue that the establishment of Gacaca jurisdiction was justified by its uniqueness in allowing the active participation of the community in trials for fair justice. They believed that the victims would receive justice as community members provided evidence to punish those who were accountable for atrocities. Moreover, those who

had been falsely accused would recover their innocence (PRI, 2010a). In the image of the South African TRC, Gacaca aimed to promote truth, justice and reconciliation for a sustainable peace among the Rwandese (Brounéus, 2010). For the first four years, Gacaca justice was put through a pilot phase, but since 2005, it has been operational throughout the country and initially had the authority for the trials of all genocide suspects, except the genocide leaders and rapists who were in category one, who were judged at either the ICTR or through the conventional justice system. However, because the ordinary court experienced difficulty in dealing with all the cases of genocide suspects in a reasonable time, Gacaca law was amended in 2008 to allow them to carry out the trials of category one suspects. Gacaca judges, therefore, had the power of acquitting genocide suspects, sentencing them for community work services or for life imprisonment. The sentence varied in accordance with the crime committed (PRI, 2010b).

Evidence has shown that the Gacaca courts processed trials faster than the regular courts, with hundreds of thousands of cases having been processed since its inception, as against the 222 cases tried by the regular court between January 2005 and May 2008. Integrated Regional Information Networks (IRIN) reported that at the time of handover, 8000 cases of rape that were on the waiting list for trial at the regular courts were transferred to Gacaca courts (IRIN Africa, 2012). Brouwer and Chu (2012b) reported that besides some cases of rape being tried at conventional courts, about 7,000 cases were tried during a period of one year from the middle 2008 to the middle 2009 by 17,000 Inyangamugayo.

Human Rights Watch became concerned by this transfer, believing that the privacy of rape victims would be violated by the public character of Gacaca jurisdiction. In response, the sensitivity related to rape cases was considered with particular attention. The hearings would not be conducted publicly, but would be carried out in closed chambers in the presence of a trauma counsellor. The judges received training with legal and psychological components as testimonies involving sexual violence were assumed to be potentially traumatizing for the victims. Violation of confidentiality would result in a sentence varying from being banished from the court to three years in prison (Bourke, 2012). Even with those measures, some women were reluctant to testify as they thought rape was difficult to prove or simply feared rejection once the experience was publically known (Cole, 2012). Due to the stigma and shame related to rape, many women decided not to take their case to court. This may explain

the few number of cases reported to the court as compared to the estimated number of 250,000 of women who were sexually assaulted during the genocide (Melvern, 2000).

Those who agreed to take their cases to Gacaca reported different experiences. Some of the women found healing; some felt empowered by the recognition that their aggressors had to face life imprisonment for the harm they had done; some women were harassed and stigmatized when the community learnt that they had testified; and some found the experience of recounting their ordeal very traumatizing (Brouwer and Chu, 2012b). The Gacaca courts tried close to two million genocide suspects and officially ended on the 18 June 2012. At the closing ceremony, the director deplored the psychological traumatising of genocides survivors who had attended the hearings as well as the killing and intimidation of the Gacaca judges. However, in spite of these challenges, it is believed that the Gacaca courts contributed to the unity of the population through justice (Musoni, 2012).

Even although Gacaca is over and ICTR is closing soon, their outcomes, either negative or positive, continue to have repercussions in the lives of women rape survivors. Whereas some women were relieved to see their assailants being judged, other are subjected to secondary victimization associated to their rape disclosure. This victimization may result in psychological health problems that may need to be addressed by skilled professionals in the health care system.

#### **4.10.2 The health care system in Rwanda**

The health care system in Rwanda is designed in accordance with the health needs of the population in preventing and treating disease, and promoting health (Ministry of Health, 2009).

##### **Care service delivery**

The health care system in Rwanda is greatly influenced by the after-effects of the genocide. The health sector consistently reviews its priorities according to the changes that are occurring in the context. With the loss of human resources and destruction of infrastructures, the first years following those tragic events were marked by the rehabilitation of health facilities and the training of new health professionals (Crowe, 1997). During the period from 1995 to 1999, the emerging health sector was mainly relying on international assistance. The developmental phase began in 2000 with a policy of decentralizing health care, with an

emphasis on community participation (Soeters, Habineza and Peerenboom, 2006). However, in the area of mental health, the policy of decentralization started in 1995 in order to deal with the psychological consequences of genocide (Ministere de la sante, 1995). The aim of such policy was to improve the mental health of the population.

Instituted health facilities offer preventive, curative and promotional health care services (Ministry of Health, 2005). The Rwandan population use both traditional and modern medicine, according to the health problems they have. While modern medicine follows a defined structure in line with the health care system, traditional healers are still working in isolation and are urged by the government to organize themselves into an association (World Health Organization Africa, 2009). Services of care are conjointly delivered by the public sector, faith based organizations, private for profit and non-governmental organizations. However, the Ministry of Health sets the rules and regulations, and controls and coordinates the entire health sector (Ministry of Health, 2005).

The introduction of mandatory medical health insurance has facilitated the financial accessibility to health care. There is public and private health insurance. RAMA is health insurance for civil servants working in the formal sector while MMI is for the military employees, CORAR and CORAS are for the private sector (Ministry of Health, 2011a). “Mutuelle de santé” or mutual health insurance, a co-prepayment insurance, is the most popular as it insures the informal sector and the majority of the rural population (Bucagu, Kagubare, Basinga, Ngabo, Timmons and Lee, 2012), with 10% of the bill going to the insurer for the referral cost (Vogel, 2011). The contribution cost per person and per year varies from 3000 to 7000 RWF (5-12 dollars), depending on the individual’s economic status. The poorest and most vulnerable people, such as those living with HIV/Aids, are identified by their community and get their mutual health insurance free of charge (Vogel, 2011). This is possible because mutual health insurance is subsidized by the Rwandan government in collaboration with external donors (Rosenberg, 2012). People seeking care in health facilities from the first level of the referral system to the top level must be in possession of health insurance. The “Mutuelle de santé”, however, is only functional in a specific catchment zone.

### **Organization of care service delivery**

The health care structure in Rwanda is divided into different levels in accordance with the organization of the local administration. This comprises the grassroots level that is composed of village and cells, sector, district level and central level (MINALOC, 2010).

Community health is structured according to the needs of the population of a specified village and cell. The sectors have been allocated health centres or health posts, while each district has a general hospital. Referral hospitals are at national level and provide specialized care for the entire population of the country. Each structure has its specific activities in order to avoid duplication (Ministry of Health, 2009). Community health is based on basic curative and preventive care. Providers are lay health workers working in close collaboration with social workers. They are trained on the management of some neonatal and childhood illness. Community health workers promote safe behaviours that contribute to good health (IHP, 2011; Mugeni, 2011). They sensitize the community on prevention of communicable and non-communicable diseases with the focus on the common disease that are the main cause of morbidity and mortality (Ministry of Health, 2009).

Health centres are the first level of the referral system and form a big proportion of health care facilities. While the country counts 30 districts hospitals, which equates with the number of districts in Rwanda, there are 406 health centres. However, according to the law, there should be 416 health centres, which is the number of sectors and each sector should have a health centre (Pose and Samuels, 2011).

Health centres deliver inpatient and outpatient services. They are spread throughout the country and are thus more accessible to the population. They provide curative, preventive, promotional and rehabilitative health services which cater mainly for common non-communicable and communicable diseases such as diarrhoea, respiratory disease, malaria and tuberculosis. They also provide family planning, antenatal care, immunization and monitoring child growth (Ministry of Health, 2009). Most of these facilities are managed by enrolled nurses (A2), although the Ministry of Health has acknowledged that their competences are inadequate and have started phasing out their training (Ministry of Health, 2011a).

Health posts are in remote areas where health centres are not available. Enrolled nurses perform some diagnostic tests and provide curative treatment. They vaccinate children, monitor the growth for those under five and offer antenatal consultation and family planning (Ministry of Health, 2009).

District hospitals also have curative, preventive and rehabilitative roles, but at a higher level of care than the health centres. Patients are referred by health centres to the district hospitals

where they receive care from more highly qualified nurses, physicians and paramedical staff. Each district hospital collaborates closely with all health centres operating in its catchment zone, which facilitate the referral system (Pose and Samuels, 2011).

Rwanda has five referral hospitals. Two are University teaching hospitals, namely the University Hospital of Kigali and the University Hospital of Butare, and the others are the Kanombe Military Hospital, the Neuropsychiatric Hospital of Ndera and King Faycal Hospital, which is the most specialized hospital providing care that is not available in the other referral hospitals (World Health Organization Africa, 2009; Ministry of Health, 2009). In addition, there is psychosocial centre that is an outpatient referral entity for treatment of mental health disease (Ministry of Health, 2011b). Only one of those facilities is located in the South province, with all others being in Kigali city. Referral hospitals provide specialized care which is not available at district level. These include specialized investigations and treatment in internal medicine, paediatrics, gynaecology-obstetrics, surgery, ophthalmology, endocrinology, nephrology and many others. Patients from health centres have to go through the relevant district hospital to reach one of the referral hospitals (Ministry of Health, 2009). There are some private facilities that provide the same specialized care as offered at the referral hospitals, with 70% of them being in Kigali (IHP, 2011).

It can be seen that specialized care is disproportionately distributed as the majority of providers are in Kigali city. Primary health care, however, is more available to the majority of patients as 60% of the population can access health facilities in less than 5km (Pose and Samuels, 2011).

One of the biggest challenges facing the health sector today is the shortage in human resources, especially health professionals who are well qualified. There are few specialized health professionals available in the country and almost all of them are working at one of the referral hospitals. Figures provided by the Ministry of Health at the end of June 2011 show that of the 15,038 members of staff working in different public health facilities, only 122 were specialist doctors, 498 were general practitioners, 1319 were nurses A1, 75 were nurses A0, 191 were midwives and 6723 were nurses A2. This clearly indicated that the majority of health workers are A2 nurses even although they have been considered not skilled enough in providing care of quality (Ministry of Health, 2011a).

The genocide has had a negative effect on the mental health of the Rwandan population; therefore mental health care deserves particular attention in the health care system.

### **Mental health care service delivery**

A mental health policy was introduced in 1995 which was tailored to the needs of a population traumatized by the genocide. It advocated the decentralization of mental health care and aimed to relocate mental health professionals from the referral hospitals to district hospitals and health centres so that people could be reached in their community. Each health centre was supposed to have at least one mental health nurse (Ministere de la sante, 1995). To date, however, only district and referral hospitals have specialized professionals. Furthermore, there are no mental health nurses at public health centres, but 77 of the A2 nurses working there have received a short course of training in mental health (Ministry of Health, 2011a). The other challenge facing mental health services is that many of the mental health professionals are suffering from vicarious trauma due to caring for people affected by various mental problems specific to genocide context in which they were also involved (Iyamuremye, 2010).

In 2005, in accordance with the political decentralization of public services, the mental health policy has been reviewed to adapt to the new structure. In addition, mental health problems were considered by the health sector to be a problem of public health. The need of integration of mental health care from community health level up to referral hospital was emphasized (Ministry of Health, 2005). The mental health policy was reviewed again in 2011 to be adapted to the changing context (Ministry of Health, 2011b). The high number of young people seeking mental health services as presented by the number of consultations at the referral outpatient facility for mental health problems is an illustration of such context. According to the report from the Ministry of Health for the period ranging from July 2010 to June 2011, out of 18,056 consultations done at SCPS 1,585 were new cases and 16,471 were old cases. The mean age of patients was 19 years old and the main causes of consultation were epilepsy (52%), psychiatric disorders (18.4%), psychosomatic disorders (12.3%), and neurological disorders (7.7%). The average number of visits per day was 69. Epilepsy was the first cause of consultation accounting for 9,412 (52%) of visits (443 new cases and 8,969 old cases).

As with other diseases, mental health problems are dealt with at the health centres before being referred to district hospitals and then to referral facilities. Therefore psychiatrists,



psychologists, mental health nurses and social workers are employed by referral facilities and mental health nurses and psychologists at district hospitals. As yet, there are no specialized professionals working in health centres or health posts to attend to the mental health needs of the population. Therefore, the majority of cases are dealt with by specialized professionals at the district hospitals and two of the national referral structures (Ministry of Health, 2011b). The high cost of travel to get to those specialized institutions is a significant barrier for the majority of patients who, more than likely, have limited means (Bucagu et al., 2012).

There is no aspect of the health care sector that specifically deals with the problems of rape survivors as was the case with the judicial system. This may be related to the lack of information from the decision makers on the implication of the consequences of rape on the mental health of the victims. The existing social support available in the living context of rape survivors may be a reliable source in helping them to prevent or to deal with some of their psychological problems.

#### **4.10.3 The social support system in Rwanda**

In Rwanda, the social support system aims to guarantee poor and vulnerable people access to health care, education, housing and other core public services. The Ministry of Local Government has taken the lead in social protection and has been complemented by other ministries, local associations, and national and international non-government organizations (NGOs) (Ministry of Local Government, 2011).

##### **Public social support**

The governmental social support is based on three principles; firstly, it is protective by providing the needed support for those who are poor; secondly, it is preventive by supporting those who are in risk of becoming poor; and thirdly, it is promotive in that the support it provides empowers the needy to become self-sufficient (Ministry of Local Government, 2011). According to this source, the Rwandan government offers different schemes of social support, some for the general population and others designed for specific groups. Although genocide survivors are supported by FARG, they may also benefit from other support existing in their communities, such as from VUP Umurenge, which is part of a large governmental programme named Vision 2020, and “Girinka”, which means one cow per poor family. While FARG has a broad social support and operates at a national level, other

schemes are community based and focus mainly on poverty eradication in amelioration of living conditions.

The main goal of this program is to promote a sustainable economic growth which may place Rwanda into a middle-income country by 2020 (UNFPA, 2010). The Rwandan government assumes that the welfare and social security of the population is a pillar for a productive workforce able to contribute to the economic growth of the country (Ruberangeyo, Ayebare and Astrid, 2010). Thus, VUP Umurenge aims to eradicate poverty in rural areas through a public works programme. It also has a microcredit scheme which provides cash money. The VUP Public Work Scheme offers priority for temporary work to those who are poor, but able to work. Working opportunities are mainly found in projects such as building roads, schools, bridges and other facilities, allowing the underprivileged to earn significant money. VUP cash transfers are for those who have no capacity for labour and are paid monthly, allowing beneficiaries to respond adequately to their daily needs and may also allow saving and investing. The VUP microcredit scheme encourages the spirit of entrepreneurship. Therefore it offers credit for individuals who are capable of setting up business projects and income generating activities. This allows the beneficiaries to overcome their poverty for a sustainable self-reliance. The loan may be applied for individually or as a group. In addition, this VUP financial service provides financial literacy skills (NISR, 2012). Girinka, or one cow per poor family, is a farm program which provides a dairy cow to poor households. This aims to improve their nutrition status and also improve the fertility of their land by using cow manure to increase their crop (Ruberangeyo et al., 2010).

FARG provides comprehensive support for genocide survivors. It was established by Law No. 02/98 of 22/ January 1998 for assistance to victims of genocide and massacres perpetrated in Rwanda from 1 October 1990 to 31 December 1994 and this law was reviewed by law No 69/2008 of 30 December 2008 (OG. N° Special of 15 April 2009). FARG is funded from 6% of the annual government budget and other sources in accordance with this law (Ruberangeyo, 2011). The eligibility to FARG support is determined by the community and official documentation is required from local authorities prior any support. Services from FARG are obtained from all levels of the administrative structures, such as sector level, district level or at the headquarters of FARG. The services provided to genocide survivors, as presented within FARG citizen's charter 2011, include education, health, shelter, social assistance and assistance for income generating projects. Support for education includes payment of school fees and school materials, such as notebooks, pens, uniforms and other

basic school needs. Eligible students are covered for nine years of basic education, high school and up to second cycle of higher education (Ruberangeyo, 2011).

Health care support is provided in terms of “Mutuelle” or mutual health insurance, for those who have been contaminated with HIV/AIDS, have mental health problems, and are physically handicapped from injuries inflicted during the genocide or for any other disease. At the beginning of each financial year, FARG pays the medical insurance for the needy genocide survivors. In cases when special treatment is needed, an application letter by the patient along with the medical care request is submitted to FARG. Thereafter, the patient receives the requested care from any of the referral hospitals. Those are paid monthly on presentation of the invoice in accordance with a memorandum of understanding made with FARG (Ruberangeyo, 2011). However, in a study conducted to assess the impact of FARG for their beneficiaries, participants reported that they had not been treated for their specific disease as their medical insurance was judged as being too small to cover the cost (GPO Partners Rwanda, 2012).

Social assistance or direct support is permanent financial support determined by the Board of Directors of FARG. It is provided to the very needy who are no longer productive, such as the elderly and the severely disabled, who are provided with household items, livestock, clothes and others basic items (Ruberangeyo, 2011) Financial support is provided to individuals who have the ability to invest in activities to generate income to get over dependency to FARG. Small business, artisanal activities, livestock and agriculture production were the areas most invested in (GPO Partners Rwanda, 2012).

Shelters or houses are built for genocides survivors whose houses were destroyed in 1994 and who have no means to rebuild. Once identified by their community as the neediest, their details are submitted to the district, and then to FARG, which provide funds for construction. FARG also rehabilitates old houses (Ruberangeyo, 2011). However, in a FARG impact assessment study, it was reported that, for various reasons, about 20% of those who qualified for shelter support had not yet received it (GPO Partners Rwanda, 2012).

FARG has been criticized for its poor quality in service delivery as well as inadequate support and lack of follow up for programmes that have been implemented. It has been applauded, however, for its contribution in improving the living conditions of genocides survivors.

Although the social support system was not designed specifically for rape survivors, they can receive support from the described structures once they have been identified by their community leaders as being vulnerable. Support may also be obtained from the private sector.

### **Private social support**

Private social support has been largely provided for women genocide survivors by women's associations, which have been complemented by local NGOs, and international governmental and non-government organizations.

Awakening from the darkest days of genocide, women survivors felt isolated and frightened by a dislocated society. Families members had been killed, houses destroyed and property looted. Sharing similar troubles of being homeless, widowed, raped, left alone and childless, women come together for consolation and mutual support (SURF, 2012). Some associations were specially initiated by widows or rape survivors and those have been joined by others with different backgrounds. These associations have allowed women to overcome their loneliness and regain their sense of life and security (Ryan, 2011). In addressing their immediate needs, many associations started by focussing on housing and on dealing with the psychological trauma of its members. They have progressively extended their activities in response to the complex problems of their members (Newbury and Baldwin, 2000).

Women's associations operate at various levels, such as at national level, district level or simply at the community level. Even although the focus of those association varies in terms of specific survivors supported and the kind of support delivered, all of them share an ultimate common goal, which is helping women survivors to reconstruct their lives (Ryan, 2011).

While some associations offer comprehensive support, others offer a limited service in accordance with their limited means. Some services offered by women associations are similar to those offered by the Rwandan government. However, in associations, the uniqueness of individual needs is highly considered. A young single woman, an elderly woman, a childless woman, a widow or a rape survivor will have their problems dealt with differently according to their specific needs. In addition to supporting women survivors, some women's associations also support their family members (Medica mondiale, 2012; Kanyarwanda, 2010; AVEGA, 2010; RWN, 2009).

Women genocide survivors are also supported by local NGOs which have been initiated by Rwandan men and women from different backgrounds. Some are genocide survivors, others not, some are secular, others are faith based, but all those NGOs are collaborating closely with women associations to help women survivors to reach their expected wellbeing (Ibuka, 2011).

Both governmental and non-government international organizations are helping women survivors in overcoming genocide related problems. Support from international institutions is translated into advocacy for rights and justice for women survivors, capacity building through formal and informal education and into funds which contribute to the running of various activities carried out by women associations and local NGOs (Russell, Umubyeyi and Nick, 2012). Support provided to women survivors range from health care to housing, material assistance, income generating activities, vocational training, advocacy and legal issues.

**Health care:** The health care delivered by women's associations is both preventive and curative. Women are taught how to prevent health problems and are also treated for their physical and psychological problems. Such comprehensive care is mainly delivered by NGOs or associations having health facilities, such as AVEGA or the Women's Network (RWN). AVEGA has three health centres and the RWN has four health centres throughout the country. Those health facilities also serve the surrounding communities (AVEGA, 2010; RWN, 2009). Other associations and NGOs mainly offer preventive care and psychological care to their members.

Preventive care is provided to members in terms of health education by health professionals, where available, or trained lay health workers. The emphasis is on reproductive health, prevention of communicable disease and how to prevent disputes which were causing trauma. A focus was made on how to prevent and how to deal with psychological trauma, mainly during the mourning period (AVEGA, 2010; RWN, 2009; Mukasarasi, 2007b). Curative medical care is valuable to many women who are suffering from chronic diseases and disabilities. Due to the magnitude of mass rape to which women were subjected during the genocide, particular attention has been paid to women rape survivors. During counselling sessions they are encouraged to test for HIV so as to know their health status. Those who are HIV positive receive free ART and regular home visits are offered when needed. Patients who can't access certain facilities make use of medical insurance to allow them to get the care they need at higher levels (SURF, 2012).

Psychological care is another important service offered to women survivors in helping them to overcome the atrocities they went through (AVEGA, 2010). This is provided by professional counsellors in terms of individual or group counselling or by lay community counsellors trained by AVEGA or ARCT Ruhuka, which is an association of Rwandan trauma counsellors (Ibuka, 2011). Some NGOs and associations have trained their members to provide counselling. Support groups have been initiated and women meet on a regular basis. Such spaces allow women to address their various concerns, and recreate social ties and sense of belonging (Keienburg, 2012a; SURF, 2012; AVEGA, 2010). Individual counselling, ad-hoc support and therapeutic groups were created by SEVOTA and Kanyarwanda specifically for women survivors who had children as a result of rape. Such group support permits women to open up and share their experiences, which helps them to deal with the shame, guilt and feelings of hatred towards their children (Keienburg, 2012a).

**Housing:** Having a decent shelter is a basic right for anyone and a first step in building one's life (Newbury and Baldwin, 2000). Due to the extensive destruction of houses during the genocide, reconstruction became a priority for the Rwandan government and international agencies. Damaged houses have been repaired and new ones built. However, to date, some genocide survivors are still waiting for adequate accommodation (GPO Partners Rwanda, 2012; Russell et al., 2012).

**Capacity building:** Capacity building was a mechanism put in place by associations and NGOs to support women survivors in putting an end to their dependency. This was translated in terms of vocational and formal training, along with income generating activities (SURF, 2012).

This was not only offered to women survivors, but also to their dependents. In terms of Rwandan solidarity, it was assumed that once a family member becomes economically wealthy, he/she will help the others (Kanyarwanda, 2010). The support accorded to beneficiaries depended on their background, and school fees and scholastic material were made available to those who were able to continue formal education while others attended vocational training in shoe making and repair, tailoring and handcrafts (RWN, 2009). For those who were involved in income generating, activities focused on small businesses if they were living in urban areas, and on agronomical projects, such as bee keeping, livestock farming and trade, if they were in rural areas (Sentama, 2009; Blizzard, 2006). To make

activities more successful and sustainable, women and their dependents were equipped with skills in business planning, marketing and selling (Russell et al., 2012).

**Permanent social assistance:** This assistance was provided in term of money, food, clothes and other basic items. Beneficiaries were those women whose physical conditions didn't allow them to work. Many of them were elderly, bedridden or had a severe handicap. In addition to the assistance offered, these women are regularly visited for emotional support (AVEGA, 2010).

**Advocacy:** Advocacy was conjointly carried out by associations and NGOs supporting women survivors. The focus was on fundraising and justice. In defending and promoting women survivors' rights, in 1998, such commitment led to the recognition of rape as a crime of genocide by ICTR. Kanyarwanda, which is an human right organisation, focuses on the rights of women and children, specifically those who were born of rape (Kanyarwanda, 2010). Paralegals have been trained with international funds and many cases have been resolved with their help. They were active during the Gacaca courts when they supported women survivors. Currently those paralegals are involved in issues such inheritance where they are helping women survivors to regain their property and land (Schimmel, 2012).

Women associations and local NGOs are playing a pivotal role in taking care of women genocide survivors by specifically addressing their physical, psychological and social concerns.

This social support for rape survivors positively influences their wellbeing.

#### **4.11 CONCLUSION**

This chapter has outlined the historical background of the 1994 genocide in Rwanda, the use of rape as weapon in armed conflicts and the way in which women were raped. The relevant theories confirm that rape was used as a weapon during the 1994 genocide in Rwanda. In supporting this statement, the prosecution of the culprits at the International Criminal Tribunal for Rwanda (ICTR) and Gacaca courts were reviewed. The theories on the post trauma reactions show that rape was a risk factor for lasting psychological effects among women survivors. Assuming that the suffering related to the traumatic experience of rape is universal, the literature from developing countries as well as western countries was reviewed. Despite the limited information that is available on the long term effects of rape committed

during times of war as compared to rape in times of peace, empirical studies of war rape have shown persistent negative psychological outcomes that were similar to those resulting from rape in peace time. The difference exists in term of severity and multiplicity of the symptoms. Those were translated mainly into various anxiety disorders, PTSD, depression, suicidal attempts and substance abuse. In many case those mental disorders were comorbid. There was a paucity of literature assessing the long term impact of rape in women genocide survivors. However, with the existing information that shows the psychological problems among Rwandese as a consequence of the genocide, the results of other studies may be extended with caution to these rape survivors.

The literature showed that risk and protective factors to long term psychological effects of rape depended on the women's characteristics as well as a supportive or hostile environment. Pharmacological and psychotherapeutic approaches were recommended if the experience of rape results in mental disorders. While all Rwandese were working together to address the aftermath of the genocide, it is mainly women's associations and NGOs that actively offer support to rape survivors.

The reviewed literature provided limited information on the specific long term psychological effects of rape among Rwandan women who have survived the 1994 genocide. Information on how to take care of these women was also lacking. This study addresses this gap by providing a description of women's suffering related to their experience of rape that occurred in 1994. This is presented along with a theory on the management of the long term psychological effects of rape among women survivors. The following chapter will present a discussion of the findings.



## **CHAPTER FIVE: DISCUSSION**

### **5.1 INTRODUCTION**

This discussion involves comparing and the contrasting the results of this study on the phenomenon of rape in armed conflicts with the available literature. This chapter is presented in line with the paradigm model (Strauss and Corbin, 1990), which guided the emerging theory of the management of long term effects of rape among women rape survivors of the 1994 genocide in Rwanda. The discussion relates to causal conditions; phenomenon; context; intervening conditions; actions/interactions strategies; and consequences.

### **5.2 CAUSAL CONDITIONS**

The causal conditions which contributed to the occurrence or development of Genocide Rape Trauma happened in two distinctive periods of time. Some events took place during the genocide, which involved rape with unspeakable cruelty and multiple losses. Others involve the continuous challenges and secondary victimization which only became manifest after the genocide, which also play a significant role in the development of psychological trauma in rape survivors.

#### **5.2.1 Rape with unspeakable cruelty**

The rape of women in the 1994 genocide in Rwanda was carried out with extreme violence. According to Brownmiller (1975), the feminist pioneer who denounced rape of women in the 1970s, rape was not a matter of a sexual act, but it was rather an expression of dominance, power and violence against women. This study has shown that women were at the mercy of the genocide perpetrators who had the power to kill them or rape them. Those who survived the vicious attacks of rape also endured the pain of torture and humiliation. Dutton (2007), who wrote on the theory of genocide, states that when rape is used as a weapon of genocide, it involves the torture and humiliation of the victims. Referring to this statement I may assume that the rape of the Rwandan women was a weapon of the 1994 genocide.

According to the present findings, torture was expressed in different ways. Women were individually or gang raped, or held in slavery to be regularly assaulted. The results of this study corroborate previous findings that indicated the use of brutality and cruelty in the rape of women in 1994 genocide (Mukamana and Brysiewicz, 2008; African Rights, 2004; Amnesty International, 2004).

According to Kivlahan and Ewigman (2010), rape becomes an act of genocide when victims are subjected to deliberate physical and psychological pain. The findings of the current study revealed that rape perpetrators did not only use their genital part to rape women, they also used objects. This is illustrated by the testimonies of participants who repeatedly cited the use of objects, such as sticks and banana trees, as a means of rape. The cruelty of rape perpetrators was described by a participant who related how, after being raped by many men, the last in the queue had used sticks, saying that he didn't want to dirty his organ. Women who refused to be raped were beaten or burned to weaken their resistance. Women were raped both individually and in groups. This study has also shown that women were held in rooms to be collectively assaulted and some were gang raped to death. Women not only endured the physical pain that was inflicted on their bodies, they were also psychologically affected by having to witness the rape of others. The most painful experience reported by rape survivors by this study was witnessing the killing of family members and being spared to be raped. In the view of these results, it appears that in 1994 genocide, rape was not used for sexual pleasure, but rather as an act of torture.

The mutilation of reproductive organs reported in this study might be viewed not only aiming to cause deliberate pain to the victims, but also to deprive those women of their sense of womanhood and their capability of procreation. Such measures may also constitute an act of genocide. It appears that the attacks were not only limited to the women's bodies, but were extended to the society in which they lived by destroying their means of reproduction. Madley (2008) pointed out that altering an ethnic group's capacity of giving birth constitutes a paramount act of genocide. The attackers not only used torture to subjugate the women they were raping, they also used humiliation.

The humiliation that women were subjected to in the Rwandan genocide has been reported in other studies (Mukamana and Brysiewicz, 2008; Desforges, 1999). Women were humiliated by being publicly raped in front of their community and family members. The present findings indicate that although some women were raped by unknown persons when they were trying to escape from one region to another, the majority of them were raped by their neighbours or people known to them. This was facilitated by the acceptance of interpersonal violence which prevailed during the time of genocide. The restrained sexual instincts along with self-respect and respect of others were replaced by aggressive sexual behaviours that were encouraged by the chaos of genocide (Winton, 2011). Women were made to stand

naked in the open and those who were estimated as being the most beautiful were raped first to be rejected later when more beautiful women were identified. The humiliation of women was exacerbated by being raped by those who were considered to be thieves or thugs in the community. The fact is that the Rwandan genocide was planned and it is from the group of such people that the potential killers were actively recruited (Prunier, 1995). They were trained to commit atrocities and encouraged to take revenge on those they might not have had access to in normal time (Desforges, 1999). Humiliation dehumanizes the victims by denying them their sense of being. Such annihilation left the victims with a sense of powerlessness, shame and guilt (Katz, 2012).

In the case of this study, those destructive feelings might not only have affected the women who survived rape, but might also affect the community and family members who helplessly witnessed such sexual violence. Gottschall (2004) points out the risk that women survivors of wartime rape might be rejected by their husbands, if they believe in chastity. Circumstances in which rape is conducted on a large scale might constitute an act of genocide as it results in the rejection of women survivors who are therefore denied their role of sexual reproduction to perpetuate their group.

Besides their horrific experiences of rape, the findings of this study showed that rape survivors were also faced with multiples losses.

### **5.2.2 Multiples losses**

All victims of rape, in both peace and wartime, are confronted with the loss of their self, which is related to the loss of control of their own bodies. However, in wartime and specifically in times of genocide, that personal loss is exacerbated by the loss of their loved-ones and their possessions. Shanks and Schull (2000) and Miller and Rasmussen (2010) indicate that in armed conflicts, in addition to being raped, women suffer the loss of their family members and property.

Added to the torture and humiliation they endured while being raped, Rwandan women survivors have lost their friends, and members of their nuclear families as well as their extended families. The magnitude of human loss that occurred in 1994 genocide is explained by the way in which it was carried out. The planners split the Rwandese into distinctive groups. One group consisted of the Hutu, who were in the majority and were the killers. The second group was composed of the Tutsi minority, who were to be killed and any Hutu who

was reluctant to kill or was involved in the protection of Tutsi (Desforbes, 1999). This was confirmed by the participants of this study who reported the killing of their friends who were trying to hide them.

The Rwandan genocide differs from other previous genocides mainly in terms of its speed and the involvement of the whole civilian population in the killing. Official mass media used the historical contention between Hutu and Tutsi to feed the hatred amongst those groups. Journalists and authorities incited people to murder their neighbours, and even young children and old people were encouraged to participate (Rwafa, 2010). The 1994 genocide was also marked by the active participation of women in the killing (African Rights, 1994). The human loss that occurred in Rwanda has been well documented. Pham, Weinstein and Longman (2004) estimated that 70.9% of those who survived the genocide had lost a close relative. The extent of the killing was reflected in this study where all women rape survivor who participated in this study reported that they had lost at least one person who was close to them and many of them reported that they had been widowed. Jones (2002) attributes this phenomenon to what he called “gendercide”. He explains that boys and men, being potential fighters, were targeted first by the killers.

Munyandamutsa, Nkubamugisha, Gex-Fabry and Eytan (2012) reported that genocide survivors not only lost their loved ones, but were also witness to their murder. These researchers found that among the young participants who took part in their study, only 25.1% had both their parents still alive; 16,4% had lost and witnessed the killing of their fathers while 13,3% had lost their mothers; 26,8% had been exposed to the murder of their siblings; 6,2% witnessed the death of their child; and 6,1% witnessed the death of their spouse. While this previous study was a national survey, a study with widows and orphans from the South province conducted by Schaal, Dusingizemungu, Jacob, Neuner and Elbert (2012) provided even higher figures. These researchers state that some of participants had experienced multiple losses. Those losses involved: loss of a partner (48.5%); a mother (72.9%); a father (90.7%); a sibling (86.0%); a child (38.8%); another family member (96.8%); or another close person (79.5%). The current study had similar findings in that the rape survivors who participated had all experienced the loss of loved ones. Some had lost their husband as well as their sons and daughters. Those who were young at the time of genocide were affected by the killing of their parents and siblings. There were even some participants who were left

alone after the all their relatives had been wiped out. Those who witnessed the killing of their loved ones reported that it was their neighbours who had killed them.

In addition to the loss of their loved ones, genocide survivors also lost their belongings. The loss of property involved mainly the looting and destruction of houses. Rape survivors from this study explained that at the end of the genocide they were disoriented and they didn't have any place to stay. They found themselves homeless as their houses had been destroyed. In addition, their furniture, cattle, all their farming and cooking utensils and even the stored food had been taken. This looting was attributed to the poverty that prevailed in Rwanda in 1994 where some 86% of the population were estimated as living beneath the poverty line (Jones, 2002). The rape survivors, however, viewed this phenomenon as the cruelty of Interahamwe, who destroyed everything they came across, even once they knew they couldn't profit from it. SURF (2012) interprets this vandalism, particularly the destroying of crops, as the deliberate will to prevent survivors any means of subsistence. Human Rights Watch, who conducted extensive research on the preparation, the execution and the outcomes of the 1994 genocide against Tutsi, noted that the Tutsi killings were consistently accompanied by the destruction of their property (Desforges, 1999). One may assume then, that the destruction of property which led to the material deprivation of survivors might have been part of the plan of genocide.

### **5.2.3 Continuous challenges**

After the genocide, rape survivors continue to face difficulties on daily basis that put them at high risk of having psychological trauma. These difficulties have a direct link with what happened during the genocide and include material deprivation, poor physical health and the burden of rearing children born of rape.

In the post genocide context, even although the majority of Rwandese are considered psychologically affected by poverty (Munyandamutsa et al., 2012; Sentama, 2009; Mugabe, 2007), women genocide rape survivors are the most affected (Keienburg, 2012b; Zraly et al., 2011). Hagen and Yohani (2010) state that the lasting psychological problems experienced by women who survived rape in armed conflicts were caused and reinforced by their multiple losses which placed them in condition of poverty.

This study has shown that the psychological vulnerability of rape survivors was reinforced by material deprivation. Their precarious situation was attributed to the loss

of their belongings and their family members who had been the breadwinners. The majority of the rape survivors were unable to escape from their impoverished circumstances due to their lack of education. Only one of rape survivors among the participants in this study had reached secondary school. Poor education was viewed as a limiting factor for women in being competitive in the labour market for significant revenue (National Institute of Statistics of Rwanda et al., 2009). Most of the women in this study were involved in farming activities with little income. Participants reported that women were in despair when they were unable to fulfil their own needs, those of their family members and specifically those of their children.

Poor living conditions are associated with psychological distress as it places women in a situation where the future seems hopeless, which is translated into depression or other mental disorders (Bryant-Davis et al., 2010). In a study conducted by Munyandamutsa et al.(2012), it was found that women genocide survivors who were living in poverty were frequently reported as having PTSD.

Rape survivors who were unable to attend useful activities due to their poor health conditions were at high risk of developing psychological trauma. On one hand, poor physical health makes rape victims vulnerable to poverty as it prevents them from working and thus earning a fair living. On other hand, those rape survivors with poor physical health spend much of their time seeking care for their health problems which prevents them from working or becoming involved in useful activities.

The poor physical health status presented by Rwanda rape survivors was also present among other women who have been victims of rape in armed conflicts (Amnesty International, 2010b). Amnesty International (2010a) states that women who were raped during armed conflicts were subjected to long term physical health problems that were the consequences of the physical violence that accompanied their sexual victimization. Women rape survivors who participated in this study claimed that the psychological trauma that they are having today was caused by the lasting injuries they got from their experiences of rape. Some were physically disabled and reported that they were often upset because they were not autonomous in fulfilling their needs. Some suffered from chronic urinary infection, others from severe gynaecological diseases and sexually transmitted diseases. In various other studies, uterus cancer has been attributed to complications from sexually transmitted diseases (Hagen and Yohani, 2010; Clifford, 2008; Wasco, 2003). The participants from this study,

however, thought that the uterus cancer that was affecting Rwandan women rape survivors was linked to the direct damage of the uterus when women were raped by sharp objects.

The results showed that women were desperate by the incurability of their chronic diseases, the most disturbing being HIV/AIDS. The existence of HIV/AIDS among Rwandese victims of sexual violence has been documented elsewhere (SURF, 2012; Zraly et al., 2011; Blizzard, 2006). According to Amnesty International (2004), 70% of women rape survivors were estimated as being affected by HIV/AIDS. This high rate of infection was related to the deliberate use of HIV/AIDS as weapon of genocide (Donavan, 2002; Landesman, 2002; Desforges, 1999). Researchers have shown that Rwandan women who have been affected by HIV/AIDS were at high risk of developing depression, PTSD and others psychiatric disorders (Umubyeyi, 2010; Cohen et al., 2009).

Beside the worries of their poor health status, rape survivors were also experiencing challenges in raising the children who were fathered by their perpetrators. Clifford (2008) argues that children of rape are a lasting negative outcome of rape. They are viewed as impacting negatively in the lives of their mothers, being both a psychological and a social burden (Keienburg, 2012b; Godard et al., 2012; Landesman, 2002). This study showed that these children were a challenge for their mothers. Participants reported that rape survivors were psychologically distressed by the presence of their children who were a permanent reminder of their experience of rape. The situation became more complicated when the father of the child had been implicated in killing the family members of the women they were raping. The women were disturbed that they didn't have normal feelings of affection for their children. In worst cases, the women had feelings of hatred and experienced difficulties in overcoming these feelings. The negative feelings mentioned above were often reinforced by families and community members condemning the mothers for raising the children of their killers.

Mothers have the full responsibility of raising children born of rape because their fathers are either unknown or in prison. Women reported that raising children born of rape made their living conditions even more difficult. These children were not planned so therefore it became very tough for their mothers to provide for their education, health insurance and other basic needs. The participants were of the opinion that the government has responsibility for dealing with these children in the same manner it deals with other negative consequences of the genocide. They also suggested that FARG, which assists genocide survivors, has a

responsibility in taking care of these children because they were a direct consequence of rape which occurred during the genocide. Failure to recognise children of rape as victims was considered as discrimination. However, according to the law on the assistance from FARG, only those who were born before December 1994 are eligible to the assistance (Ruberangeyo, 2011). Some women were very worried that they had failed to get the help they needed for their children and spent sleepless nights thinking how they could ensure a bright future for them. Some participants reported that being upset by the problems of their children resulted in psychological trauma. This situation was made worse by the secondary victimization that rape survivors had to endure.

#### **5.2.4 Secondary victimization**

Secondary victimization of women victims of sexual violence during armed conflicts was marked mainly by stigmatization (Moszynski, 2004). What became evident in this study is that Rwandan women who survived the sexual assaults were not only stigmatized, they were also confronted with different kinds of psychological and physical aggression.

According to Herman (1997), psychological healing of rape victims is facilitated when their assailants are made accountable for crimes through the courts of justice. In Rwandan context, however, while the judgments of rape perpetrators contributed to the psychological healing of the women by the recognition of harm done to them, it also led to various kinds of persecution (Brouwer and Chu, 2012b). Some women were repeatedly accused of profiting from their testimonies, while others were physically assaulted when their rapists were incriminated. Those who victimised the women did it in such a way that their aggression could not be traced back to them. They beat the women when there were no witnesses or threw stones on their houses during the night. These reprisals were related to the lack of confidentiality that occurred in the prosecution of rape cases (Human Rights Watch, 2004).

The psychological wellbeing of rape survivors was not only affected by the verbal and physical abuse they were facing, it was also affected by stigma.

This study shows that the stigma endured by rape survivors is both from their family members and the larger community. Clifford (2008) states that public rape in times of war is often followed by stigmatisation by those who witnessed the sexual assault. This



study demonstrates that in most cases, women were raped in front of their family members and communities. It was not an easy task, therefore, for those who survived to keep their experience of rape secret. They become ostracized and their disgrace and dishonour is linked to the value which is attributed to the chastity and virginity of women (Messina-Dysert, 2012). The participants of the current study reported that some women were accused by their family members, who witnessed their rape, of being responsible for the event as they didn't escape from their aggressor. Such accusations obviously added to the women's grief. Amnesty International (2004) reported rape survivors being rejected by their communities who accused them of being accomplices of the rapists and, still worse, being collaborators of genocide perpetrators because they had been left alive. The consequences of such stigma were that some girls were deemed unsuitable for marriage and some married women were abandoned by their husbands (Mukamana and Brysiewicz, 2008). This study showed, however, that some husbands have kept their wives who survived the rape, despite pressure from the community to chase them away although the single girls have had little chance to get married as they were less valued by their community.

It is likely that this climate of hostility in which women rape survivors are living has a negative impact on their mental health, and exposes them to a high risk of developing psychological trauma.

### **5.3 PHENOMENON: GENOCIDE RAPE TRAUMA**

Genocide Rape Trauma was conceptualized as an interrelation of factors which resulted from the incident of rape itself and other factors from women's surrounding context during and after the genocide. Genocide Rape Trauma captures the traumatic experiences that have affected the memories, feelings, meaning of life and interpersonal relationships of women survivors. This suffering was also expressed in terms of physical health problems. Studies of the psychological consequences of rape in peace and war time have been translated mainly in terms of PTSD, other anxiety disorders, depression, suicide attempts and substance abuse. In many cases those mental disorders were comorbid (Munyandamutsa et al., 2012; Hagen and Yohani, 2010; Clifford, 2008). What appeared in this study is that although rape survivors may express one or more symptoms of mental disorder, the way in which they expressed their suffering might not fit the standard criteria of the mental disorders related to the aftermath of rape as classified in the Diagnostic and Statistical Manual of mental Disorders (DSM) or the

International Classification of Disorders (ICD). These standard criteria limit the complexity of their suffering. In the words of the participants their Genocide Rape Trauma was expressed in terms of (a) unbearable memories; (b) overwhelming feelings; (c) sense of helplessness; (d) somatic distress; (e) negative self-image; (f) altered intimate relationships; and (g) social isolation.

**Unbearable memories:** Rape trauma reactions were conceptualized as Rape Trauma Syndrome by Burgess and Holmstrom (1974). These researchers have consistently shown the occurrence of traumatic memories related to the rape experience. However, the findings of the current study revealed that the traumatic memories experienced by Rwandan women rape survivors seem to be different from those described in Rape Trauma Syndrome. Their traumatic memories were not only related to the horrific experiences of rape, but these incidents were intimately interconnected with the brutal killing of their loved ones. Even although the annual anniversary of genocide was considered by most participants to be the biggest trigger which evoked unbearable memories, some of them said that their traumatic memories could not be associated to a specific trigger, and said that those memories troubled their inner peace. They viewed themselves as being continually haunted by those memories which occurred in flashbacks when they were awake and nightmares when they were asleep. The participants referred to flashbacks as “*ihahamuka*”. In this context the term “*ihahamuka*” conveys the unbearable nature of the memories where women reacted to flashbacks by losing consciousness, crying, screaming and rolling on the ground or by becoming speechless when they were psychologically distressed by the resurfacing of their traumatic memories. Walsh (2007) mentioned that memories are unbearable when they are linked to deliberate acts of violence and loss of innocent lives.

According to Horowitz (1975), traumatic memories are encoded in active memory and erupt in the consciousness with the same characteristics that had been encoded when the individual is confronted with an event that recalls the original trauma. This would explain the intensity, the pain and the persistence of traumatic memories among women rape survivors when one takes into account the horrific violence that they were subjected to in addition to witnessing the brutal murder of their loved ones. Furthermore, the living context of rape survivors is full of reminders, such as children born of rape, permanent disease related to rape and the sticks and bananas trees that were used for rape that are found everywhere.

**Overwhelming feelings:** Memories and feelings are interrelated. According to Pearlman (2003), in cases of extreme violence, memories are encoded in five separate fragments according to their specific aspects, with emotions being one of them. Pearlman maintained that if the memory fragments have not been fully integrated into the existing cognitive system, they continue to disturb the lives of the victim. Horwitz (1986) has explained that the greater the traumatic experience, the more difficult it will be for the memories to be processed.

Although many years have passed, women are still suffering from feelings that they might have had at the time of genocide. They are confronted with persistent fear, fright and feelings rage and anger. For some rape survivors, such feelings were so intense that they felt that their lives were falling apart or that they would lose their minds. Those overwhelming feelings might be related to the intense fear those women had when they were being raped and witnessing other inhuman atrocities. Herman (1997) states that traumatized victims of extreme violence such as rape may become overwhelmed by their traumatic experience which will inspire fear. Miller and Rasmussen (2010) maintained that daily stressors can maintain the psychological trauma reactions related to post war time conflicts for long time. In this study, women were daily distressed by their chronic illnesses, the responsibility of raising their children born of rape with limited means and by the social stigma. Those overwhelming feelings impaired the daily functioning of rape survivors as they interrupted their normal daily activities to a point that they had to stop what they were doing.

**Sense of helplessness:** Rape involves loss of control and power of one's own body. Rape disempowers the victim and may leave her feeling helpless for a time, challenging her abilities in dealing with its after effects (Ricchiardi, 2011). Seligman (1975) argues that individuals exposed to extreme violence were at high risk of experiencing helplessness after the traumatizing experience is past. In the view of the current findings, women were in situation of helplessness for a period of three months. As shown previously by Mukamana and Brysiewicz (2008) and also from this study, women were subjected to the terror of being killed or raped, with little chance of escape. Even although they hid in the bushes and swamps and fled from one village to another in the hope of avoiding danger, they were caught and then raped. Furthermore, they were helpless when significant others were murdered. In accordance with Seligman's theory, it might be plausible that women who survived such tragedies may feel a sense of helplessness for a long time after the events

(Seligman, 1975). Jones (2008) indicates that a sense of helplessness leads the victims in doubting their own capacity for controlling their lives. In addition, helplessness obstructs the sense of hope for survivors. This study has demonstrated that women rape survivors were desperate and had lost hope for the future. Henry (2005) argues that helplessness impairs the performance of the victims. As it was shown in this study, the capacity of women in solving their problems was diminished, with some even attempting to take their lives. Suicide attempts were also reported in a study of rape survivors of the Bosnia Herzegovina war (Loncar et al., 2006). While for those women the main reason of suicide was the humiliation related to pregnancy, in this study it was related to the failure in facing the challenges of their hard living conditions. Some of the women had suicidal tendencies that appeared to be linked to the difficulties in mourning their loved ones. This destruction of one's own life may be also attributed to an internalised sense of annihilation related to both rape (Herman, 1997) and to the genocide (Dutton, 2007).

**Somatic distress:** This study has shown that women rape survivors have expressed their psychological pain related to the experience of rape in different ways. These include disturbed memories, emotions, behaviours and also through somatic manifestations. Kirmayer, Lemelson et al., (2007) indicate that somatic expression was a common result of traumatic stress in victims of sexual violence. Those authors maintained that somatic symptoms were associated with alterations in the emotion motor system, which involve the autonomic nervous system, the sympathetic nervous system and the hypothalamic pituitary adrenal, as well as alterations of pain modulation, with high levels of endogenous pain facilitator against a low level of pain inhibitor modulator. Pain back, headaches, as well as gastro-intestinal cardiopulmonary, dermatological, muscular and gynaecological manifestations were the most frequent of such neurotransmitter disregulation (Wasco, 2003).

The results have shown that a number of women felt pain all over their bodies. However, the most common somatic symptoms reported included abdomen pain, chronic headache, persistent back pain, urinary infections, gastritis and uterus pain. The participants highlighted the intensity of pain, its persistence and their concerns about the incurability of such problems. The pain presented by those women mostly involved the parts of the body that were affected by the rape. The physical violence used put these women at high risk for developing somatic problems. The repeated use of health services by the women with somatic complaints was also observed. Kirmayer et al. (2007) argue that a severe traumatic event can be correlated with severe somatic problems. Palmer (2002) points out that in African culture,

the body is a privileged channel in expression of psychological pain. This appears to be true for Rwandan people where 12.3% of those seeking care at SCPS an outpatient psychiatric referral facility were suffering from psychosomatic disorders, as reported in the 2010-2011 annual report from the Ministry of Health (Ministry of Health, 2011a). According to Walsh (2007), somatisation was a way of expressing unspeakable violence.

**Negative self-image:** One's self-view is refers to the way individuals perceive themselves, how they perceive the world and how they believe others perceive them. In accordance with fundamental assumptions, people attempt to hold a positive view of themselves and believe in the goodness of others. These assumptions also rely on the predictability of the world which has rules and principles, where specific behaviours lead to specific outcomes. This illusion of the controllability of the world makes individuals feel safe and invulnerable (Brewin and Holmes, 2003). In the 1994 genocide, women were made totally vulnerable by the very government that was supposed to protect them. The act of rape was legitimised and whoever wished to sexually abuse these women had the right to do so, thus rendering them helpless. During the genocide, rape victims were no longer considered as human beings, but were viewed as sexual objects Katz (2012).

The dehumanization and humiliation that rape survivors endured shattered their fundamental beliefs and, since then, rape survivors have not only doubted their own self-worth, but have also doubted the integrity of others. The change in the way these women view themselves and the world has had a negative impact on their lives. They believe that they have lost their wholeness and perceive themselves as worthless, and are under the impression that others perceive them in that way too. Their self-sufficiency and competence in acting in the of face adversity have also been challenged (Bolton and Hill, 1996). This was illustrated by participants who mentioned that women were reluctant to become involved in activities that may ameliorate their living conditions. On one hand they assume that they are not competent enough to participate in successful activities and on the other hand they have doubt in the reliability of others.

**Altered intimate relationships:** The findings revealed that some rape survivors were no longer enjoying their sexuality and accounts from rape survivors themselves and from their community members have identified sexual dysfunction as the main cause of such troubled relationships. Reasons evoked were aversion or disgust, intense fear, painful intercourse, and lack of desire and sexual satisfaction. Weaver (2009) attributes absence of sexual desire and

arousal to the shame and guilt associated to rape experience. The women in this study, however, did not feel guilty about their experience, which be explained by the fact that they did not feel that they were accomplices to their rape. They tried their best to hide and resist their rapists, but with rape being part of the rules of genocide, those women had little chance to escape. However their shameful public rape may be viewed as unresolved sexual trauma.

Resnick and Acierno (1997), in line with learned theory mechanism and anticipatory anxiety, indicate that a life threatening event represents unconditioned stimuli that bring out an automatic response with cognitive, behavioural and physiological components. For these women, therefore, any sexual activity will recall their rape and may produce the original fear, pain, disgust and any other cues that were related to the experience. In view of their accounts of the extreme violence of rapes, it is not surprising that these women will encounter difficulties in their sexual activities. In a study conducted by Resnick and Acierno (1997) it was found that sexual dysfunction was often caused by a tense relationship in couples. However, these authors argue that sexual dysfunction is maintained by conflictual relationships. They also reported that chronic pain and social problems were also factors which contributed to difficulties in intimate relationships.

While some of the women reported that their experiences of rape resulted in their aversion to sexual relationships, for others it had the opposite effect as some of the women became promiscuous. These were mostly girls who had been very young at the time of the genocide. Promiscuity among women genocide survivors was also reported in early study by Munyandamutsa and Mahoro (2009). Trippany, Helm and Simpson (2006) indicate that sexual violence among children interrupts a positive attachment experience leaving the victims with maladaptive interpersonal skills. This may result later in harmful behaviours including inappropriate sexual conduct. Bryant-Davis, Cooper, Marks, Smith and Tillman (2011a) argue that prostitution may be both an expression of the disconnection from the body as consequence of rape, or sign of financial difficulties. In this study, participants reported that for some women prostitution was a way of earning a living as the majority of those who were involved were poor.

**Social isolation:** Social isolation reported in this study was translated into a diminution of interactions between rape survivors and their community members. Social isolation of women survivors of war rape has also been presented by other researchers (Lueger-Schuster et al., 2012; Hagen and Yohani, 2010; Mukamana and Brysiewicz, 2008). In this study,

women rape survivors were described as being withdrawn, cold, not sharing their opinions and not appreciating the company of others. These attitudes may be understood as a response to what Herman has called “disconnection”. She explained that the experience of rape destroys the basic trust, which is an element in any relationship (Herman, 1997). It is likely that rape survivors may no longer trust their neighbours after having felt betrayed, as rather than protecting them as they should have, they raped them. On the other hand, however, their social isolation may be a result of the stigma participants reported, as it is known that stigma has broken the connections between rape survivors and their community (Messina-Dysert, 2012).

This study has also shown that some women were specifically avoiding interactions that involved men. This may be interpreted as avoidance behaviour and might be related to the fact that men constitute a powerful reminder of their traumatic experience. Therefore, by avoiding such interactions, they are protecting themselves from distressing emotions that may be triggered by them. However, avoidance behaviour prevents access to traumatic memories which need to be processed for healing to take place, and thus hinders recovery (Leiner et al., 2012).

The women who lived on their own and had no one to talk to were more susceptible to social isolation. This study has shown that social isolation prevented women survivors from having access to the social support that is highly necessary for their recovery.

## **5.4 CONTEXT**

The results indicate that in the post genocide-context, Rwanda as a country has been confronted with many challenges in responding to the consequences of the genocide for the whole population in general and for rape survivors in particular. Efforts have been made by both the public and private sectors, and by the national and international communities. These include the establishment of (a) legal action against genocide perpetrators; (b) formal public support; and (c) formal private support.

### **5.4.1 Legal action against genocide perpetrators**

The participants in this study indicated that all those who had been involved in the planning or execution of the genocide, whether military or civilian, were brought to trial. Those who committed the crime of rape were prosecuted at ICTR or at the Gacaca courts.

The trials at ICTR included those who had planned, organized and executed the genocide against the Tutsi or committed sexual violence. The first indictment of rape took place in 1998, three years later after the court has been established. The delay of indictment as well as the tardiness in the prosecution of rape crime was viewed as a limitation of this court (Haddad, 2011). It appears from this study that these trials were very significant for the women victims of rape in that the horror they had been through was recognized and the culprits sentenced accordingly. Women rape survivors had been worried that the perpetrators would not be brought to justice as they had told them that no one would care about their cases.

The ICTR considered that the sexual atrocities committed against the women extended beyond the normal definition of rape according to international law. It thus became a challenge for the court to define the sexual violence that Rwandan women had been subjected to (Eboe-Osuji, 2007). Evidence shows that the definition of rape was elaborated in accordance with the testimonies on the occurrence, execution and circumstances of rape. The content of the retained definition as stipulated under article 3 of ICTR's statute (ICTR, 1998) is consistent with the accounts of the participants of this study. Both include the use of violence in raping women, either by penis or with objects, along with acts of dehumanization such as public nakedness and gang rape, to name a few.

This study has shown that it was a painful and embarrassing experience for women to testify. They were requested to describe their experiences of rape in detail and it was hard for those women to report the extent of their degradation, while remaining credible. The women found the intrusive questions of the judges at ICTR extremely distressing and these were subsequently denounced by human rights activists (Human Rights Watch, 2004). Henry (2010) indicates that difficulties in testifying about rape crimes are related to the taboo associated with rape and to the discomfort of revealing the details of one's intimacy.

Even although women reported being distressed by testifying at Arusha, they were satisfied by the outcomes. They believed that their testimonies did not only contribute to their own cause, but hoped they would also serve the cause of other women in similar conditions. They believed that the law on rape as a crime against humanity may



prevent similar occurrences in the future as perpetrators would have to face punishment.

The Gacaca courts had the responsibility of not only judging those who raped women, but also those who participated in the killing, looting and destruction of houses. The Rwandan government had reviewed the content of Gacaca law to fit the needs of justice for the Rwandan population. The first trials of rape at the Gacaca courts started officially in 2008 with 8000 cases transferred from the formal justice system (IRIN Africa, 2012) and the individuals were sentenced in relation to the crimes they had committed. Despite the absence of professional lawyers at Gacaca's courts, those courts had the power to acquit the innocent, and determine the sentence of the accused, to proceed to the remission of sentence or prosecute for life sentence (PRI, 2010b). The Inyangamugayo who were conducting the trials had received informal training in law and counselling before they attended the jurisdiction.

Those who were convicted for rape were sentenced to life imprisonment. Participants from this study pointed out that there was disagreement among the population regarding the sentence for perpetrators of rape. The rape survivors and their supporters felt that life imprisonment was appropriate, but the rape perpetrators and their family members found the sentence too severe and felt it was disproportional to the crime committed. There was also disagreement among scholars regarding the rules and regulations of the Gacaca courts. While some doubted the fairness of judgment in the absence of professional lawyers (Wells, 2005; Donnah, 2003; Daly, 2000), others took the stance that it was a good alternative in view of the huge number of people involved in the genocide and the scarcity of material and human resources in the traditional justice system (Cobban, 2002; Drumbl, 2000).

The challenges in testifying at Gacaca courts were also reported in this study. Some women reported that people discouraged them from testifying or tried to bribe them to prevent them from reporting their case to the courts. Others were distressed by firstly having to confront their rapists at the courts, and then hearing them deny the evidence and accuse them of false testimony. The participants reported that witnesses found it beneficial when the Gacaca courts requested that counsellors be present at the hearings (Bourke, 2012). Once emotionally supported, the women felt more confident in facing their rapists until they won their cases.

Women who testified at Arusha or Gacaca courts reported similar experiences. Both said that they had been troubled by the thought of testifying, but they had been determined to do so and were proud of the result. Fazio and Fazio (2005) mentioned that the determination of the victims in attending the trials of their aggressors was a form of revenge that brought a sense of justice and satisfaction.

#### **5.4.2 Formal public support**

This study has shown that the majority of rape survivors who are in need are gaining support from FARG. FARG was established by the Rwandan government to provide comprehensive support to genocide survivors through public funding. It offers shelter, health care insurance, microcredit, and direct assistance and support in education (Ruberangeyo, 2011).

Even although one of the priorities of FARG has been to provide shelter to those left homeless by the genocide, a study conducted on the impact of FARG on the lives of genocide survivors has estimated that about 20% have not yet received shelter (GPO Partners Rwanda, 2012). Despite this, however, rape survivors from this study whose houses had been destroyed are now living in new houses built by FARG. For fair distribution of social support, those who are in need are identified by their community leaders (Ministry of Local Government, 2011).

Another focus of support from FARG is on health and it provides medical health insurance to those who are in need, primarily those who are living with HIV/AIDS or those who have been mentally or physically disabled by the genocide. The medical insurance provided by FARG is used at all levels of the health care system in Rwanda (Ruberangeyo, 2011) and it is currently recommended to have health insurances to get care from public health facilities (Ministry of Health, 2011a). This information was consistent with the participants' accounts of how FARG was facilitating their care through the delivery of medical insurance. However, some of them were discouraged by the bureaucracy that accompanies services delivered by FARG.

The direct support from FARG is crucial for the most destitute of the genocide survivors who receive basic household goods from this fund. Participants recognized that the neediest of their community depended on FARG for giving them support in terms of clothes and food. In order to get over dependency, FARG also helps its beneficiaries with the financial means to

start small businesses. It also contributes to the education of those who are suitable for studies.

Even although there is no programme designed specifically for rape survivors, they have access to all the services mentioned above, which ameliorates their living conditions.

Beside FARG, which was specific for genocide survivors, there were also others programs under the social protection from the Ministry of local government which aimed to help vulnerable people, which may include rape survivors. To name few, VUP Umurenge and Girinka were among them (NISR, 2012). However findings didn't indicate that rape survivors were supported by those structures.

### **5.4.3 Formal private support**

Formal private support was mainly provided by women's associations and NGOs. This study has shown that associations are valuable resources for rape survivors as they offer them opportunities to deal with their everyday problems. This is achieved through different kinds of support provided in terms of health care, housing, income-generating activities, permanent assistance and education. In addition to offering the women much needed support, these associations provide the space where women regularly gather for their self-help groups. In cases where women have been the sole survivors of their families, those associations have brought them together with other survivors and have thus recreated their sense of belonging (Ryan, 2011). The usefulness of such associations was highlighted by one of the participants who remains thankful to SEVOTA as it helped her and other women in similar situations to get over their isolation and feel that they are part of a family again.

According to the reviewed documents, similar support is also provided by national and international NGOs. Some of these are Rwanda Women Network, Solace Ministries and SURF (Russell et al., 2012; RWN, 2009). However, in this study, participants referred mainly to AVEGA and SEVOTA and sometimes to Kanyarwanda (an NGO), while describing the support received by rape survivors. This might be related to the fact that these are the activities operating in the areas of this study, with AVEGA working at national level and SEVOTA having its headquartering in the Kamonyi district.

While the women's associations also provide certain services to the public, the main aim of the associations is to provide support specifically for women genocide survivors and, in

many cases, is tailored to the needs of each individual (AVEGA, 2010). This was confirmed by a participant who said that in giving support, whether it be financial, medical care, education or in any other area, members are assisted according to their request.

Medical and psychological care is the focus of associations and NGOs supporting rape survivors (Russell et al., 2012; AVEGA, 2010). In this study, rape survivors commonly reported physical and psychological problems and from their accounts, both SEVOTA and AVEGA were offering psychological counselling to their members who were suffering from psychological trauma. Women were having their physical problems attended to in the health facilities of AVEGA. It appears that the two associations complement each other. Services that are not offered by SEVOTA can be obtained from AVEGA.

From a Rwandan perspective, once a family member is prosperous, he/she is expected to help relatives who are in need (SURF, 2012). Therefore, those associations are not only supporting rape survivors, they are also supporting their family members. This was illustrated by the support given by SEVOTA and Kanyarwanda to children born of rape to assist with their medical insurance and education.

In addressing rape survivors' bio-psychosocial needs, this study has shown that rape survivors are supported individually, in groups or with their family members. This holistic approach given by associations is a key component in the healing process of women survivors recovering from their rape trauma.

## **5.5 INTERVENING CONDITIONS**

Intervening conditions refer to those factors which have either a positive or negative influence on the actions towards the management of long term psychological effects of rape among women genocide survivors (Strauss and Corbin, 1990). Community solidarity was identified as facilitating condition while inadequate resources for rape survivors' care were identified as hindering conditions.

### **5.5.1 Community solidarity**

Community solidarity contributes to a sense of belonging, which is urgently needed in the aftermath of mass trauma (Mason, 2000). The results of the current study showed that

community solidarity is playing an important role in the wellbeing of rape survivors. It was translated through supportive relationships and material support towards rape survivors.

Community members who participated in this study pointed out that everyone among them should be aware of the vulnerability of rape survivors and take responsibility for taking care of them. Some rape survivors were known by their community members because they were regularly having “ihahamuka” (Psychotrauma) in the open. Some of the community members were committed to helping their neighbours to atone for those who had betrayed them and harmed them during the genocide. The results showed that there are community members who are concerned about the wellbeing of rape survivors, who visit them and provide emotional support with comforting conversation.

Comfort and reassurance from others have been reported by different scholars as a key element in the recovery of rape survivors (Littleton, 2010; Goldenberg, 2009; Walsh, 2007). Rape survivors viewed the visits of community members, mainly the local leaders, as a sign that they are accepted in their community and their problems were understood. Feeling understood and accepted is a major element which decreases the social isolation affecting rape survivors as the healing process of rape trauma relies on the recognition of others of the pain endured (Ahrens et al., 2009). Fazio and Fazio (2005) indicate that informal support from the surrounding community is a powerful ingredient in the healing process of recovery from the wounds of psychological trauma. The results showed that in cases where rape survivors are very sick with mental health problems or weakened by HIV/AIDS and didn't have any relatives to help them get treatment, neighbours helped them to get access to needed care. Walsh (2007) argues that rape victims need reliable community members to accompany them in their journey of recovery.

Debilitating health problems, permanent physical disabilities and poverty have put rape survivors in a situation of material dependence. According to Amnesty International (2010b), women rape victims in times of war are not only affected psychologically by their traumatic experience, but are also affected by material deprivation, which is a common outcome of armed conflicts. Therefore, material support is a priority to help those women recover.

Littleton (2010) and Ahrens et al. (2009) suggest that for material support to be efficient, it has to consider the specific needs of the person supported. The results showed that rape survivors were getting support from their neighbours which allows them to fulfil their fundamental needs. Rape survivors attested that they have been able to get to hospital

because their neighbours have given them the money to do so. Some women were living in conditions of such extreme poverty that they were eating only when the neighbours provided food.

The majority of women who participated in this study indicated that farming activities were their only source of income, and women with physical handicaps were not able to attend to such activities. In some of these cases, community members volunteered to take on the work of those women. Such support was offered by individuals or groups during community work instituted by the Rwandan government to help those who were in need (Ministry of Local Government, 2011; Handicap International, 2009).

The support received by rape survivors have shown that people living alongside them are concerned for their wellbeing. This sign of solidarity contributes to the psychological and physical wellbeing of rape survivors as it protects them against the feeling of desperation which may result from their state of deprivation (Bryant-Davis et al., 2011b).

### **5.5.2 Inadequate resources for rape survivors' care**

Inadequate resources to care for rape survivors were the main hindering conditions. They were translated through lack of appropriate support and lack of appropriate health care service delivery. These negative factors inhibit the actions designed to address the specific problems experienced by women survivors as a result of their Genocide Rape Trauma.

In the post genocide context, the Rwandan government has put in place different structures to help its population to deal with the consequences of the genocide. As far as rape survivors are concerned, rape was recognised as a crime by the judicial system and perpetrators were brought before the Gacaca and ICTR courts (PRI, 2010b; ICTR, 1998). However, the reprisals endured by those women who testified at the Gacaca courts went unpunished. This was attributed on one hand to the lack of a specific law addressing the negative after effects of Gacaca jurisdiction and on the other hand by the non-recognition of local authorities of the insecure predicament of rape survivors. While participants in the study reported that the security of rape survivors had been compromised by their testimonies, the authorities and those who were employed by the local administration felt that this was not the case and that the Gacaca hearings had in fact brought their assailants to justice. This lack of awareness of the real situation of rape survivors might be a barrier in searching for an appropriate solution to their problems of insecurity (Cox, Lang, Townsend and Campbell, 2010). According to

these authors the absence of a safe environment constitutes an obstacle to the recovery of traumatized individuals.

Rape survivors felt that their cause has been neglected by the Rwandan government in the domain of health and social support as no appropriate structures have been put in place to specifically address the consequences of rape.

According to the findings, women rape survivors are suffering from gynaecological problems related to their brutal rape, in addition to other physical injuries that are common to genocide survivors. Their poor health status is not being adequately addressed and there is a lack of appropriate care being offered to these women. It appears that the Ministry of Health has focused on the health needs of the whole population rather than on those of a specific group, such as the rape survivors, despite the fact that they are experiencing persistent psychological problems related to the genocide. The lack of such support was attributed to the lack of understanding on the part of decision makers of the mental health problems which have arisen tragic events that occurred during the 1994 genocide (Ministry of Health, 2011b).

Furthermore, the social economic problems that the country is facing (NISR, 2012) are impacting negatively on the social assistance offered to those who are in need. Participants explained that the limited budget of social services in the public sector, added to the high number of people who are in need, limited the chance of rape survivors getting support if they have not been designated as first line beneficiaries.

The other unique problem that rape survivors are facing is the lack of support they receive in raising their children born of rape. Clifford (2008) pointed out that the situation of these children must be considered as it dramatically influences the wellbeing of their mothers. However, the results have indicated that there is no regulation which protects the basic rights of those children. It appears from findings that the support provided to rape survivors and their children may be limited by the absence of appropriate structures and established regulations.

On the other hand, lack of appropriate health care service delivery was preventing rape survivors from getting the services they needed. Results have shown that the majority of rape survivors attended the health centres for treatment of their health problems. These women complained that there were no specialized professionals at that level who had the necessary

expertise to treat their cases. This lack of service care delivery may be attributed to both the shortage of specialized health professionals in Rwanda and to the way in which health care service delivery is organized by the Ministry of Health. This Ministry allocates specialized professionals to the district and referral hospitals in the expectation that clients who fail to get the necessary treatment from health centres will be referred to these more specialised facilities (Ministry of Health, 2011a). The majority of NGOs and private health facilities are also located in Kigali city (Zelaya and Fellow, 2009; IHP, 2011).

Although the mental health decentralization policy from 1995 provided for the allocation of mental health nurses at health centres, there are, as yet, no such professionals at those health facilities and most of the skilled mental health professionals are located in the two national referral institutions, which are in Kigali city (Ministry of Health, 2009). This has proved to be a major barrier to care for those living in rural areas as, due to their poverty, they have no means to get to the cities (Bucagu et al., 2012). The results showed that participants were of the opinion that the health of those rape survivors living in poverty who could not afford the transport money to get to Kigali city had deteriorated due to the inaccessibility of the required care.

The findings also showed that the system of Mutuelle de Santé (mutual health insurance) provided another challenge to the access of relevant care. Although women were in possession of medical insurance, they were not receiving the full benefits because it was only functional in the particular area in which they lived and could not be used if they needed to move to another district to access care. The regulations of the mutual health insurance stipulates that the owner may only access health care services in the catchment zone in which the health medical insurance has been delivered (Ministry of Health, 2010). In addition, the “mutuelle de santé” is co-prepayment insurance, which requests the insured individual to cover 10% of the bill of their treatment (Bucagu et al., 2012). The results have shown that due to poverty, some women were unable to pay their part and it was therefore impossible for them to get the prescribed treatment. Although FARG does make provision for assisting survivors of the genocide to get specialised treatment, many some rape survivors were not using this means because they had become discouraged by the long official process that had to be followed to become eligible. First, the woman has to get official documents from grassroots authorities attesting that she is a genocide survivor and does not have the means to pay for her treatment. She then has to get a referral prescription from the health centre to the



district hospital, and from the district hospital to the referral hospital, showing that the health centre is not sufficiently equipped to treat her complaint (Ruberangeyo, 2011).

According to Strauss and Corbin (1990), such above hindering intervening conditions have to be managed because they are constraining the actions which may be addressing the identified problems.

## **5.6 ACTION/INTERACTION STRATEGIES**

The action/interaction strategies in this study aimed to contribute to the management of Genocide Rape Trauma. Those actions consisted of (a) psychological care; (b) medical care; (c) advocacy; (d) economic empowerment; (e) women support groups; (f) education of the community; and (g) self-help coping strategies.

### **5.6.1 Psychological care**

According to the findings, psychological care to rape survivors was provided in terms of counselling and psycho education.

A review of the literature has made it evident that taking care of traumatized people, specifically those who are victims of rape, requires specific skills. Supportive counselling has been identified by scholars as one of the most efficient techniques which will help survivors of atrocities to overcome their trauma reactions (Mulhauser, 2011; Sanderson, 2010). Participants in this study suggested that those providing counselling should be professionally trained in order to help rape survivors efficiently. Unfortunately, in Rwanda, there are not enough mental health professionals working in the health facilities to respond to the large number who are in need of their services. According to (WHO, 2011), there are only 0,05 psychiatrists; 1,3 nurses; 0.07 psychologists; 0.12 social workers and 0.02 occupational therapists respectively per 100.000 population.

Participants indicated that counselling is one of the best ways of attending to their psychological needs, but pointed out that this should be carried out with empathic professionals who are able to listen carefully to the rape survivors. According to (Mulhauser, 2011), a trusted relationship is built through empathetic understanding, whereby the experiences of clients are valued and understood. This kind of relationship restores the clients' sense of safety and trust in others (Edwards and Lambie, 2009). If such positive

interactions could be extrapolated outside the therapeutic relationship, it would facilitate more positive interactions between rape survivors and their neighbours, which were seen as problematic.

Participants proposed that continuous counselling could be a solution for rape survivors who are constantly disturbed by their psychological problems. The advantage of supportive counselling is that it helps traumatized individuals to give a meaning to their experience. Once this has been achieved, the memories can be successfully integrated and they can move forward in their lives (Sanderson, 2010).

Cognitive Behavioural Therapy (CBT) was advocated by clinicians to treat trauma reactions as it facilitates the change of dysfunctional thoughts, emotions and behaviour related to the traumatic experience (Kaminer and Eagle, 2010). This change is brought about via the main components of CBT which are anxiety management, psycho education, exposure and cognitive restructuring (Cahill et al., 2009). It appears from the results that professionals are incorporating CBT into their practice as the results showed that they were using anxiety management and psycho education in the treatment of rape survivors during group sessions. Kaminer and Eagle (2010) suggest the use of CBT in groups where the needs of clients can't be addressed individually in a situation where there is a shortage of professional health care.

Some of the women testified that they had benefited from such sessions, which were offered from time to time when their associations had invited specialized professionals to lead such groups. The women said that they had learnt different techniques of relaxation during these sessions, which they continue to practice on their own when the sessions were over. In line with the principles of psycho education, which promote self-knowledge on one's trauma reactions (Schnurr et al., 2007), women were taught how to be aware of their trauma and self-care was encouraged. Results show that even although the women survivors have learnt to identify the signs of psychological trauma and how to handle it, the majority of them did not understand why they are still experiencing psychological trauma after so many years. Participants believed that if it was explained clearly and comprehensively to rape survivors why they are still having psychological trauma, they would understand their situation better and would therefore be able to accept it. Moreover, they would learn to identify the trigger factors and find appropriate ways on how to avoid them or, in other cases, how to handle their psychological problems in a more efficient manner. Those participants who had had the opportunity to benefit from education opportunities from health professionals know that they

were at high risk of having trauma after being subjected to atrocities such as rape and murder of their loved ones. They learnt about the specific signs, the different techniques in dealing with them and under what circumstances they should seek help from a neighbour or skilled health professional. Turró and Krause (2009) state that education fosters self confidence in an individual.

In addition to psychological care, medical treatment was also used in addressing the health needs of rape survivors.

### **5.6.2 Medical care**

It has become evident that medical treatment is required to address the women's mental health problems as well as the physical health problems that have resulted from rape. Hetrick, Purcell, Garner and Parslow (2010) indicate that clinicians may use medication in cases when psychotherapeutic interventions did not respond appropriately. This was in accordance with the results of the study which showed that women were firstly treated with counselling for their psychological problems, but if those problems were persistent, then medication was used. The drugs recommended for psychotrauma reaction are antidepressants from the new generation, such as Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin Norepinephrine Reuptake Inhibitors (SNRIs) due to their therapeutic efficacy and because they have less side effects compared to the tricyclic antidepressants (Jeffreys et al., 2012). The results revealed that despite their contested therapeutic impact and their hepatotoxicity, Anafranil (Clomipramine) and Amitriptyline (Tryptizol), which are tricyclic antidepressants (Jeffreys et al., 2012), were largely prescribed because they are more readily available (Nkubili, 2012). Those women who were experiencing traumatic memories in the time of commemoration were prescribed valium (Benzodiazepin). Even though this medication was used for its sedative reaction due its side effect of addiction, Propanolol was preferred. The latter is an Adrenergic-inhibiting agents which is efficient in treating traumatic memories and does not have such addictive side effects (Nappi et al., 2012). Unfortunately this medication is not available at health centre where rape survivors are seeking care and is only found at referral institution. Valium is available at health centres (Nkubili, 2012), which may explain the extensive use of valium.

In some cases, where psychological problems were concomitant with somatic distress, patients responded positively to psychotropic treatment. However, some women are suffering

the consequences of severe injuries and their treatment is determined in accordance with the manifestations of the physical illness that are presented. Therefore, clinicians are encouraged to carry out an extensive assessment for appropriate medical treatment (Campbell, 2007).

The findings showed that although women with fistulas had benefited from reconstructive surgery and those living with HIV were under antiretroviral treatment, the majority of rape survivors with chronic diseases were dissatisfied with the care they had received.

### **5.6.3 Advocacy**

Koss (2006) stated that advocacy may be used to bring about changes in the social system which may result in positive outcomes in the lives of women victims of sexual violence. The lasting effects of rape on Rwandan women survivors have been exacerbated by the lack of health care, many social and economic problems, and the problem of raising children born of rape. The findings of this study show that advocacy is needed to make the voices of women heard, their needs known and their questions answered. According to Ramsay et al. (2009), advocacy intervention can help women victims of sexual violence in different ways, such as providing information or any other means which may allow women to have access to needed resources. It appears from the findings that spreading information was not outlined as one of the key components of advocacy, although this should be at the frontline of advocacy activities. The non-use of designed programmes and other resources from NGOs to support socially vulnerable people, such as rape survivors, might be attributed to the lack of information about their existence (UNFPA, 2010). Ramsay et al. (2009) added that advocates must be aware of women's requirements and the resources which are available from their social context. This is fundamental for the success of the advocacy interventions.

The participants suggested that advocacy should be multifaceted and include social and financial support, and better health care services. Participants believed that if people were advocating for the case of rape survivors, many of their problems would be solved. They placed emphasis on financial support for income generating activities which may help them to overcome their material deprivation. They also emphasised access to better health care services, sufficient cover of the medical insurance and specialized care which fitted the needs of their health, either physical or psychological.

The results of the present study suggest that advocacy will be more effective if it addresses both the needs of women survivors and those of their children born of rape. Participants

highlighted the role of community leaders in changing the existing policies and officially recognising the rights of children born of rape, specifically in term of education and health care. Some participants went further, suggesting that the regulations of FARG be amended to include an article stipulating that children who were born as a direct consequence of what happened during the genocide may benefit from the same advantages as those who survived it. Participants are aware that for such changes to be achieved, it will require the commitment of people who clearly understand their situation and who have the ability to convince the decisions makers of the need to change. Evidence suggests that effective advocacy results in system change, and leads to new policies and programs that are aimed to improve the well-being of individual beneficiaries (Koss, 2006).

#### **5.6.4 Economic empowerment**

Rape survivors are successfully empowered if their specific needs have been clearly identified and adequately addressed. Victims of sexual violence lose control of the situation, thus depriving them of their sense of power (Ullman and Townsend, 2008). Such disempowerment is translated into threatened self-esteem, feelings of despair and other difficulties related to troubled thoughts, emotions and behaviours. Once those women are re-empowered they become transformed (Harrell, 2011). Psychological suffering was evident in women rape survivors who participated in this study. However this was not only due to the rape itself, but also to the dependence which resulted from the loss of their belongings which accompanied the rape and resulted in material deprivation. According to Duffy (2011), empowerment is viewed as a process in which individuals are given opportunities in terms of necessary resources and skills to meet their needs and solve their problems so that they feel that they are fully in control of their own lives. Participants suggested different ways of successfully empowering survivors, such as educating them in skills which will help them to cope efficiently with the psychological problems they are facing and providing them with knowledge and financial assistance to initiate income generating projects. For empowerment to be effective, it requires the active involvement of concerned individuals who have defined the important issues, are aware of the challenges rape survivors are facing and recognise the abilities they possess to bring about significant changes (Luttrell, Quiroz, Scrutton and Bird, 2009).

Participants mentioned that rape survivors were psychologically affected by having to depend on donations to survive and felt that they would to be able to provide for their needs if they

are supported with significant funding. They suggested that they could be empowered with skills according to their personal abilities to engage in productive activities. Those who are physically handicapped could be provided with funds to start a small business as this would not involve too much physical strength. Others preferred to be supported in farming activities, such as growing tomatoes or cassava plants due to their high demand at the local market. Receiving a loan from a bank was also suggested as another source of gaining funds for empowerment. Participants suggested that in order to get the maximum benefit from their loan, women would have to be careful with the kind of project they might invest in. Some of the community members who were more skilled in the elaboration of projects to generate income offered their services to any woman who would be in need of them.

It was also suggested that rape survivors could get vocational training or informal training from local NGOs or women associations so that they could be appropriately upskilled in activities which could generate income (SURF, 2012; AVEGA, 2010). Bakelaar (2010) and Turró and Krause (2009) indicate that it is necessary to consider the specific context when empowering women. She pointed out that multiple initiatives that combine different resources are most successful as they address the multidimensional nature of human life.

Using the skills they have learnt, women rape survivors are able to set specific goals and put actions in place to achieve them. Empowered people are able to overcome adversity through the self-sufficiency they have acquired.

### **5.6.5 Women's support groups**

The literature has promoted self-help groups or support groups as spaces where individuals with common problems meet together to share their problems and come up with solutions (Munn-Giddings and McVicar, 2006; Mok, 2004). In the present study, the participants described support groups as a safe environment where women rape survivors have been able to share the testimonies of their survival, and attend to various activities which help them to address their health needs as well as their economic needs. In addition, they are places where they can offer support to each other.

The findings of the study indicate that some rape survivors were the sole survivors of their families and don't have any one to talk to and while others have family members, they are hesitant to share their shameful experience, despite their need to speak about it. However, they were comfortable to talk about what happened to them when they were with their peers

in the support group. The advantage of being in a support group is that it offer its members the opportunity to freely express their thoughts, emotions and feelings (Walijarvi, Weiss and Weinman, 2012). The women believed that their experiences were unique until they heard about the ordeals of others and realised that they were not the only ones who had been exposed to such hardship. As stated by Goldenberg (2009), women believed that their stories might be heard and understood by those who had followed similar pathways. Women reported that sharing their stories in their support group was facilitated by the openness and active listening of the other women. This climate of common understanding strengthened the relationship of trust which prevails amongst women. Women were encouraged by the knowledge that their experiences and their feelings have been taken into consideration by their peers. The validation of one's suffering is an indicator of an effective support group (Schutt and Rogers, 2009).

While the objectives of most of the support groups are to protect members from social isolation and provide emotional support and health information (Munn-Giddings and McVicar, 2006), there were some self-help groups that were helping the women to generate income. As became evident by the results, rape survivors have been impoverished by the destructiveness of the genocide. They therefore found that it was relevant to initiate activities in their support groups that will contribute to their economic development. The women divided themselves in different groups according to their interests, with some involving themselves in farming activities and others in trade, business or handcrafts. This initiative has multiple benefits, such as being active and self-reliant. It is also believed that those activities will keep the minds of women busy, and they will therefore worry less about their everyday difficulties.

Moreover, the coordinator of SEVOTA organizes workshops for the groups of women, inviting health professionals to teach them certain health information. The participants explained how much they enjoyed learning techniques of relaxation, which they could practise at home or during the group itself. It also became evident that dance sessions carried out to the rhythm of traditional Rwandan music or religious songs were among the most cherished activities of the support group. Participants viewed dance as powerful medium of therapy as it allows them a positive body experience and other uplifting emotions (Koch and Recke, 2009).

One of the main values of support groups was the spirit of mutual support which reigns among members. Women feel that they have become as one knot and the sense of friendship goes beyond the group. They visit each other at their homes and help anyone who expresses the need. This social network that they have created plays a big part in overcoming social isolation (Anderson-Butcher et al., 2004; Mok, 2004). Furthermore, women indicated that they were eager to participate in such fruitful exchanges where they get useful advice and learn new coping skills inspired from the experiences of their peers. It is believed that women will cope better with their conditions if they become empowered with new skills (Adame and Leitner, 2008).

### **5.6.6 Education of the community**

Participants divided education of the community into two elements. One involves raising community awareness and concerns the population in general, while the other concerns upskilling selected members of the community in basic counselling skills.

Cox, Lang, Townsend and Campbell (2010) indicate that community awareness focusing on the understanding of rape related issues is a key element in facilitating the community to change their behaviours towards women victims of rape. The results from this study show that women rape survivors are regularly harassed by their neighbours, who accuse them of being responsible for the sexual violence that they were subjected to during the genocide. These women believed that their neighbours may behave differently if they knew that their attitudes are hurtful and that the bad attitudes shown to their children born of rape were triggering their psychological trauma. Participants thought that educating the population on the lasting effects of rape and on the positive outcomes of appropriate interactions may result in better relationships.

Cox et al. (2010) recommended using existing channels of communication during activities of community awareness. While the participants of the present study highly value and advocate the use of mass media, such as the radio, as a means of spreading information, (Cox et al., 2010) indicate that its impact may be smaller compared to the diffusion of information through face to face contact within the existing social network. Those authors argue that communication of information by leaders who are knowledgeable, well regarded and appreciated by the community members is a key factor to increase the chance of the message being heard and applied. Therefore, for more effective community awareness, it is suggested



that the information about the suffering of rape survivors and the expected change of behaviours from the community is not only passed through radio, but also reinforced by public education delivered by the village leaders. The participants proposed that *Umuganda*, which is monthly community gathering for public work involving every habitant of the village, was a relevant space to circulate such information. Participants also proposed that an existing programme on education against gender based violence which exists at village and sector level may include a topic on rape, explaining that it was a heinous crime that deserves punishment by law, as was the case at the ICTR and Gacaca courts. In the education session the effects of rape should be explained and how they are impairing the lives of women victims. Elliott, Bjelajac, Fallot, Markoff and Reed (2005) suggested that any individual involved in the education of rape has to emphasise the importance of recognising the suffering of these women as such validation and recognition of their pain enhances their sense of safety and hope. Bearing this statement in mind, the lack of sense of safety and hope expressed by rape survivors might be largely attributed to some of their community members who have not recognised their suffering, but have rather made them victims of stigmatization, thus leading the women into a state of social isolation that was aggravating their psychological trauma. Some participants pointed out that when raising awareness, the message should not be limited to the grassroots level, but should reach all levels of society. Others suggested specifically targeting those people who deal with the rape survivors on daily basis and educating them how to handle the problems efficiently.

Educating the community in basic counselling skills was suggested as another important component of education to the community. The results showed that due to the shortage of mental health professionals, there is a need to train reliable people from the village on how to approach and talk to women rape survivors who are in need of psychological support. Participants believed that such training would help community members in knowing when they are able to help women on their own and when they need to refer them to a qualified health professional. Participants urge the Ministry of Health to organize the necessary training in counselling on a large scale. Meanwhile, some associations of genocide survivors and national and international NGOs who are collaborating closely with genocides survivors have organized training for volunteers from the villages in the Helpful Active Listening technique (HAL) (Nsabiyeze, 2011). In the HAL sessions, learners are equipped with skills in active listening. Such skills are indispensable when communicating with traumatized individuals. An active listener facilitates the expressions of emotions, feelings, needs,

problems and expectations of the traumatized individuals, who, at the same time, are encouraged to use their own potential in addressing their concerns (Bacharach, 2011). The organizers of HAL sessions indicated that even although those who had done the short course of HAL did not possess a high level of competency in counselling skills, they believed that the lay trauma counsellors could help in decreasing the psychological crisis of those who are in need (Gishoma, 2011). Community members who had benefited from such training reported how they were particularly helpful during the period of commemoration as they were able to prevent psychological trauma among women rape survivors by explaining to them how to behave in hard times. They also took care of those who experienced psychological trauma when attending genocide memorial ceremonies.

The results show that the psychological problems of some women worsened when they had to seek the services of employees of the public sector, specifically those who were in charge of social affairs as they believed that these social agents were not paying attention to their cases. Social agents on their side explained that they were aware of the psychological vulnerability of rape survivors, but were lacking the skills in dealing appropriately with those women. Participants believed that training in counselling is a must in order to be able to interact efficiently with rape survivors and it was therefore proposed that those who are responsible for dealing with rape survivors at all levels, district, sector and village, should receive training in counselling skills and on how to talk to rape survivors in an appropriate manner. This is supported by the literature which indicated that workers who are dealing with women victims of rape may benefit from training, where they will acquire knowledge on the persistent impact of rape trauma, how to take into consideration the unique needs of rape survivors and the challenges they encounter while seeking services (Elliott et al., 2005). In addition, it would be beneficial if they displayed respectful and welcoming attitudes while receiving rape survivors making them feel that they are in safe environment. By doing so, the workers promote the process of recovery and reduce the risk of retraumatization that is inherent in the procedures that may recall the traumatic experience, thus making the women feel emotionally unsafe. Such attentive practice is fundamental while caring for rape survivors (Ullman and Townsend, 2008).

### **5.6.7 Self-help coping strategies**

Women victims of rape use both internal and external strategies to cope with the outcomes of their sexual assaults. Women who believe that they have the inner capacity to cope with a

traumatic event are at a lower risk of suffering from lasting psychological effects of rape (Sarkar and Sarkar, 2005). The findings from this study revealed that Rwandan women victims of rape were using journal-writing, relying on prayers or various activities of relaxation as mechanisms to cope with their psychological trauma.

Journal-writing was identified as an effective strategy which helps women victims of sexual violence to overcome trauma by writing their traumatic memories and painful feelings related to their shameful experience of sexual violation (Harrell, 2011). A journal is considered a supportive, non-judgmental companion that is always there when rape survivors need it to work out the problems that flood into their minds. It also has the advantage of fitting the lifestyle of any user (Grason, 2005). The study revealed that the women rape survivors were using a note book to write down their disturbing emotions, memories and shameful experience that they felt embarrassed to share with anyone. These findings also showed that some rape survivors considered their journal as their counsellor as it helped them to manage their psychological trauma.

Pennebaker (2004) points out that writing a journal or diary facilitated the process of recovery of rape survivors as it lessened the negative impact related to the distress caused by the traumatic experience. Grason (2005) suggests, however, that victims of traumatic events should also focus on positive events while writing which will encourage them to think about a positive future. The findings showed that the women rape survivors in this study were not only using their journal in talking about their ordeals, but were also writing about their achievements, joy and happiness. Harrell (2011) argues that writing enables the transformation of past painful feelings into positive feeling of hope.

Although journal writing was found to be a powerful instrument in helping rape survivors to overcome the negative outcomes of their experience (Davidson and Robison, 2008), the poor education of rape survivors revealed by the findings of this study, however, may prevent them from pursuing this course. Furthermore, used on its own, its impact was limited in helping women victims of severe sexual violence (Batten, Follette, Rasmussen Hall and Palm, 2002). Findings indicate that rape survivors were using other means, such as relaxation and prayers, in addition to writing to cope with their traumatic experience.

Prayers were found to be a powerful means of support as people believe they can get strength, hope, courage, comfort and safety from a divine power (Bryant-Davis et al., 2011b)

From the results of this study it appears that those women who attributed their survival to God's power, continue to rely on Him during tough times. They pray relentlessly, believing that God has the solution to their problems. Some reported that they found consolation in prayer when they have no solution to their problems of poverty. Others said they found comfort when they felt overwhelmed by negative feelings. Similar findings have also been identified by others researchers (Bryant-Davis et al., 2011b; Harris et al., 2008).

The women who were violated at the hands of their neighbours said that they have lost trust in all human beings and preferred to open up to God as they believed God would understand them and heal their wounds. Trusting in God's healing power fosters the resilience of those who survived atrocities (Hourani et al., 2012). Various studies have demonstrated that religious beliefs have a positive influence on the mental health wellbeing of traumatized individuals (Bryant-Davis et al., 2011b; Chang et al., 2001). Some rape survivors from this study testified that their lives had changed since they knew God. Before becoming Christians they had been drinking excessively as a means of coping with the daily living conditions, hoping that alcohol would help them forget their problems. By reading the bible they were comforted and strengthened by its message of hope and courage, which helps them to deal more efficiently with their hardships.

Relaxation was also used by women survivors as a coping strategy to help them address their unsolved trauma. Relaxation was identified as an important tool in maintaining a healthy body and mind as it protects individuals against the side effects of a stressful life (Robinson et al., 2012). Results indicated that women rape survivors were using various methods of relaxation to combat the stress which was undermining their wellbeing. Relaxation was used to prevent stress and to reduce or treat its damaging effects. The various techniques of relaxation that were reported most in this study included listening to soft music, singing, physical exercises and breathing techniques. Sanderson (2010) states that physical exercise, walking and listening to music assist individuals to relax. Robinson et al. (2012) point out that relaxation has better results when it fits one's specific needs, preference and manner of reacting to stress.

Women rape survivors reported that listening to soft music helped them to overcome their stressful feelings. They explained that listening to soft music from the radio or singing were not only cost effective, but also reduced feelings of tension and kept their bad thoughts at bay. A number of women used natural ways to take care of themselves, such as walking and

physical exercise. They are convinced that sport does not only help for relaxation, but is also a must to be physically and psychologically healthy. Some of the women used deep breathing techniques they had learnt from mental health professionals. Many of the women indicated that they preferred this technique because it was easy to learn and may be practiced anywhere, whenever they were stressed by their distributing thoughts and feelings. Katherine (2012) suggests that to get the most benefit from such kind of relaxation, one must practice it regularly until it becomes part of one's habits.

## **5.7 CONSEQUENCES**

Consequences are the results of the combined efforts and suggested strategies from various stakeholders and women rape survivors themselves which are expected to lead to their Genocide Rape Trauma Recovery. As some actions were lacking or poorly performed, some of the consequences have taken the form of responsive actions (Strauss and Corbin, 1990).

### **5.7.1 Genocide Rape Trauma Recovery**

According to Duma, Mekwa and Denny (2007), rape trauma recovery is a personal experience and its meaning differs from one rape victim to another. Burgess and Holmstrom (1978) defined rape trauma recovery as the capacity of women who have been sexually victimized to cope with the effects of her sexual assault in such a way as to be socially integrated within a period of six months and have no more symptoms after a period of one year. For Astbury (2001), cited in (Duma et al., 2007), rape trauma recovery involves regaining the purpose, meaning and enjoyment of lives within a period of time, while according to (Duma et al., 2007), rape victims have recovered from their trauma when they have returned to their former self. This study, which concerns rape that occurred in the genocide, differs from events of rape in times of peace as the incidents took place in conjunction with other traumatic events which have to be considered in the recovery of rape survivors. Therefore, in this study, Genocide Rape Trauma recovery involves (a) psychological relief; (b) recovery from physical illness; (c) regaining a positive self-image; and (d) social integration.

**Psychological relief:** According to the participants, psychological relief involves alleviation of psychological pain expressed by rape survivors, such as painful memories, negative thoughts and feelings, sexual discomfort and self-isolation. Markel (2011) defines

psychological relief in the context of disaster and mass violence as a concept which implies a decrease of stress which challenges the individual's coping strategies.

Community members, women from support groups, health professionals and the rape survivors themselves contributed in different ways to achieving psychological relief.

The results show that the emphasis in providing care for rape survivors has been in dealing with their psychological trauma crisis. However, some participants believed that it is better to prevent rather than cure. Thus, they suggested that the Ministry of Health should train lay counsellors from the grass roots level who would then know how to help those women and prevent them from falling into psychological crisis. This should strengthen the efforts of women associations and NGOS that were conducting such training (Nsabiyeze, 2011; AVEGA, 2010). The trained lay counsellors would help also to address the needs of genocide survivors who are traumatized by testimonies, exhumation or other activities specific to genocide remembrance (Godard et al., 2012).

The community members are encouraging rape survivors to think positively about their future rather than focusing on their traumatic past. Positive thinking has the advantage of contributing to both psychological and physical well-being by decreasing the level of distress. In addition, by its optimistic tone, positive thinking restores hope in depressed individuals (MFMER, 2011). Women testified that comforting conversations with trusted neighbours who are sympathetic and understand their pain helps them to overcome their sorrow. However, some issues related to sexual discomfort were perceived shameful and are only shared in the support groups. The non-judgmental aspect of self-help groups encourages their members to talk about any experience which disturbs them in the knowledge that it will be understood and valued by peers (Goldenberg, 2009). Participants described this open sharing as a key element in obtaining psychological relief. Those women who were uncomfortable to disclose to others their traumatic experience have found relief in journal-writing. Davidson and Robison (2008) attribute the benefit of journaling to the release of painful emotions when the content of the extreme experience is put into words through writing.

In some circumstances, women are aware of their psychological problems and are able to take care of themselves. This self-knowledge has been reinforced by the education received from mental health professionals. Rape survivors have learnt what events might trigger their psychological disturbances, how to identify their symptoms early and how to address the

situation in a responsive manner. Psycho education was, in fact, very empowering because with the learnt skills, individuals became self-reliant and thus contribute actively to the process of their personal recovery (Phillips and Schade, 2012).

The power of prayer cannot be overestimated in providing psychological relief. The results show that prayers do not only restore hope among rape survivors, but they also serve as a channel of connection with the members of their community. Overwhelmed by their feelings and traumatic memories, women turned to God for rescue. They believe that God has the power to relieve them from their suffering and instil hope in their lives. Prayers are protecting factors against psychological distress as they give meaning and propose to life for those who are in despair (Bryant-Davis et al., 2011b). Some rape survivors were socially isolated and their neighbours organized prayers at their home, helping them to get away from their lonely lives. According to (Bryant-Davis et al., 2011b), praying in a group is a source of social support which is highly needed for the survivors of rape, who have been disconnected by the stigma related to their experience. The results show that women did not only increase their social network through prayers, but were also emotionally released, thus benefitting their health.

The findings of the current study show that rape survivors do seek the help of professionals in acute periods. Women, who viewed their life as being meaningless, some even attempting suicide, have been helped by medical treatment and counselling. While the medication restores the equilibrium of neurotransmitters disturbed by the traumatic event (Sharpless and Barber, 2011), the supportive counselling has the merit of allowing traumatised individuals to give sense to their traumatic experience in order to accept it (Sanderson, 2010). Results indicate that women regained their psychological stability after they had received the mentioned care. However, the lack of follow up noted by the participants could be a barrier to sustainable recovery. Ashoka and The International Center for Attitudinal Healing (2008) indicate that the lack of commitment of stakeholders in providing psychosocial services to the traumatized individuals has led to the delivery of acute mental health care to the detriment of continuous follow up.

**Recovery from physical illness:** Findings indicate that women rape survivors are expecting appropriate actions to recover from their physical illness. Rape that has been carried out with extreme violence, such as in wartimes, leaves the victims with severe injuries which may last for a long time if not adequately treated (Hagen and Yohani, 2010; Clifford, 2008).

Therefore, to recover from their rape trauma, women survivors require specific treatment which responds to the physical sequels presented.

The findings indicate that some women are dissatisfied with the physical care they are receiving in term of quality and accessibility. Rape survivors were expecting the health professionals to thoroughly assess their physical health and treat their unique problems accordingly. Campbell (2007) maintains that a successful treatment plan requires an accurate and comprehensive clinical assessment. The women reported that the clinical skills of those attending to them lacked competence and the quality of care they received was far from what they wished. Rape survivors believed they would have been cured from their disease if they had been treated by specialized professionals. Unfortunately the majority of them had been treated at health centres, mostly by A2 nurses (enrolled nurses) who have limited knowledge about complicated health problems (Ministry of Health, 2011a). Women felt they should have direct access to specialised health facilities because the required referral from health centres was delaying the treatment and thus reducing their chance of being cured.

Participants doubted that the Ministry of Health is aware of the challenges rape survivors are facing in term of their health. They suggested that research may be used as a way of advocating for the cause of these women. The usefulness of research as a means of advocacy is well established as is its contribution in changing policy in favour of underserved populations (Campbell, Robinson, Meghani, Vallerand, Schatman and Sonty, 2012). Thus, participants suggested that if studies were conducted on the impact of rape on women's health conditions, particularly how chronic pain and disease are affecting their reproductive health, the results may inform the relevant authorities on the magnitude of the problem. This may then encourage policymakers to put in place the appropriate measures or policy in treating health problems of women rape survivors.

**Regaining positive self-image and self-reliance:** Various researchers indicate that psychotherapeutic interventions were most fruitful in helping rape survivors to regain their positive self-view (Resick et al., 2012; Vickerman and Margolin, 2009). The results of the current study show that psychotherapeutic interventions were useful in helping women to deal with their psychological crises. However, they put more emphasis on justice, which restored their dignity and at the same time increased their self-esteem. The healing power of justice has been mentioned by previous researchers (Brouwer and Chu, 2012b; Pham, Vinck and Weinstein, 2010; Mills, 2006). Rape survivors reported their satisfaction in the justice



meted out, mostly by the Gacaca courts. Results indicate that even although rape survivors were distressed by the confrontation with their rapists at Gacaca courts, they were satisfied with the outcomes. They felt valued by the judges, who acknowledged the crime against their persons and punished the perpetrators. It appears that these judgments have restored the women's feelings of control. Mills (2006) indicates that direct interaction between the victim and the perpetrator contributes to the reduction of fear and restores the sense of lost power. Brouwer and Chu (2012b) reported that the women who testified in the Gacaca courts affirmed that they felt more valued and empowered. However, Mills (2006) added that justice alone is not enough in healing rape trauma and that additional actions are needed. This statement was shared by the participants from this study who viewed the restoration of self-esteem being threatened by economic dependency. Therefore, they suggested the economic empowerment of these women. Dependent women were viewed by themselves and their neighbours as unworthy because they were relying on others for their survival. Participants believed that with tangible financial support, rape survivors could put in place income generating activities which would put an end to their material deprivation and thus have a positive effect on their self-view. Results have shown that the women who participated in groups and associations had the advantage of getting funds from sponsors. It appears that these women were not only contributing to their self-development, but also to the wealth of their families and communities. Participants asserted that the more rape survivors were self-reliant, the more positively they perceived themselves. Self-reliance procures a sense of self-efficacy, which, in turn, has a positive effect on one's self-esteem (Turró and Krause, 2009).

**Social integration:** Participants reported that rape survivors would recover from their rape trauma if they felt safe and their children were integrated into the community. Sanderson (2010) and Herman (1997) argue that safety is a precondition in the process of healing from rape trauma. Women rape survivors asserted that they no longer feel frightened since their rapists have been imprisoned for life by the Gacaca courts. Supporters of such transitional justice in the context of armed conflicts, mass violence and genocide maintain that it can affect the impact of trauma, prevent future violence and promote social reconstruction (Pham et al., 2010). According to the results, the outcome of justice was controversial. While for some it contributed to their sense of safety, for others, it led to insecurity and social stigmatization. Participants suggested that if authorities take appropriate measures to ensure the security of these women and educate the population to change their hostile attitudes, women will feel safe and integrated in the community. However, for this to be achieved, it is

essential that the children born of rape are also accepted by the communities, as the happiness and problems of rape survivors are interconnected with their children born of rape (Godard et al., 2012; Clifford, 2008). Participants suggested that a law should be put in place specifically for those children, which promotes their basic rights in terms of medical care and health insurance. The promotion of such a law will be a sign that those children are no longer victims of discrimination and are fully accepted by their society. Acceptance of both rape survivors and their children will foster their social integration.

It has been found that social integration has a positive effect on individual's mental health as it provides a sense of belonging and facilitates interactions between community members, which increases their self-worth and self-esteem (Gore, 2007; Kunovich and Hodson, 1999).

## **5.8 CONCLUSION**

This chapter discussed the findings on how the conditions of violent rape and extreme loss, followed by the hard living conditions of rape survivors, contributed highly to the development of Genocide Rape Trauma. Its main concepts highlight that rape in a genocide context has severe long term effects, which deeply disturb the physical, psychological and social spheres of women's lives. The difficulties in fitting these phenomena into the existing nomenclature of Post-Traumatic Stress Disorder have been raised. An international court was put in place and for the first time rape was defined and recognized as a crime against humanity. Although this did a great deal to restore the self-esteem of the women, it has not addressed all of their problems. To help women recover from their rape trauma requires the combined efforts of rape survivors, their community and the government. Both psychological and medical care is crucial for women's recovery from rape trauma, along with advocacy for policy changes, education of the community and the empowerment of rape survivors. The discussed concepts will be used in designing a middle range theory for the management of Genocide Rape Trauma in the following section.

## **CHAPTER SIX: THEORY DEVELOPMENT, RECOMMENDATIONS, LIMITATION OF THE STUDY, CONCLUSION AND PERSONAL REFLECTIONS**

### **6.1 INTRODUCTION**

This chapter is on the development of a middle range theory of the management of the long term psychological effects of rape among women genocide survivors. It begins by defining theory in general, and thereafter explains the purpose of the present theory that has been developed in this study, along with the stated assumptions. The identified theory's concepts are defined, the structure of the theory is described and the relationships between the concepts are explained. Evaluation of the quality of the theory, as well as the contribution of the study is presented. The recommendations that have emerged from the findings and the developed theory are outlined as well as the limitations of the study and the conclusion which provides the overall picture of this study. Lastly, my personal reflections are presented.

### **6.2 DEFINITION OF THEORY**

According to George (1985), the word theory has different meanings in the area of nursing, which may lead to confusion. She indicates that the word theory comes from "*theoria*", which is a Greek word meaning "vision" and has the aim of leading to the truth. She points out that various interpretations of the word, theory are the result of various works in searching for and exploring truth and clarity for studied phenomenon. Therefore, she suggested to theory builders to make a succinct definition of what they mean by theory and to be consistent with the presented meaning in their work. Duldt and Giffin (1985: 5) have defined theory as "*a system of interrelated propositions which should enable a phenomenon to be described, explained, predicted and controlled*". Close to this definition, Chinn and Jacobs (1987: 70) state that theory is a set of concepts, definitions and propositions that project a systematic view of phenomenon by designing specific interrelationships among the concepts for the purpose of describing, explaining, predicting and/or controlling phenomena.

Strauss and Corbin (1998) emphasized the systematic interrelationship of concepts to explain a phenomenon and, according to their view, theory is a set of well-developed categories, themes and concepts that are interrelated in systematic way through statements of relationship to form a theoretical framework that explains the phenomenon. This is the paradigm of developing theory that was used in this study.

Later, (Chinn and Kramer, 2008), inspired by different aspects presented by other researchers in defining theory, stated that theory implies a creative and rigorous aspect of structuring ideas that project a tentative, purposeful and systematic view of the phenomenon. These authors went further, proposing that the components of theory identify its purpose, concepts, definitions, relationships and structure, as well as its assumptions. The theory of this study is presented in line with Chinn and Kramer's components (Chinn and Kramer, 2008). It builds on the concepts presented in chapter four and discussed in chapter five.

Glaser and Strauss (1999) have suggested that researchers who are developing theory should be precise about what kind of theory they are building, and be specific about its purpose. This study intends to generate a middle range theory for the management of the long term psychological effects of rape among women survivors of the 1994 genocide in Rwanda. This is in line with McKenna (1997), who indicates that middle range theory is produced for specific situations, is mainly descriptive and may be used to guide practice.

### **6.3 PURPOSE OF THE THEORY**

George (1985) argues that the purpose of a theory remains its fundamental characteristic, because it explains the reason for which it was formulated. According to Chinn and Kramer (2008), that purpose has to be found and identified. I have previously conducted research on the lived experiences of women survivors a decade after they had been raped during the 1994 genocide against the Tutsi that occurred in Rwanda. The findings of that study indicated that a great number of rape survivors continued to suffer psychologically from the negative impact of their rape trauma (Mukamana and Brysiewicz, 2008).

As a mental health nurse working in the same field, I have observed that no comprehensive structure has been put in place to take care of rape survivors. Furthermore, when I searched the literature, I was confronted with a lack of information on how women in such situations can be helped efficiently.

Thus, I took the initiative of developing a middle range theory that might contribute to the management of those chronic reactions of rape. In addition, I wanted to explore the factors which are contributing and inhibiting the presence of the long term psychological effects of rape. I also wanted to identify what structures there are that are already helping these women and what else needs to be put in place. Thus, the developed theory should be adapted to the women's context and fit their crucial needs.

## **6.4 ASSUMPTIONS**

Assumptions are statements that are considered as being true. While they don't need to be empirically tested to be accepted as truth, they have to be coherent with the goal and the relationship within the correspondent theory. McKenna (1997) and Chinn and Kramer (2008) argue that assumptions are important elements of a theory because they underlie its essentials ideas.

The assumptions of this theory are as follows:

- The long term psychological effects of rape are strongly influenced by the women's living context and the management of these effects have to take such context into consideration;
- Effective management of the long term psychological effects of rape depends on the combined actions of the rape survivors themselves and their community, as well as actions from private and public sectors, and from national and international organizations;
- An holistic approach addressing women's physical, psychological and social needs is crucial for women to recover from their Genocide Rape Trauma;
- Trained community members and support groups offer basic care in helping women survivors to manage the long term effects of rape, while specialized health care professionals are on hand for those who need more specialized care;
- Advocacy is a means which can be used to initiate laws, programs and policies to promote better care for rape survivors;
- Rape is a crime and the punishment of the perpetrators is an act of justice considering the political and social ethics of society. Furthermore, punishment brings therapeutic benefits because it implies the validation of the harm caused and allows restoration of the dignity that has been lost.

## **6.5 IDENTIFICATION AND DEFINITION OF CONCEPTS**

A concept is defined by Chinn and Kramer as “*a complex mental reformulation of experience*” and the experience refers to the totality of what is perceived (Chinn and Kramer,

2008: 158). In other words, a concept is a tool used to represent the reality (McKenna, 1997). According to George (1985), concepts are building blocks of theory and are identified through searching and sorting out those ideas or thoughts which convey the meaning of the theory.

As concepts are represented by experiences, such experience should have objective ways of being measured, observed and verified. Chinn and Kramer (2008) point out that similar concepts may have different meanings and may result in different interpretations, depending on the way the conceptualized phenomenon has been perceived, or depending on where the analyst needs to put the emphasis (Corbin and Strauss, 2008). Therefore, those authors encourage analysts to clearly define the concepts used in their theory, as they are crucial in determining the focus and the meaning of the theory in order to facilitate its understanding. George (1985) insists on the operationalisation of the concepts, because they are important elements in determining the particularity and the specificity of the theory.

Thus, in order to convey the particular meaning of the theory on the management of Genocide Rape Trauma, the concepts that explain the management used in this theory will be defined in accordance with the words and the unique experience presented by the participants of this study. The core concept, namely, facilitating the management of Genocide Rape Trauma, is defined below, followed by its seven sub-concepts, which are: psychological care; medical care; advocacy; economic empowerment; women's support groups; education of the community; and self-help strategies.

### **6.5.1 The core concept: Facilitating the management of Genocide Rape Trauma**

The core category is the main theme of the study and it has powerful relationships with other categories of the paradigm (Corbin and Strauss, 2008).

In addition, the whole meaning of the study is embedded in the core category. The grammatical formulation of the core category doesn't matter: it can be a noun, combined adjective and participle, but the most important aspect is that the chosen concept encompasses the central ideas of the study (Strauss and Corbin, 1990). Facilitating the management of Genocide Rape Trauma was chosen as the core category because it was abstract enough to represent the central idea of the study, which is about the management of the long term psychological effects of rape, or Genocide Rape Trauma, in order to promote the recovery process of women rape survivors.

Facilitating the management of Genocide Rape Trauma requires a number of actions that are aimed to help survivors to work towards a sustainable recovery. This Genocide Rape Trauma is expressed in term of unbearable memories, overwhelming feelings, a sense of helplessness, somatic distress, negative self-image, and altered intimate relationships and social isolation. These psychological troubles are exacerbated by poor physical health due to lack of effective care and appropriate support, material deprivation, secondary victimization and the burden of children born of rape. Psychological care, medical care, advocacy, economic empowerment, women's support groups, education of the community, and self-help strategies were the main actions that were identified that could address both Genocide Rape Trauma and its perpetuating factors. The above mentioned interventions could be made possible by the combined efforts of the women themselves, community solidarity and formal support from government institutions, women's associations and NGOs. It is believed that such actions will bring rape survivors some relief from their psychological pain and help them to recover from their physical illnesses and restore their positive self-image so that they can become fully integrated into their communities and feel valuable once more.

### **6.5.2 The sub-concepts**

#### **Sub-concept one: Psychological care**

In this study, psychological care refers to the interventions of health care professionals to give psychological support to rape survivors to help them cope with their Genocide Rape Trauma. Communication is a key component in this psychological care. Through the skills of active listening, health care professionals give traumatized women the opportunity to ventilate their emotional distress by encouraging them to talk about their disturbed thoughts and behaviours. In addition, women are able to express their negative self-perceptions and the challenges they experience related to their sexuality and social isolation.

Other important components of psychological care involve explaining to the women why they experience such impairing psychological reactions and teaching them how to recognize the signs of oncoming reactions as well as strategies for coping with them. Once these women can apply such strategies into their lives, they have a chance to manage effectively their past trauma.

### **Sub-concept two: Medical care**

In the context of this study, medical care implies any administration of remedies provided by health care professional to address the health problems of rape survivors, either physical or psychological. This medical care includes the use of psychotropic medication for the psychological problems. Medication is also used to treat chronic physical conditions related to the traumatic injuries of rape and to transmissible sexual disease. Surgery is used for the reconstruction of genital organs which have been damaged by violent and repetitive rape.

### **Sub-concept three: Advocacy**

Advocacy means speaking and acting on behalf of women who were raped during the genocide and for their children born of rape, to promote and defend their fundamental rights. This advocacy has to be carried out in accordance with the interests, needs and priorities expressed by beneficiaries and emphasis should be placed on the creation of an appropriate structure to deal with the unique problems facing rape survivors and their children born of rape. It should be based on research and analysis of the women's needs. The particular needs of these women relate to their health conditions, economic status and safety. Advocacy should be oriented towards actions for specialized biopsychosocial care, funding to improve economic conditions and regulations to ensure their safety. Advocacy should also be oriented to address the issue of children born of rape who are not eligible for health care services and education. Overall, the advocacy should influence and change the legislation, policies and practices, and specific law for the protection of rights of both mothers and children should be established.

### **Sub concept four: Economic empowerment**

Economic empowerment refers to the empowerment of women rape survivors in promoting business opportunities by the provision of financial support, with the focus on eliminating dependency and assisting the women to become fully self-supporting. The first women to be addressed should be those who are capable of working, but who are currently relying on charity and welfare. With funding, these women would be able to develop themselves by creating small businesses or investing in agricultural activities which would give them a sufficient income to support themselves and their families. They could also be economically empowered by giving them farm animals, such as cows, which could increase their income though selling milk or fertilizer to their neighbours. There is need to also consider how to



economically empower those with physical disabilities who are not able to perform manual labor. Another strategy of economic empowerment would be to educate the women on how to earn money and budget expenditure, and then, once equipped with these skills, encouraging them to apply for a loan.

With economic empowerment, rape survivors can develop the competences which will not only allow them to overcome their material deprivation, but will also help in their self-development and indirectly in the development of their family and community.

#### **Sub-concept five: women support groups**

In this study, a women's support group refers to a safe and responsive space where a number of rape survivors can gather together in order to help each other in responding to the problems they encounter in their everyday lives. Women's support groups are playing several roles in the lives of rape survivors. Women feel accepted in these groups and view their groups as their new family and, due to the social network they have created there, they no longer feel alone. They support each other and respond to each other's concerns, whether within the group or outside it in their homes. As the women have come to trust each other, they are comfortable in sharing their traumatic experience of being raped. Those who have been badly affected by such experiences can benefit from advice from peers who have managed to cope better in overcoming their trauma. They also benefit from mental health professionals who come to the group sessions from time to time to help the women address the consequences of rape. Furthermore, the women's support groups contribute to their self-development through the income generating activities carried out in that group. It is also a place where women take time to get away from their worries and have fun when they are praying, dancing and laughing together.

#### **Sub concept six: Education of the community**

Educating the community refers to the sessions where members of rape survivors' community are sensitized about the impact of their attitudes on the wellbeing of rape survivors. The sensitization or community awareness encompasses explaining to the population the consequences of rape, that the rape perpetrated against women during the genocide was a crime and that they had no responsibility in its occurrence and thus the punishment of rapists was justice rendered to rape survivors. They should, therefore, not be blamed and stigmatized, but rather comforted to help them to recover from the wounds of

such a traumatizing experience. To reach the biggest possible number of people, it is suggested that this information be spread via mass media or delivered during public gatherings.

Educating the community also involves establishing programs where community leaders or social workers from grassroots level who are dealing with rape survivors on daily basis are provided with basic counselling skills on how to interact efficiently with rape survivors, or on how to appropriately handle those who are in psychological crisis. They would receive training on how to talk to those women without triggering their psychological trauma or exacerbating it. They would also be equipped with listening skills which would allow them to listen attentively to those women in order to clearly identify their concerns so that they can be helped accordingly or referred to professionals, if necessary.

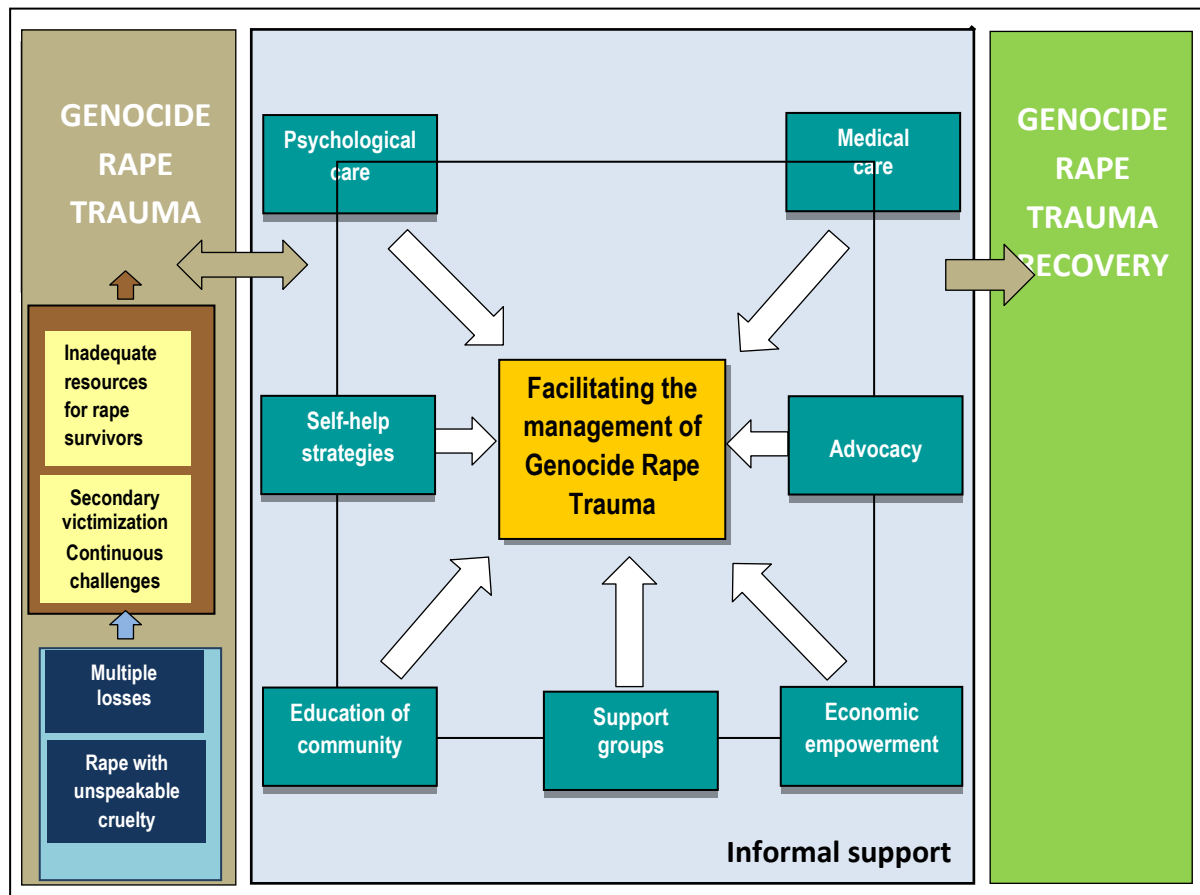
### **Sub-concept seven: Self-help strategies**

Self-help strategies refer to the actions the rape survivors do on their own to manage their psychological problems and this study has identified various strategies that some of the women have found helpful. However, these actions depend on the level of each woman's self-knowledge, which differs according to their background. Those who are educated make use of journals, where they write down events which are troubling them, such as disturbing memories, thoughts, feelings or behaviours. Some also write about their achievements, which contribute to their happiness, an important element for the recovery process. Prayer is another self-help strategy used by rape survivors. Prayers enable women to express their distress to the divine power, and they believe that they are heard and that there are solutions to their problems. The feeling of being understood raises a feeling of hope inside them, which gives them the courage to cope with their psychological problems. Other self-help strategies that were identified as being beneficial were listening to music, dancing, talking to a friend, walking or practicing deep breathing exercises. The rape survivors explained that these relaxing activities helped them to cope with their psychological distress.

The above explained concepts play a pivotal role in the structure of the theory of the management of the long- term effects of rape among women genocide survivors.

## 6.6 STRUCTURE OF THE THEORY

The structure of this theory in figure 4 highlights the relationships between the concepts which provides a comprehensive way of looking at the management of Genocide Rape Trauma.



**Figure 5:** Theory of Genocide Rape Trauma Management

Chinn and Kramer (2008) state that the totality of a theory can only be identified when its concepts are structured and interconnected in a systematic way. The theory on the management of the long term psychological effects of rape amongst women genocide survivors is logical in nature and follows the principles of chronological reasoning, as suggested by George (1985). This theory is built of three main interconnected sections. The first section includes the factors which contributed to the development of the phenomenon

and the phenomenon itself and this is then followed by the responding solutions and the expected outcomes.

The first section in the rectangular shape includes three connected sections. The base section includes two squares figures representing what happened to these women during the genocide. This is linked by a directional arrow to the second section which is divided into two levels. In ascending order, the first level represents what happened to these women after the genocide, as a direct consequence of what they endured during the genocide. The second level represents the lack of appropriate resources to care for rape survivors. This failure has led to the main problem, which is linked by a directional arrow, which is Genocide Rape Trauma. It is represented by a rectangular figure which is at the top of the section.

This first section is interconnected to the second section by a bi-directional arrow, which means that the actions described in section two are required to assist in resolving the problem. The arrow in the opposite direction confirms the execution of needed actions in addressing the problem.

Section two consists of three squares. The outer square is divided in two components with a broken line which indicate the relationship between the formal and informal support in allowing actions which contribute to the management of Genocide Rape Trauma. The one represents the support provided by the formal sector which involves mainly the support from women associations, NGOs and governmental structures. The second represents the support from the informal sector which implies the support received from the community within which the rape survivors are living.

The second square illustrates the specific actions which need to be taken to manage Genocide Rape Trauma and those actions are linked to each other by a thin line, which signifies their interdependence or influence on each other. The last small square, which is in deep inside the section, represents the heart of the theory as it defines the process which leads to the management of Genocide Rape Trauma.

The third section which is rectangular in shape is connected by a directional arrow with section two. This signifies that the actions taken in section two will lead to Genocide Rape Trauma Recovery in section three, which represents the ultimate expected outcome.

## **6.7 RELATIONAL STATEMENTS OF THE THEORY**

Strauss and Corbin (1998) indicate that theory construction may be represented in terms of interrelated concepts rather than a list of themes. According to (George, 1985), relational statements give structure to the theory because they are propositions which create the connection between the concepts. Along the same lines, Chinn and Kramer (2008) suggest that the relationship between the concepts are clearer when they are presented in a structured form by means of a symbolic representation. Therefore, the theory of this study is presented by a diagram showing the complexity of interconnection between the concepts which made up this theory.

As stated previously in this study, the long term psychological effects of rape among women genocide survivors are rooted in rape with unspeakable cruelty that was endured by those women, where they have been tortured and humiliated. In addition, they have lost their loved ones as well as property. This happening of the genocide is directly linked to the challenges and secondary victimization those women are facing. The womens challenges are represented by children born of rape, women's poor physical health status and material deprivation. Children born of rape and rape survivors' poor health status are directly interconnected to the event of rape, while material deprivation is interconnected to the loss of loved ones who were the breadwinners and material loss. Secondary victimization represented by stigma is interrelated to public rape, while the hostility towards rape survivors is related to the punishment of those who raped them. Without appropriate resources to take care of women rape survivors, this successive interconnection of negative events from the time of rape until today has contributed to the development of long term psychological effects of rape which was conceptualized as Genocide Rape Trauma. This concept represents the suffering of those women that is manifested via unbearable memories, overwhelming feelings, a sense of helplessness, somatic distress, negative self-image, altered intimate relationships and social isolation.

The interconnections described below show how different actions which facilitated the management of Genocide Rape Trauma are contributing to the journey of recovery of these women survivors. Psychological relief, recovery from physical illness, regaining a positive self-image and self reliance; and social integration represent Genocide Rape Trauma Recovery.

Genocide Rape Trauma is interconnected with the formal support which is given by government institutions and NGOs, such as FARG, government health facilities and women's associations. The benefit of these structures has been combined with the beneficial effect the judicial system has had through the legal actions in addressing Genocide Rape Trauma in facilitating rape survivors' recovery. During the legal hearings, women felt that they were respected in their community as the judges paid attention to their testimonies, acknowledged their pain and punished the culprits. Such hearings helped rape survivors to regain the feeling that they were respected in their communities and this restored dignity played a major role in the recovery of a positive self-image.

Community solidarity from the informal sector is interconnected with both Genocide Rape Trauma and Genocide Rape Trauma Recovery because the actions of supportive relationships and material support facilitate the recovery of women rape survivors who have been traumatized by their experience.

Psychological care is interconnected with formal support from public and private sectors. This means that the psychological care which contributes to the process of Genocide Rape Trauma Recovery is facilitated by the formal support of mental health professionals from the health sector, women's associations or NGOs. Professionals offer these women opportunities to express any concerns regarding their wellbeing. Such sessions of active listening allow women to find plausible solutions to their problems, and this in turn helps them to cope better with their hardships. FARG provides medical insurance to facilitate access to health care, either psychological or medical healthcare.

Medical care which contributes to the recovery from physical illness, is interconnected with psychological care because women need both their psychological and physical health care services to be addressed jointly. Poor health has negative psychological impacts, and psychological problems can lead to lapses in personal health maintenance and may also lead to psychosomatic problems. Thus, psychological and medical care are two fundamental aspects in facilitating the management of Genocide Rape Trauma.

The interconnection between advocacy, medical care and psychological care, economic empowerment and legal action from formal support highlights the influence that advocacy may have in changing those aspects. Advocacy is carried out mainly by women's associations and NGOs, who speak on behalf of the genocide rape survivors. Advocacy impacts indirectly on the management of Genocide Rape Trauma by urging policy makers to put appropriate

structures in place in terms of health care services, as well as social and financial support to meet the needs of rape survivors. The financial support gained from advocacy may also contribute to the economic empowerment of these women.

In addition to being connected to advocacy, economic empowerment is also connected to women's support groups, where some of the activities carried out by the women are income generating. This allows women to earn the money they need to buy basic goods or access health care services. This is a way of overcoming their dependency which was undermining their self-esteem. Thus, economic empowerment facilitates Genocide Rape Trauma Recovery as it also helps rape survivors regain a positive self-image and self reliance.

Women's support groups are interconnected with social integration as they contribute to the creation of a network for isolated rape survivors. In addition, these groups offer a space for sharing everyday events and the mutual support of group members relieves their psychological pain. Women support groups are also linked to the core category to signify the role they play in facilitating the management of Genocide Rape Trauma.

Education of the community is connected to both the core category and women's social integration. Rape survivors will be more socially integrated if they feel that they and their children are accepted by their community members. Such social integration may be achieved by educating the community in terms of raising awareness on how their social relationships can have an impact on the recovery of rape survivors. Findings have shown that negative interaction hinders the recovery process, while positive interaction facilitates Genocide Rape Trauma Recovery.

Education of the community is also linked to psychological relief. If volunteer community members are provided with basic counselling skills, they will know how to deal with rape survivors who are in psychological crisis and thus help them find emotional relief.

Self-help strategies are interconnected with psychological care because for rape survivors to fully benefit from the psychological care offered by the mental health professionals, they have to be involved in their own care by using their own strategies and those learned from mental health professionals during the psycho-education sessions. In addition, self-help strategies are also connected to the core category as they facilitate the management of Genocide Rape Trauma with prayer and relaxation activities which contribute to their

psychological relief, an important element in the journey of Genocide Rape Trauma Recovery.

## **6.8 QUALITY AND EVALUATION OF THE THEORY**

Corbin and Strauss (2008) indicate that it is necessary to evaluate a grounded theory study in order to assess its quality, and these authors emphasize that the assessment of the theory is the most important step of grounded theory approach. Luckerhoff and Guillemette (2011) point out that theory is “good” if it can be assessed by clear guidelines or criteria. According to Charmaz (2006), who provided the criteria for a self-evaluation in developing theory, the scientific rigour and creativity which reflect the quality of grounded theory research is translated through its credibility, where the core categories represent the empirical observations; originality, where the categories provide new insights on the studied phenomenon; resonance, where the categories represent the fullness of the studied phenomenon; and usefulness, where the results provide information that can be used by people in their everyday lives. Glaser and Strauss (1999) developed five criteria in assessing the quality of grounded theory research. It should be credible, which implies the accuracy of data; applicable, which means that the theory should fit the areas from which it has emerged and in which it will be used; understandable, in that it can be understood by professionals and non-professionals; and general, so that it can be applied to diverse situations similar to the situations from where it has been developed. Lastly, it should provide the user the control in bringing change to the studied situations.

Along similar lines, Strauss and Corbin (1990) stated that the theory should fit the area of the study, meaning that the theory should reflect the everyday reality of substantive area and the people studied; be understandable, thus being comprehensible to the participants and the professionals who are supposed to use it; be general, therefore the data should be broad and identified concepts have extensive variations to allow the theory to be applicable to different contexts in the areas; and, finally, provide control as it helps in bringing change into the phenomenon under study. As this study was guided by the paradigm model developed by Strauss and Corbin (1990), it was their criteria that guided the assessment of the quality of the theory of this study.

Despite their recommendation to follow guidelines in evaluating theory, Corbin and Strauss (2008) encourage researchers to be critical thinkers because the value of theory resides in scientific rigour. They also encourage creativity to be used by the researcher along the



research process, which is to produce reasonable claims, presentation of evidence and the ability of critically using the above mentioned approach. Those authors added that a valid theory is useful and fitting if it explains or describes the phenomenon studied, it is built on the rigour of the research process and the findings hold up to the scrutiny fit of similar situations and are valid in practice. As suggested by Keri Smith and Biley (1997), I relied on the main principles of the Grounded Theory approach to ensure the quality of this study and the developed theory, which requires the relevance of data collected, its saturation, and the repetitive process of comparing and contrasting concepts as they emerged. I made sure that the emerged concepts represent the meaning of the data they stand for through the process of open coding, axial coding and selective coding. Lastly, in writing the report, I had many discussions with my supervisors and colleagues from Rwanda in the areas of mental health to make sure that the theory developed responded to the criteria of fittingness; understanding; generality; and control, as suggested by Strauss and Corbin (1990).

### **6.8.1 Fittingness**

To achieve the fittingness of this theory, the living context of the participants has been described in this report, the information reported by the participants on their perceptions of the long terms effects of rape has been faithfully transcribed and the hindering and facilitating factors on the management of those effects have been discussed. The transcribed information has been checked by the participants and the diagram representing the developed theory has been checked in groups in order to ensure that my interpretations reflect the reality. Furthermore, the whole process has been followed by my supervisors, who ensured the fittingness of the developed concepts to the findings. I also discussed the research with Rwandan colleagues who are mental health professionals and who have a thorough knowledge of the context. They have given their assurances that the theory fits the reality from where it has been developed, and that it should adequately address the long term psychological effects of rape.

### **6.8.2 Understanding**

To ensure their understanding of this theory, the words from the participants were used to name the concepts so that it will make sense to those who might apply this theory. The advantage in utilising those specific concepts is to facilitate the understanding of the health care professionals and other stakeholders who are involved in the care and wellbeing of rape

survivors of the particular situation of these women and how their Genocide Rape Trauma could be managed and the recovery achieved.

### **6.8.3 Generality**

The use of memos helped me to keep the process of developing the theory on track and to ensure that Genocide Rape Trauma Recovery had been addressed in all its different aspects. Using the diagram did not only stimulate my sense of creativity, but it also allowed me to move from the level of description of the concepts to its analytical aspect. With a higher level of abstraction, it developed into a theory which includes extensive variations and, with the comprehensive data collected from participants with different background with rich information, this theory can be generalised to other similar contexts.

### **6.8.4 Control**

This middle range theory has been developed to enable the users to control the situation of rape survivors by understanding and analysing the reality of the situation in order to produce and predict a change in their situation. The use of the paradigm model identifies the conditions which hinder or enhance the recovery of rape survivors, and the actions which may facilitate change in the situation of rape survivors. Due to the interrelation of the concepts which make up the theory, the users can manipulate the various conditions to achieve a particular outcome which might be desired to promote the interests of rape survivors. Thus, this theory intends to provide a guide to those who are interested in the wellbeing of rape survivors to know how they might be helped in an effective manner.

## **6.9 CONTRIBUTIONS OF THE STUDY**

The main contributions of this study consist in increasing the body of knowledge regarding genocide rape trauma, informing the clinical practice and education of health care professionals, and advocating for rape survivors.

### **6.9.1 Building body of knowledge**

According to Charmaz (2006), a study is useful when it can contribute to new insights to build the body of knowledge on the phenomenon under study. Even although there were numerous studies in Rwanda on the psychological problems of genocide survivors (Munyandamutsa et al., 2012; Schaal et al., 2011; Zrally et al., 2011; Mukamana and

Brysiewicz, 2008; Palmer, 2002), there was limited information on the long term psychological effects of rape survivors and, to date, no theories have elaborated on the management of the long term psychological effects of genocide rape. Genocide Rape Trauma, which is the conceptualization of the lasting effects of rape among genocide survivors, did not yet exist in current literature, neither was there a theory for its management which leads to Genocide Rape Trauma Recovery. Therefore, this study does not only enrich Rwandan knowledge in the domain of sexual violence, but it also contributes to the worldwide body of knowledge by providing a new concept, Genocide Rape Trauma, to designate the suffering that affects women victims of rape in times of genocide and Genocide Rape Trauma Recovery for their healing.

### **6.9.2 Clinical practice**

According to the findings, there was no existing comprehensive way of addressing the long term psychological effects experienced by rape survivors. This may be attributed to the lack of theories which currently address this unique phenomenon. The contribution of this study is that it provides a theory presenting a holistic approach with concrete propositions based on the reality of the context and how the long term psychological effects of genocide rape should be managed. Referring to Chinn and Kramer (2008), a theory can contribute to clinical practice when it was grounded in the experience for which it was designed. Therefore this theory should contribute to the management of the long term psychological effects of rape among women genocide survivors as it has been developed from the data regarding the experience of rape survivors as reported by themselves, and from the perceptions of their community members of these problems. Women rape survivors clearly indicated what they thought might be useful in helping them to recover from their Genocidal Rape Trauma, as did their community members.

The theory which emerged from this study can be used to guide nursing practice by exposing it to any nurse involved in the care of rape survivors. Such nurses should learn from this theory that the after-effects of rape are everlasting and that they invade the psychological, the physical and the social lives of rape survivors. And to recover from that trauma the needs from those three areas have to be addressed adequately. From this theory nurses will learn that the holistic care of these women should be possible if nurses are relying conjointly on the resources available from the formal and informal sectors, from rape survivors themselves and the community where they are living.

### **6.9.3 Education**

The literature reviewed had shown a gap of a comprehensive care of rape survivors in the context of the aftermath of armed conflicts. Given that the experience of the survivors in this study is similar to that of other women in situations of major armed conflict and civil unrest, it is relevant beyond the narrowly defined situations of genocide. The present findings may be used to inform the curriculum of health professionals of such areas. And specifically, the theory developed in this study can be used to enhance nursing education by its inclusion in the curriculum of nurses as well as in the curriculum of others professionals concerned by the wellbeing of rape survivors. The relevance of the holistic approach presented in this theory should be explained clearly to the learners who may be guided by it once they are confronted to the care of rape survivors. In addition this theory could be referred to while educating community leaders and members on the care of rape survivors.

### **6.9.4 Advocacy**

This study serves as a way of advocating for care of rape survivors as it clearly established how the long term psychological effects of rape were manifested, the reasons why rape survivors were continuing to suffer from the negative outcome of rape and what concrete steps must be taken to help those women to recover from their Genocide Rape Trauma. During the data collection, some community members become aware of how the problems of rape survivors have persisted because stakeholders have not considered their plight as a priority to be addressed. Furthermore, these community members indicated that, having had the problem highlighted to them, they felt responsible to play a role which may positively influence the care of rape survivors by acting on their behalf and making the decision makers aware of the emergency.

## **6.10 RECOMMENDATIONS**

According to the findings, the management of the long term psychological effects of rape requires several interventions from different stakeholders. Thus, some recommendations are addressed to government institutions, such as the Ministry of Health, the Ministry of Education and the Ministry of Local Governance and others are related to clinical practice, education and research.

### **6.10.1 Recommendations for the Ministry of Health and the Ministry of Education**

The Ministry of Health reviews mental health policy on a regular basis, with the last review being carried out in 2011. I suggest that the next review of policy may include a specific component that contains the clear strategies identified in this study in addressing Genocide Rape Trauma.

The policy of decentralisation put in place in 1995 stipulated that mental health workers must reach all levels of the system of health care in Rwanda, specifying that mental health nurses would be available at the health centers (Ministere de la sante, 1995). However, specialized mental health professionals are currently only at referral and district levels and are still lacking at the health centre level (Ministry of Health, 2011a). Thus, I am suggesting that the Ministry of Health may identify the number of mental health professionals that are needed to adequately cover all three levels and that the Ministry of Education provides the necessary training of the required number of specialized professionals. An emphasis should be placed on training mental health nurses to be allocated to the health centre facilities which can be easily accessed by the large number of rape survivors who rely on those facilities.

### **6.10.2 Recommendations for the Ministry of Local Government**

The Ministry of Local Government is in charge of social protection and it is recommended that this ministry should work closely with women's associations and NGOs in promoting the self-reliance that is needed for the sustainable recovery of rape survivors. In addition, it is recommended that this ministry promote the elaboration and implementation of law protecting the basic rights of rape survivors and their children born of rape.

### **6.10.3 Recommendations for clinical practice**

According to the findings of the study, it is recommended that health professionals, especially mental health professionals, follow a holistic approach while taking care of rape survivors using the developed theory as a guide.

Mental health professionals should be aware of all the available medical, psychological, social and economic resources aimed to help vulnerable people, and inform the rape survivors about their existence so that they can benefit from them.

Mental health professionals should collaborate with women's associations, women's support groups and NGOs in sharing up-to-date information which might be useful in the care of rape survivors. The collaboration with local women's groups is an essential feature of this model.

#### **6.10.4 Recommendations for education**

In terms of education, the developed theory should be included in the curriculum of formal and informal training for health care professionals in the context of the aftermath of armed conflicts. In the Rwandan context, a module could be integrated into their curriculum, dedicated to the consequences of rape that occurred in the 1994 genocide and how it can be managed. Such a module could follow a holistic approach and highlight the roles of the community and the state structures in handling Genocide Rape Trauma, thus helping learners to understand the background to Genocide Rape Trauma and how it can be managed.

#### **6.10.5 Recommendations for research**

This study has revealed the persistence of the long term psychological effects of rape. Thus, it is suggested that comprehensive research identifying the consequences of rape be conducted at national level to serve as a baseline. This baseline may then be used in the future to assess the evolution of the impact of rape on women's lives across time.

The future nursing research in this area should privilege the use of mixed method using surveys and in-depth interviews to highlight the magnitude of lasting impact of genocide rape trauma. Interventions research may be useful in the adaptation of strategies that are designed for the care of rape survivors.

Additionally, this theory can be tested, validated and modified to serve the clinical practice of rape survivors throughout Rwanda or other areas of post conflicts.

### **6.11 LIMITATIONS OF THE STUDY**

According to Grove and Burns (2009), limitations of a study refer to the restrictions in terms of its generalizability. Such restrictions may be methodological or theoretical.

One of the limitations of this study is related to the small size of the sample, which is not representative of the population studied. However, the chosen methodology placed emphasis on the development of well-established concepts which represented the phenomenon under study rather than the number of the population studied.

The second limitation is the fact that the study was carried out in specific areas in the Kamonyi district, involving only two sectors, and therefore the results may only fit the mentioned areas and not other regions of the country. However, the presented findings give a broad idea of how women survivors are affected by the long term effects of rape and how the latter are dealt with.

The third limitation relates to the paucity of literature used in discussing the findings. There is little literature available on the long term impact of genocide rape and the subsequent care of rape survivors, with very few specifically focusing on the rape survivors from the Rwandan genocide context. Most of the literature consulted offered information on rape from western contexts.

Translation was also considered as a limitation of this study as Kinyarwanda was the language for data collection and analysis was done in English. Some participants used the same words for different experiences and their significance depended on the context in which they were used. The professional translator working with me was aware of the nuance of wording and paid particular attention to this in translating. From my side, I cross checked the translations before proceeding to a deep analysis. The participants frequently used the word “*ihahamuka*” to signify psychological trauma related to flashbacks being speechless or another disturbing emotions, thoughts or behaviours and this was written in brackets because I had the impression that there is no equivalent word in English to convey its meaning.

## **6.12 CONCLUSION**

This study highlights the complexity of the negative outcomes of rape among women genocide survivors. It also discusses why these effects are so persistent and presents various solutions which may address them.

The particularity of the long term psychological effects of rape in times of genocide arise from the fact that the psychological effects are not only related to rape, but are also linked to other traumatic events such as the loss of loved ones and the loss of material resources and livelihood. Such poly-traumatization results in traumatic memories that are hard to bear, along with upsetting feelings, disturbed behaviours and challenges to sexual intimacy. The acts of dehumanization that those women endured are still affecting their sense of self-worth, and some have lost hope in the future, while others view their lives as being meaningless. These negative perceptions of reality have also affected the relationships they have with

others and has led to social isolation. This is associated with the women's mistrust of their community members and is reinforced by their social stigmatization from the same community. The physical scars that these women bear signify the brutality of the sexual violence they experienced, which has now been considered as torture. Children born of rape and material deprivation are additional challenges to the situation of these women.

Genocide rape survivors need to receive specialised care from appropriate professionals to manage their physical and psychological injuries, as well as significant social support from their communities. However, lack of appropriate health care services and social support has contributed to the perpetuation of these women's health, psychological and social problems.

The communities where those women live play an important role in the process of their recovery. While some community members are caring and offer both material and emotional support to the rape survivors, others are more hostile and stigmatizing. This hostility has been linked mainly to the family members of those who have been imprisoned after having been convicted of the crime of rape. However, despite these negative outcomes of the legal processes, rape survivors were satisfied by the sentencing of their rapists by ICTR or the Gacaca courts, and were proud of their contribution to the recognition of rape as a crime against humanity into the international law.

The women gave tribute to FARG, women's associations and NGOs who have been involved in searching for solutions to solve the various problems facing genocidal rape survivors. However, it was felt that their efforts were not sufficient to deal with the range of problems that needed to be solved. Local women's support groups were seen as alternative structures to public institutions in addressing the needs of rape survivors by facilitating economic empowerment, organising access to health care services, and imparting information via broader women's associations that are working closely with such groups.

Advocacy was highlighted as means through which the voices of the women could be heard in order to ensure the development of policies and programs responsive to their specific needs.

Community education in providing basic skills for preventing and managing some of the problems of rape survivors within their community was suggested as a valuable resource. It was felt that raising community's awareness of the stigma attached to rape survivors and their children was needed to facilitate their social integration. However, psycho-education and



women's self-knowledge was viewed as the most important single element in enabling women to manage their problems themselves.

The overall findings have underlined the necessity of a holistic approach in facilitating the management of Genocide Rape Trauma, and shown how this requires the combined efforts of the women rape survivors themselves, and both formal and informal social support structures.

### **6.13 PERSONAL REFLECTIONS**

Personal reflections involve the accounts of the researcher regarding their subjective experience while conducting their research (Wolcott, 2001). This study was challenging both academically and emotionally, however on its completion I felt that I have experienced a great deal of personal and professional growth, particularly in terms of expertise as a qualitative researcher.

I knew before that going into this project that rape and its attendant suffering imposed in the context of genocide were criminal atrocities far beyond the norm of everyday experience. Now I know that we cannot remain the same after we have been exposed to the hearing of these unspeakable cruelties.

When I was conceptualising the study I found that Grounded Theory was the best approach for my research area as it privileged the encounter with others, and remained faithful to their experience. I thought that using Strauss and Corbin's (1990) approach would be easiest as their guidelines are clear and straightforward, thus helpful for a novice researcher. Using this paradigm was more challenging than I thought. At the beginning it was hard for me to make a clear difference between the causal conditions, intervening conditions and context, and I had the impression that the content of those components was overlapping. It was also hard for me to see a clear difference between actions and consequences, especially when the expected consequences were not emerging clearly. I realised that I was experiencing what Glaser calls "forcing the data". When I met my supervisors they suggested that I not be a "slave of the methodology" but rather use it as a tool to assist and guide the analysis. Even though I was then feeling a little insecure at not following the paradigm as closely as I thought I should, I decide to take a little distance from the guidelines of the paradigm model and try to listen to what the participants were telling me through the collected data. In doing this I felt relieved and had the impression that I was moving closer to my data, and that my data was becoming more meaningful to me. Once I felt more comfortable and confident with my analysis I then

cross-checked the process of the analysis in terms of the paradigm model. At that time I realized that it was in fact assisting me in organizing my data, and I was pleased to see the flow and how the theory was then emerging. I then continued more confidently. This struggle helped me to explore how to organise my findings in a logic manner and also in a way that the “voices” of the participants would then be heard by anyone who may be reading this work.

The challenges encountered in this study were not only linked to the methodology I was using, but they were also related to the kind of data I was collecting and the context I was working in. When I undertook this research my role as researcher was clear to myself and I communicate this to my potential participants at the first meeting when I invited them to be part of my research. However, when I started to collect data the first challenge I encountered was in relation to the difficulties associated with maintaining role boundaries, being a researcher and a healthcare professional. It has been impossible for me to separate these two roles. This occurred mainly in the anniversary month of April where health professionals who participated in my research and who knew that I was attending ceremonies at the memorial sites of the Genocide, became overwhelmed by the large number of people suffering from “ihahamuka” (psychological trauma) and they called me for help. Being aware of the shortage of mental health professionals in that region and the emergence of such cases, I responded to such requests and provided what assistance I could.

From my previous research for my Masters degree, which was carried out on the lived experience of rape amongst women genocide survivors, I was aware that collecting data on sexual violence that occurred in the genocide would involve a degree of emotional distress among the participants as well as for myself. This required continuous effort on my part to be very vigilant that the participants were not harmed psychologically by the accounts they were sharing, and by me remaining calm and having an attitude of empathy and reassurance towards the participants. This expressed empathy facilitates to build a trust relationship which allowed conducting in depth interview with rich data (Campbell, Adams, Wasco, Ahrens and Sefl, 2009a; Rager, 2005) and also provides emotional support and reassurance for the survivors. However this exercise was psychologically exhausting, and in addition to listening to these shocking stories of the emotional pain and trauma that the women genocide rape survivors went through, I needed time to deal with my own emotional distress.

Transcribing the interview was more exhausting as it exposed me repetitively to the continuous suffering of these women. I was left with feelings of anger or frustration that was hard to bear. These feelings of exhaustion are common among researchers of sensitive topics (Dickson-Swift, James, Kippen and Liamputtong, 2007). However what encouraged me to keep going ahead is that some time was my belief that this study may make a difference in the lives of these women as it would contribute to an improved care. Being confronted with the trauma of rape survivors so repetitively, while taking care of these women as a clinician and collecting data as a researcher, challenged some of my own beliefs in the goodness of humanity. Now I know that what Maier (2011) said is indeed true; that providing care to victims of violence and collecting data related to the impact of violence on victims' lives, especially those who survived a brutal rape, involves profound emotional distress for the listeners. Lalor, Begley and Devane (2006) suggest that researchers involved in any sensitive research which may evoke highly emotional responses, think about the ways in which way they can protect themselves from being harmed by the research. I used a diary journal to debrief, and I was also privileged to have close friends with whom I could share my thoughts and feelings with throughout my research, and this provided a great deal of support. This sharing prevented me from developing vicarious trauma, which is otherwise frequent amongst professional dealing with the victims of rape (Cauchie, Ntamagiro and Bruyninckx, 2011).

Even though this experience was stressful it helped me to become better at the art of listening to others. The affective component of this study which involved significant emotional distress, and the amount of work that is involved in a PHD study, has made me increasingly aware of my weakness and strengths in dealing with stressful situations. This developing self-awareness has contributed to my emotional and intellectual growth. The use of grounded theory which requires a deep understanding of the experience of the participants, as well as my discussions with my colleagues and supervisors have sharpened my interest in research. I have become more aware of the ways in which producing good qualitative research on sensitive topics requires both skills in conducting interviews to collect significant data, and a grasp of its relevance to clinical practice.

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## ANNEXURES

### Annexure 1: Ethical clearance from the University of KwaZulu-Natal



4 February 2011

Mrs. D Mukamana (202515532)  
School of Nursing

Dear Mrs. Mukamana

**PROTOCOL REFERENCE NUMBER: HSS/1275/0100**  
**PROJECT TITLE: Developing a model to manage the long-term psychological effects of rape amongst women survivors of 1994 genocide in Rwanda: Grounded Theory Approach**

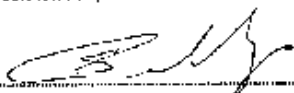
#### **FULL APPROVAL NOTIFICATION – COMMITTEE REVIEWED PROTOCOL**

This letter serves to notify you that your application in connection with the above was reviewed by the Humanities & Social Sciences Research Ethics Committee on 8 December 2010, has now been granted full approval following your responses to queries previously addressed.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach/Methods must be reviewed and approved through an amendment /modification prior to its implementation. Please quote the above reference number for all queries relating to this study. PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Best wishes for the successful completion of your research protocol

Yours faithfully




.....  
**PROF. STEVEN COLLINGS (CHAIR)**  
**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE**

cc. Supervisor – Dr. P Brysiewicz  
cc. Anthony Collins  
cc. M. S Reddy

Postal Address: Telephone: Facsimile: Email: Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)

Founding Campuses: ■ Edgewood ■ Howard College ■ Pietermaritzburg ■ Westville

Annexure 2: Ethical approval for the amendment of the research title



**UNIVERSITY OF  
KWAZULU-NATAL**  
INYULVESI  
YAKWAZULU-NATALI

19 October 2012

Mrs Donatilla Mukamana 202515532  
School of Nursing and Public Health  
Howard College Campus

Dear Mrs Mukamana

Protocol reference number: HSS/1275/0100  
New project title: "Management of the long term psychological effects of rape among women survivors of 1994 genocide in Rwanda: A Grounded Theory Approach"

Full approval notification-Amendment


This letter serves to notify you that your application for an amendment, dated 25 September 2012, has now been granted Full Approval.

- Purpose for research, research objectives and significance of the study reworded to fit theory development.

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the school/department for a period of 5 years.

Best wishes for the successful completion of your research protocol.

Yours faithfully




Professor Steven Collings (Chair)  
Humanities & Social Sciences Research Ethics Committee

cc Supervisor Professor Petra Brysiewicz  
cc co supervisor Dr Anthony Collins  
cc Academic leader Professor M Mars  
cc School Admin. Mrs C Dhansraj

Professor S Collings (Chair)  
Humanities & Social Sc Research Ethics Committee  
Westville Campus, Govan Mbeki Building  
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Founding Campuses: ■ Edgewood ■ Howard College ■ Medical School ■ Pietermaritzburg ■ Westville

**INSPIRING GREATNESS**



## Annexure 3: Ethical clearance from Kigali Health Institute



Annexure 4: Permission letter from Kamonyi District

LETTER OF PERMISSION TO CONDUCT RESEARCH

Mayor of Kamonyi District

Southern Province

P.O.Box 03 Muhanga

Rwanda

Donatilla Mukamana

University of KwaZulu-Natal

School of Nursing

Durban 4041, South Africa

April, 11<sup>th</sup> 2011

Dear Sir,

**Application to conduct a research at kamonyi District**

I am a PHD student at the University of KwaZulu-Natal, Faculty of Health Sciences, School of Nursing. I am requesting the permission to conduct a research with the women and men village leaders of your district.

The title of the research is "Developing a model to manage the long-term psychological effects of rape amongst women survivors of the 1994 genocide in Rwanda". If the permission to conduct the study is granted, I would appreciate to know how to contact the village' leaders of your district. The participation will be voluntary, anonymity and confidentiality will be preserved.

It will be highly appreciated if my request receives your favorable consideration

Yours sincerely

Donatilla Mukamana

Supervisors: Prof. Petra Bryzwick

Anthony Collins



*Approved*  
UWINEZA Claudine  
Vice Mayor in Charge of  
Economic Development  
KAMONYI DISTRICT

Annexure 5: Permission letter from the coordinator of SEVOTA'association

Donatilla Mukamana  
University of KwaZulu Natal  
School of Nursing  
Durban 4041, South Africa.

God-freya MUKAMANA  
Association SEVOTA  
P.O.Box 3607 Kigali  
Rwanda

5 February 2011

Dear Mrs. Mukamana,

**PERMISSION TO CONDUCT RESEARCH**

Your request to conduct research "Developing a model to manage the long-term psychological effects of rape amongst women rape survivors of 1994 genocide in Rwanda: Grounded Theory Approach" was received.

It gives me pleasure to inform you that the permission is granted.

Best wishes with your study

Yours sincerely  
MUKAMANA God-freya  
Coordinator of SEVOTA



## **INFORMATION DOCUMENT**

Dear Participant,

I am Donatilla Mukamana I am doing my PHD at the University of KwaZulu-Natal in the School of Nursing. For the purpose of my degree, I am conducting a research study. The title of the research is *“Developing a model to manage the long-term psychological effects of rape amongst women rape survivors of 1994 genocide in Rwanda”*

I want to explore the perceptions of the rape survivors and also the perceptions of their community members on the long-term psychological effects of rape amongst women rape survivors of the 1994 genocide in Rwanda. And develop a model which will help in the management of the long-term psychological effects of rape among women survivors of the 1994 genocide in Rwanda. I am inviting you to participate in this study because your contribution is highly needed in the elaboration of the model.

Should you agree to participate in this study, I would like to conduct an interview with you for 45 minutes to one hour approximately to explore the following areas: (a) your perceptions of the long-term psychological effects of rape amongst women rape survivors of the 1994 genocide in Rwanda; (b) the contributing and risk factors of the long term psychological effects of rape amongst women rape survivors of the 1994 genocide in Rwanda; (c) available support for rape survivors and how does the community enhance or inhibit the efforts of the women rape survivors to manage the long-term psychological effects of rape and lastly; (d) what model may be developed to help in the management of the long-term psychological effects of rape among women genocide survivors. With your permission the interview will be recorded with a digital voice recorder.

I would like to make you aware of the potential risk of painful memories related to the discussion of the consequences of the genocide, namely the long-term psychological effects of rape that occurred during that time. If you become distressed the trauma counsellor will be available for any help and myself as an experienced mental health I will support you emotionally with active listening, relaxation or other techniques according to the way you will express your distress. If the distress persists despite the emotional support offered by myself and the trauma counsellor from SEVOTA. You will be referred to mental health service of Remera-Rukoma hospital which is in 100 meters from SEVOTA centre for more care and follow-up. I will cover any cost related to your care.

If you should want to address any complaints from the study you will be given different contacts detail such as my personal contact the one of my supervisors, contacts of the Director of Kigali Health Institute Review Board and the address of the secretary of ethical committee of the University of KwaZulu Natal.

You can participate in this research only when you are feeling comfortable to do so. Your participation in this research is voluntary. If you decide not to participate there will be no negative consequences for you. If you do decide to participate we will agree where we can meet for the interview. Once involved in the study you can also withdraw from it without any penalty if you feel uncomfortable about continuing.

All information obtained from the interview will be kept confidential. With your permission the English translator and my research supervisors will have access to the collected information. Pseudonyms will be used for the research report. The electronic copy of the transcribed interview will be destroyed after completion of the study.

If you have read and understood the information of this document you can sign the informed consent to volunteer to participate in the study.

**Thank you**

If you require additional information, please feel free to contact either of the following:

**Researcher**

Donatilla Mukamana

Cell: 0788304396

E-mail: donatillam@yahoo.fr ;donatillam@hotmail.fr

**Supervisors**

Petra Brysiewicz

Anthony Collins

School of Nursing

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**Administrative officer of the Research Ethics office of Humanities and Social Sciences**

**Phume Ximba**

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## **Annexure 7: Information document Kinyarwanda version**

### **IBISOBANURO KU BUSHAKASHATSI**

Nshuti witabiriye ubu bushakashatsi,

Ndagushuhuje,

Nitwa Donatilla Mukamana nkaba niga icyiciro cya gatatu cya kaminuza kuri Univerisite ya kwazulu Natal muri Africa yepho. Kugirango mbone impamy bushobozi yi kirenga itangwa nicyo cyiciro ngomba gukora ubushakashatsi. Ubwo nahisemo gukora bujyanye no kureba ukuntu abakobwa cg abagore bafashwe ku ngufu hamwe n'abaturanyi babona ibibazo byo mumutwe biza nki nkurikizi kuri abo bantu bafashwe ku ngufu muri jenocide yi 1994. Ibyo bizamfasha gushyira ahagaragara uburyo abo bantu bafashwa guhangana nizo nkurikizi. Izina ryubwo bushakashatsi ni ***“Uburyo ngenderwaho bwo gufasha abagore n’abakobwa gukemura ibibazo byo mumutwe biza nki nkurikizi zuko bafashwe ku ngufu muri jenocide ya 1994 yo mu Rwanda”***

Yaba witabiriye kuba muri buno bushakashatsi turakorana ikiganiro gishobora kumara iminota 45 cg isaha yaba ubyemeye ndagufata amajwi. Ingingo tunganiraho nizi zikurikira:(a) kumbwira uko ubona inkurikizi zijyanye ni bibazo byo mu mutwe abakobwa cg abagore bafashwe ku ngufu muri jenocide ya 1994 bahura nabyo; (b) ni zihe mpamvu ubona zituma ibyo bibazo byiyongera cg bigabanuka; (c) wowe nku muturanyi wabo ubafasha iki mu gukemura ibyo bibazo; (d) ubona hakorwa iki ngo ibyo bibazo byabo bahuye niryo hohoterwa ngo bikemuke.

Nagirango nguteguze ko cyino kiganiro gishobora gutuma wumva umerewe nabi kubera kwibuka ibyabaye muri jenocide yi 1994 mu Rwanda. Niwumva utameze neza ubimbwire, nku muforomokazi uwugukiwe nibyo ubuzima bwo mumu twe nzi neza buryo ki nagufasha ariko nu mu jyanama wa SEVOTA yagufasha uramutse ubikeneye. Uwo nsaba kwitabira icyi cyiganiro nuwumva afite ingufu zihagije muri we kuburyo yumva cyitamuhungabanya. Kwitabira cyino cyi ganiro nubushake bwawe. Ushobora kuvamo igihe icyo aricyo cyose igihe wumva ubangamiwe kandi ibyo ntankurikizi mbi byakugiraho.

Ibyo tunganira nzabigira ibanga bizakorehswa gusa kubijyanye nu bushakashatsi kandi n' izina ryawe ntaho rizagaragara. Niba ubinyemereye umfasha gusemura i Kinyarwanda mu cyongereza hamwe nabankuriye mu bushakashatsi bazasoma ibiganiro byacu. Nindangiza ubushakashatsi ibyo twaganiriye nzabihanagura ku kuma ki fata majwi.

Yaba wasomye ukumva neza ibikubiye muri iyi nyandiko ushobora gusinya urwandiko rumpa uberenganzira bwo kugushyira mu bushakashatsi bwanjye.

Mbaye ngushimiye

Uramutse ukeneye kugira icyindi umenya ku bijyanye na buno bushakashatsi ushobora kumbaza cg abanyobora mu bushakashatsi. Uko wababona bisobanuye ahakurikira.

**Umushakashatsi**

Donatilla Mukamana

telefoni: 0788304396

Emeri: [donatillam@yahoo.fr](mailto:donatillam@yahoo.fr); [donatillam@hotmail.fr](mailto:donatillam@hotmail.fr)

**Abayobora umushakashatsi**

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**Utanga uburenganzira bwo gukora ubu bushakashatsi**

Phume Ximba

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Fagisi : (031) 260 4609

Umuyoboro :

<http://research.ukzn.ac.za/ResearchEthics/HumanitiesSocialSciencesResearchEthics.aspx>

**Annexure 8: Informed consent English version**

**DECLARATION OF CONSENT TO PARTICIPATE IN THE RESEARCH**

I.....give consent to be interviewed by Donatilla Mukamana for her study for Developing a model to manage the long-term psychological effects of rape amongst women rape survivors of the 1994 genocide in Rwanda. I confirm that I have read and understand the content of the information document and the nature of the research project.

I am aware of the potential risk of painful memories related to the discussion of the consequences of the genocide, namely the long-term psychological effects of rape that occurred during that time. I have been informed that if I become distressed the trauma counsellor will be available for any help and the researcher as an experienced mental health will support me emotionally with active listening, relaxation or other techniques according to the way I will express my distress.

I have also been informed that if the distress persists despite the emotional support offered by the researcher and the trauma counsellor from SEVOTA, I will be referred to mental health service of Remera-Rukoma hospital which is in 100 meters from SEVOTA for more care and follow-up. The cost related to my care will be covered by the researcher.

I have been told that if I have any complaints from this study they may be addressed to the researcher herself, her supervisors the Director of Kigali Health Institute Review Board and to the secretary of the ethical committee of the University of KwaZulu Natal. Their contacts details are available to me.

Therefore, I....., agree to participate in this study voluntary and I am at liberty to withdraw from the project at any time, Should I so desire.

Signed.....

Date.....

**Contact details for people to be contacted if you have any inquiry related to this study.**

**Researcher**

Donatilla Mukamana

Cell: 0788304396

E-mail: donatillam@yahoo.fr ;donatillam@hotmail.fr

**Supervisors**

Petra Brysiewicz

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Email: [Collins@ukzn.ac.za](mailto:Collins@ukzn.ac.za)

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**Annexure 9: Informed consent Kinyarwanda version**

**Kwemera kwitabira ubushakashatsi**

Jyewe ..... nemereye Donatilla Mukamana ko nzitabira ubushakashatsi bwe bujyanye no *“Uburyo ngenderwaho bwo gufasha abagore n’abakobwa gukemura ibibazo byo mumutwe biza nki nkurikizi zuko bafashwe ku ngufu muri jenocide ya 1994 yo mu Rwanda”*.

Ndemeza ko nasomye kandi nasobanukiwe nibikubiye mu nyandiko ivuga nibijyanye nu bu bushakashatsi.

Nzi neza ko buno bushakashatsi bushobora kumpungabanya bitewe no kuganira ku nkurikizi z’ibibazo byo mu mutwe abakobwa cga bagore bafite bitewe nuko bafashwe ku ngufu muri jenocide. Nasobanuriwe ko ibyo biramutse bimbayeho umujyanama w’ubuzima bwo mu mutwe cg se umushakashatsi uhugukiwe nibyo ubuzima bwo mu mutwe nku muforomokazi ushinzwe ibu buzima bwo mumutwe bamfasha kuva muri iryo hungabana, bakoresheje uburyo bwo kuntega matwi cg se nindi myitozo yo kwishyira mu mutuzo bitewe nuko ikibazo cyanjye cyaba kigaragaye. Igihe ubwo ubufasha bwabo budashoboye kumvura nasobanuriwe ko najya ku bitaro bya Rukoma biri muri metero 100 uvuye kuri SEVOTA aho inzobere mubyu’ubuzima bwo mu mutwe bamvura bagakomeza no kunkurikirana. Ibijyanye n’amfranga yo kwivuzza umushakashatsi niwe wayariha.

Nasobanuriwe ko ndamutse ngize ikibazo kuri buno bushakashatsi nshobora kwitabaza umushakashatsi, abamukuriye mu bushakashatsi cg abamuhaye uburenganzira bwo kubukora. Hari uhagariye ubushakashatsi ubarizwa mu cyigo cy’Ishuri rikuru ry’ubuzima rya Kigali, cg uhagarariye ubushakashatsi muri Universite ya kwazulu Natal muri Afrika yepho.

Maze gusobanukirwa, jyewe..... nemeye kwitabira ubu bushakashatsi kubushake bwanjye nzi neza ko nshobora kubuvamo igihe numva bumbangamiye kandi ko ntankurikizi.

Umukono.....

Itariki.....

**Abo ushobora kwiyambaza ugize icyibazo icyo aricyo cyose cyijyanye nu bushakashatsi**

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## **Annexure 10:** Interview guide for women rape survivors English version

### **Demographic data:**

Choose a pseudonym

Age

Marital status

Sector

Education level

Source of income

### **Open-ended questions:**

- How much do you think you are psychologically affected by your experience of being raped in the 1994 genocide?
- Could you please tell me which factors do you think are contributing or protecting you having the long-term psychological effects of being raped in 1994 during the genocide?
- Could you please tell me what kind of support is available to you to manage long-term psychological effects of being raped in 1994 during the genocide?
- Could you please tell me in what way your community members are influencing your long-term psychological effects of being raped in 1994 during the genocide?
- What do you think could be done to help you to manage your psychological effects of being raped in 1994 during the genocide?

**Annexure 11: Interview guide for women rape survivors Kinyarwanda version .**

**Umurongo w'I Kiganiro cy' abagore n'abakobwa bafashwe ku ngufu**

**Umwirondoro:**

Hitamo izina ushaka kwitwa mu kiganiro

Ufite imyaka ingahe

Uri ingaragu cyangwa warashatse

Segiteri utuyemo

Amashuri wize

Umutungo wawe uvahe

**Ibibazo:**

- Kuba warafashwe ku ngufu muri jenocide ya 1994 ubona hari ibibazo byo mu mutwe bigutera?
- Ushobora kumbwira impamvu zituma ibyo bibazo byo mu mutwe byiyongera cyangwa bigabanuka?
- Mbese nu buhe bufasha ubona bujyanye nuko wafashwe ku ngufu muri jenocide ya 1994?
- Ese abaturanyi bawe ubona bajyira uruhare mu kwiyongera cg mukugabanuka kwibyo bibazo byo mu mutwe wawe niryongera ku ngufu?
- Ese ubona hakorwa iki mu rwego rwo kugufasha gukemura ibyo bibazo byo mu mutwe wawe niryongera ku ngufu?



**Annexure 12:** Interview guide for community members (women not raped and men) English version

**Demographic data:**

Choose a pseudonym

Age

Marital status

Sector

Education level

Source of income

**Open-ended questions:**

- Do you know anyone who has been raped during the 1994 genocide?
- How much do you know about the long-term psychological effects of women who were raped during the 1994 genocide?
- Could you please tell me your perceptions of the long-term psychological effects of women who were raped during the 1994 genocide?
- What do you think are protecting or risk factors of these long term psychological effects of rape amongst women survivors?
- Could you please tell me how you and other members of the community are assisting the women rape survivors to manage their psychological effects related to rape?
- What kind of support is available to help the rape survivors to manage their long-term psychological effects of rape?
- What do you think could be done for the rape survivors to manage their long-term psychological effects of rape?

**Annexure 13:** Interview guide for community members (women not raped and men)  
Kinyarwanda version.

**Umurongo w'I Kiganiro cy' abagore n'abagabo ba abaturanyi b'abagore cg abakobwa bafashwe ku ngufu**

**Umwirondoro:**

Hitamo izina ushaka kwitwa mu kiganiro

Ufite imyaka ingahe

Uri ingaragu cyangwa warashatse

Segiteri utuyemo

Amashuri wize

Umutungo wawe uvahe

**Ibibazo**

- Ese hari abantu waba uzi bafashwe ku ngufu muri genocide y'I 1994?
- Niki uzi ku bibazo byo mumutwe bijyanye n' ingaruka ziba kuri abo bagore cg abo bakobwa bafashwe ku ngufu muri jenocide ya 1994?
- Mbese ubona ute ingaruka zijyanye niryo fatwa kungufu?
- N' izihe mpamvu utekereza ko zituma ibyo bibazo byo mu mutwe bijyanye ni fatwa ku ngufu byiyongera cg bigabanuka?
- Hanyuma se wowe nku muturanyi ufasha iki mu gukemura ibyo bibazo byo mu mutwe biterwa no kuba barafashwe ku ngufu?
  - Nu buhe bufasha uzi bwu mwihariko babona bujyanye nuko bafashwe ku ngufu?
  - Wumva hakorwa iki kugirango ibyo bibazo byo mu mutwe biterwa nuko bafashwe ku ngufu bikemuke?

## **Annexure 14: Interview transcript**

### ***Interview with Umwiza 20 May 2011***

**Researcher:** *Good morning A...Thank you for coming for this interview. When we met previously I introduced myself and explained that I was here to conduct research and explained what the purpose of my research was. Do you remember what I said?*

**A:** *Yeah you told us that you are doing research to know what problems we are having because we have been raped. Isn't?*

**Researcher:** *Yeah...You are right, but I also want to know what the lasting consequences of rape are, why those consequences of rape continue to affect your lives even today, what are the protecting and risk factors, what support is available to help you and from there I will come up with propositions that may help for the care of women who have been raped during the genocide*

**A:** *Ok now I remember... you said so*

**Researcher:** *I said also that discussing your experience of rape could be distressful. That means we can start the interview if you are feeling comfortable, but if you don't feel well during the interview we can stop it.*

**A:** *But last time you said that you are a mental health nurse... then if I am distressed you will take care of me... (Laughter)*

**Researcher:** *Yes I can, but I will make sure that you are fine throughout the interview because being distressed is a painful experience and I don't want to provoke such negatives feelings in you.*

**A:** *If so, then no worry*

**Researcher:** *With your permission I would like to use a voice recorder which helps me to keep all information that you will share with me. It will be confidential and only the translator and supervisors who are helping me in this research will have access to that information. It will be destroyed after the study has been completed. If you have any questions, you can ask them before we go ahead.*

*A: You answered the questions I had about you and your research when you came to our general assembly the first time. Everything was clear, which is why I decided to participate (Smile). For now I don't have any questions.*

**Researcher:** *Thank you once again for your willingness to participate in this research. I know your name. You are A... but for the interview I will use a pseudonym for the purpose of anonymity. What pseudonym do you want to choose?*

*A: You can call me Umwiza (Beauty)*

**Researcher:** *Nice name! Before we go ahead, please will you tell me more about yourself?*

*Umwiza: Hmmm... My name is ACN. I am fifty years old and have completed six years of primary school. Currently I am a cultivator and I am an active member of SEVOTA. I come from Gacurabwenge. I am a widow. My husband died during the genocide at the hands of our neighbours. He was killed in front of me with our best friends who were hiding us, I survived with my four children who were also disabled by the genocide and now they are depending on FARG. I had another son after the genocide so now I have five children in total.*

**Researcher:** *Sorry to hear that your husband was killed during the genocide and that your children went through a hard time.*

*Umwiza: They killed my husband and raped me and went in our house. They took everything that was inside (silence)... Do you know...My story is too long and too sad, my husband was a driver and he was well paid. As he knew that rape was commonplace during the genocide he gave me some money to pay interahamwe (militias) for my protection. These interahamwe (militias) took the money, but they didn't protect me. Instead they raped me. There were so many of them that I don't even remember their number. Talking about the consequences of rape, they are many and I worry they are forever. What quality of life do I have after what I have gone through. I remember that a young boy who was supposed to be my son raped me (silence)... pushed me down. When I fell down, I had the impression that my back and head were broken. They beat me with a stick as I was resisting and raped me. Until now I get headaches and my back is painful. Every day I endure the consequence of that tragic event. I try to show that I am in good shape but I am really not. What is the most painful is that the young boy took me as his sexual slave.*

**Researcher:** *The young boy took you as his sexual slave? What do you mean by that?*

**Umwiza:** *That boy took me under his protection. He said he will protect me and I will be his wife. I stayed in his house for four days, but he didn't care if I was hungry, thirsty or clean. He raped me every day and after those four days, he said he is no longer interested in me and he called a gang of interahamwe (militias) to rape me again. When I remember these details I really feel very sad (silence)... That gang of interahamwe (militias) who raped me have broken my body, and I am feeling sad. I mean when you are not feeling well in your body, it is quite impossible to feel well psychologically. The consequences of being raped are plenty. Like having a headache, I can't carry any luggage on my head, I can't cultivate.*

**Researcher:** *I can imagine how hard it must be to have such problems...Did the experience of rape change the way you perceive yourself.*

**Umwiza:** *I perceive myself as worthless. Because I can't earn my life properly I depend on others and I don't like it. I am often sick as they cut my perinea so I now have painful scars. I go to the health centre for treatment with my headache and I regularly take pain killers to be relieved. I try to manage my back and take an antalgic position not to feel back pain while lying down in bed...*

**Researcher:** *What else do you do to cope with your problems?*

**Umwiza:** *I use different mechanisms to help me to cope with the consequence of being raped. For example, I discuss things when I come to SEVOTA to meet with other women and I share everything with them and we comfort each other. There are also some techniques taught by a mental health professional which consist of breathing deeply and after doing that exercise I feel relieved. When we were taught that technique, I was laughing, saying that exercise is only a joke, but now when I am not feeling well I do that exercise and it helps me to feel relieved. When we come for our weekly group meeting we practice that exercise and it make us laugh... we laugh a lot as we have the impression that we are behaving like little girls. But we don't mind. The most important thing is that we feel better after the exercise (laughter).*

*My great problems are headaches and falling to sleep. I know I have a sleeping problem so I pray before I go to bed. I also listen to Radio Maria which is a catholic radio with religious songs. That radio has been the message of hope which is helpful and that helps me to fall sleep.....yeah... I sometimes listen to soft music on the radio as I have found that it is a way of relaxing my tense mind which doesn't involve any cost.*

**Researcher: You've told me what helps you to deal with your after effects of being raped. Are there any conditions that maintain or exacerbate your psychological problems related to your experience of rape?**

**Umwiza:** *Those conditions are too many... Look... when I remember how I was gang raped, in addition being raped by a young boy and staying with him for four days without eating and without energy and yet despite those conditions he continued to rape me. To tell you the truth these memories are unbearable. And I can't sleep when I remember that. What makes it worse is that one of these interahamwe who raped me was convicted of rape and put in jail, but recently his family members said that I accused him falsely and if he is not released from prison, I will be in trouble. My worries are that now they can come any time and do something bad to me.*

*But I also worry about the poverty which is undermining my life. As I told you before, we were wealthy before the genocide because my husband was driver and had a good job, but when he died our family became very poor because the interahamwe took our belongings. In order to fulfil the basic needs for my children, I searched for a job in the area and I found one as help-builder from someone who was building a house. My boss was kind to me and helped me to take care of my children and then he starts to ask me to sleep with him. Even though I was disgusted about the issues of having sex with any man after I was raped, I didn't refuse for fear of losing my job. It is in that condition that I got my fifth and last son. Now my problems of poverty are becoming worse and worse (silence)... Even though the father of my son continues to provide everything that my little one's needs, but it doesn't make any difference to my hard living conditions.*

**Researcher: I feel sorry for you... I can hear it is not easy what you are going through... Did your experience of rape have any link with your poverty?**

**Umwiza:** *The link is so clear, because now I have been handicapped by the fact of being raped because they have broken my back and my head and my whole body is painful, I worry that I can be harmed any time by the family members of the man I reported to the court. These are the specific consequences of rape. I am poor because I am an invalid and can't work. Of course the genocide took my husband who was the breadwinner of our family and other members of the extended family were killed as well and it became difficult to have help from outside. Even though the genocide has contributed to my misery, rape has made a great contribution to my current misery.*

**Researcher: Did you get any specific support as rape survivor?**

*Umwiza: Except the support we get from SEVOTA and FARG for the medical insurance there is no any other available support to us...*

**Researcher: what kind of support do you get from SEVOTA?**

*Umwiza: SEVOTA has put us together it help us to fight against loneliness. When we meet at SEVOTA we share everything and when we leave the place we feel relieved. Our sadness is over and we feel happy with positive thoughts about ourselves. Meeting with other women is the most important support. Here at SEVOTA we (members) are working closely with the coordinator. Each member is assisted according to the problems she reports. For example some come by saying, “you see I have a problem of not having been able to go to school”; for that one we put her on the list and she goes to school. Another one comes by telling “you see me I’m sick”; for this one we put her in the category of those who need medical treatment or to see a counsellor... it really depends on the needs of each and every one. There were also those who have been given goats, cows or small loans... To tell you the truth we are lucky to have SEVOTA... (Laughter).*

**Researcher: Are you neighbours supporting you?**

*Umwiza: It depends; some are saying that we are not respectful women because they know what happened to us during the genocide, those are disturbing us instead of being supportive. But there are others whom we are very close to, who are our friends, and those are very supportive. We are helping each other. They can cultivate for us. Recently they helped me to fix the roof of my house which has been destroyed due to the heavy rain.*

**Researcher: What do you think might be done to help those women who are psychologically affected by the long term effects of rape?**

*Umwiza: There many things that need to be done, but the most important I think it to help them to be treated specifically from the illness they are having as a consequence of being raped. Some are having psychotrauma (ihahamuka), others like me they are having pain all over the body like having back pain, abdomen pain, headache; we don’t sleep because even during the night we are invaded by bad memories.*

*To help us to get money in order to put in place some project with income generating. You know poverty causes despair and discontent. When you are poor and not having anything to feed your children, you become crazy.*

*But the fact that we are in support groups helps us to earn income from different activities we are doing, but the money is little and not enough. We need big sponsors for sustainable projects. Our support group is really helpful for us, it protects us from feeling lonely. Here we share our stories with others who have gone through the same experience and we feel relieved. What I like from our support group it that any kind of problems are addressed, even though all problems can't be solved in our group, other women may advise you what to do in order to have your problems solved.*

*What I have noticed which is helping us also is what we have learnt from health care professionals. Thus, mental health professionals should continue to come and teach us how to handle our problems in a specific way.*

*To pray, to dance, to have a good time with other women, but also everyone must know how to take care of herself, not waiting for others to come and help her to feel better.*

*I have been very talkative. I have to stop here. I have said everything I know that can help us to heal from the consequences of rape.*

***Researcher: I was listening to you attentively and as you said if everyone is trying to take care of herself with support from outside, there is a chance that rape survivors may heal from the consequences of their experience of being raped. Do you have anything to add on what you have said?***

***Umwiza: I want just to conclude by saying that that SEVOTA is helping us and I can advise other women rape survivors who don't have any support group to create one because it will help them to solve their problems. I think that is good advice because other women I have spoken to said that support groups were helping them in different ways. Do you think it is good advice?***

***Researcher: Yes I think it is good advice because if you are saying that your support group is helping you and other women, it must also be helpful for others. If you know other rape survivors, it will be a good idea to talk to them and encourage them to attend your group.***



*Umwiza: If you find my idea good then I will go and talk to other women I know who have been raped and are isolating themselves at their home. I think that learn how useful it is to be in a support group and maybe they will join us. If you are still around, I will tell you if they have accepted to come.*

*Researcher: I will be still around because I would like to meet you another time for you to check the transcript interview to see if I have correctly written what you have said. You can make corrections and give me additional information too. I would also like to meet you for a third time in the group with the other women who participated in this research for the feedback on the propositions made in taking care of women who suffer psychologically from the after effects of rape.*

*Umwiza: It will be great to discuss this with you again.*

*Researcher: Thank you very much for your time and for the information shared. I appreciate it.*

## Annexure 15: Nvivo codes

### Torture

[<Internals\\P2 Zaninka>](#) - § 1 reference coded [0.59% Coverage]

*I remember one day when they finished raping me it was very hard to me to walk*

[<Internals\\P2 Zaninka>](#) - § 2 references coded [1.55% Coverage]

Reference 1 - 0.57% Coverage

*My husband told them they better kill me rather than making me suffer that way.*

Reference 2 - 0.97% Coverage

*He told to my rapists why you torture her in that way you better kill her directly rather than letting her to suffer at that level.*

[<Internals\\P1 Umwiza>](#) - § 1 reference coded [1.11% Coverage]

Reference 1 - 1.11% Coverage

*I was gang raped*

[<Internals\\P1 Umwiza>](#) - § 3 references coded [2.89% Coverage]

Reference 1 - 0.58% Coverage

*They were too many I don't even remember their numbers.*

Reference 2 - 1.60% Coverage

*He raped me every day and after those four days, he said he is no longer interested in me and he called a gang of interahamwe (militias) to rape me again*

[<Internals\\Akim english version>](#) - § 1 reference coded [0.95% Coverage]

*but she also had a big scar on her thigh, that's where her rapists pressed a hot steam iron when she had refused to open her legs so they burned her thigh with the iron she opened her tight and then they raped her*

[<Internals\\Fidens English 25May>](#) - § 1 reference coded [1.02% Coverage]

Reference 1 - 1.02% Coverage

*you see one woman could be raped by many men, I know a woman who was raped and after her breast was cut off, so it is obvious that such women have suffered indeed.....*

[<Internals\\Gatete English 24may>](#) - § 3 references coded [5.80% Coverage]

Reference 1 - 1.70% Coverage

*And I collapsed when I came back to my senses I found that my head had been almost smashed, and legs and body, arms were broken, I had sperm in my genital part and then realized that I have been raped*

Reference 2 - 1.00% Coverage

*They took me to a river but I narrowly escaped being thrown into it, I was exceptionally lucky.*

Reference 3 - 3.09% Coverage

*they did all sorts of cruelty to me; they raped me, they threw me into a river and it refused me, you can't imagine that they even buried me among the dead, I've been so disabled because of their cruel beatings; my arms, head, legs have been severely hurt so I can't walk on my feet;*

[<Internals\\Muvvara English 28May 2012>](#) - § 3 references coded [0.99% Coverage]

References 1-2 - 0.50% Coverage

*Yes I know some, but the case I remember most is a woman who was raped in a horrific way. They have damaged her genital organs and later she got her uterus removed.*

Reference 3 - 0.49% Coverage

*but it can't solve the problem of the one whose reproductive organs have been removed and won't give birth anymore; for the one whose uterus was removed you can't refix*

[<Internals\\Rusaro englishversion 28May 2012>](#) - § 4 references coded [6.26% Coverage]

Reference 1 - 2.40% Coverage

*I was 14 years old, I remember those who raped me first were my neighbours, the one who tried to rape me was a big man, when he tried to penetrate me, he failed because the organ was still hard, I was still a virgin; the man kept forcing and then realised that if I screamed out people would catch him because I was near their home; he let me go; he pushed to penetrate but his organ couldn't penetrate. My case went from bad to worse when he took me far away from home and he raped me savagely so I couldn't bring my two legs together, I couldn't also leave the place. He left me there and I had difficulties leaving the place; he came back in the evening and met me there; he had left me in the bush.*

Reference 2 - 0.90% Coverage

*They gang raped me, one after another; I remember that the last one had a stick and he said rather than dirtying my genital organ me I'm going to put this stick into her genital organ and he did*

Reference 3 - 1.12% Coverage

*On the way we came back to look for food, the interahamwe that had a child of my age raped me but for him it was beyond imagination... he raped me while I was in a sitting position, I suffered a lot so I felt the back was split. You see I was raped by many men and it is the miracle of God for me to be still alive.(silence)*

Reference 4 - 1.84% Coverage

*but I can't compare it with the one I endured at that time during genocide; they can't be compared. This is because I suffered all the time, day after day, I was living painful moments. The one who penetrated me first I felt it like a sword and those who followed I also felt like a sword cutting me through; I can't describe it and say it was to such and such degree, it was indeed beyond bearing. It reached a point when I became the laughing stock of children so wherever I go they aped the way I walked because I couldn't walk normally.*

**Annexure 16: Approval letter from the editor**

Editing Declaration

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2013-05-15

TO WHOM IT MAY CONCERN

Thesis Title: MANAGEMENT OF THE LONG TERM PSYCHOLOGICAL EFFECTS  
OF  
RAPE AMONG WOMEN SURVIVORS OF THE 1994 GENOCIDE IN RWANDA-  
GROUNDED THEORY APPROACH

Author: Donatilla Mukamana

This is to certify that I have edited the above thesis from an English language perspective only, and have made recommendations to the author regarding spelling, grammar, punctuation, structure and general presentation.

A marked-up version of the thesis has been sent to the author and is available as proof of editing.

I have had no input with regard to the technical content of the document and have no control over the final version of the thesis as it is the prerogative of the student to either accept or reject any recommendations I have made.

Therefore, I accept no responsibility for the final assessment of the document

Yours faithfully

A handwritten signature in black ink, appearing to read 'Margaret Addis', with a horizontal line underneath.

Margaret Addis

