

Consequences of Gender Based Violence on Reproductive Health: A case study of female patients in Lemera Hospital in the Democratic Republic of Congo.

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DECLARATION

I, Theo Ganzamungu. Zihindula declare that

The research reported in this dissertation, except where otherwise indicated, is my original work. I further declare that:

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Submitted in partial (for coursework) fulfilment of the requirements of the degree of Population Studies in the School of Development Studies, University of KwaZulu-Natal, Howard College

DEDICATION

This dissertation is dedicated to all women of the Democratic Republic of Congo who have been victims of the multiple consequences of gender based violence during the conflict from the year (1996 to 2010). It is more specifically dedicated to the survivors of rape living at Lemera/Panzi General Referral Hospital in Bukavu, in the Eastern province of the DRC

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My Million Thanks to you all people

ABSTRACT

This study was conducted in order to explore the experiences of survivors of gender based violence in the Democratic Republic of Congo. The aim was to determine the impact of gender based violence on the reproductive health of women. The study was carried out at a hospital in the eastern province of the country. In-depth interviews were conducted with women survivors of rape and informant interviews with staff at the hospital. A total of twenty one participants participated in the study. The findings show that women suffered humiliation, physical and psychological torture during their rape. Some women were raped by a number of men. The rape also had serious consequences for their sexual and reproductive health. Some of the effects of their rape were long-term: it resulted in an unwanted pregnancy or HIV/AIDS. Many of the women expressed their fears for the future. They were particularly worried about their children, especially those who were divorced following their rape and those who lived with HIV/AIDS.

LIST OF ELLIPSIS and ABREVIATIONS

ANC: African National Congress
CEPAC: Communauté des Églises Libres et Pentecostes en Afrique Centrale
Community of Free Pentecostal Churches in Central Africa
CEDAW: Convention on the Elimination of All Forms of Discrimination against Women
CSVV: Centre for the Study of Violence and Reconciliation
DRC : Democratic Republic of Congo
GBV: Gender Based Violence
HIV: Human Immunodeficiency Virus
HRW: Human Rights Watch
IASC: International Arctic Science Committee
IFPP: Irish Forum for Psychoanalytic Psychotherapy
NGO: Non Governmental Organisation
NPRH: National Programme on Reproductive Health
PTSD: post traumatic stress disorder
RFDP: Raison de Femme pour la Défense de Droits et la Paix
Women's Reason for the Rights defense and Peace
SADC: Southern African Development Community
SFVS: Synergie des Femmes pour les Victimes des Violences Sexuelles
Synergy of women for the victims of sexual violence
WHO: World Health Organization
STIs: Sexually Transmissible Diseases
UNAIDS: United Nations programme on AIDS
UN: United Nations
UNFPA: United Nations Population Fund
UNESCO: United Nations Educational, Scientific and Cultural Organization
UNDP: United Nations Development Programme
UNICEF; United Nations Children's Fund

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CHAPTER ONE

INTRODUCTION

1.1 Background and outline of research

In the year 1996 the Democratic Republic of the Congo had known a so called liberation war led by the former president Laurent Desire Kabila, who after his death in early 2001 was succeeded by his son Joseph Kabila. This war has caused many problems, but the most serious one still prevalent in the country is the problem of gender based violence. A report from Amnesty International indicates that the eastern province was the most affected by the war and that at least 40,000 female civilians have been raped over the past ten years during the conflict in the Democratic Republic of the Congo (DRC) (Cherie, 2006). While the above statistics represent the whole country, the United Nations reports 27,000 sexual assaults in South Kivu province alone (UNAIDS, 2005-2006).

Cherie (2006) compares the Congolese situation with what has happened in Rwanda in the 1994 genocide, and observes that in the DRC gender based violence is used as a weapon to weaken the fabric of communities that women work so hard to maintain. Furthermore, UNFPA (2006) reports that fear of sexual violence severely restricts the economic activities of women for example, going to the market, collecting water, gathering firewood, among others. In order to document the experiences of survivors of gender based violence, the study draws on in-depths interviews with female patients at a hospital in the eastern province of the DRC.

According to Baker (2007) there is no single or universal definition of gender-based violence (GBV). The meaning of GBV differs according to country, community and legal context. The lack of a clear and commonly accepted language inhibits the development of an effective reporting system and/or databases, and thus hinders prevention, monitoring and advocacy efforts. The term “gender based violence”, in its widest sense, refers to the physical, emotional or sexual abuse of a survivor. This study adopts the inclusive terminology employed by the World Health

Organization (2003b), which defines gender based violence as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work”. The scope of the definition is here expanded to include forced sex, sexual coercion and rape of adult and adolescent men and women, and child sexual abuse. The definition also includes: the use of physical violence or psychological pressure to compel a person to participate in a sexual act against their will, whether or not the sexual act is consummated; a sexual act (whether attempted or consummated) involving a person who is incapable of understanding the nature or significance of the act, or of indicating his or her refusal to participate in the act; e.g. because of disability, or because of the effects of alcohol or other substances, or because of intimidation or pressure (WHO, 2003b; Saltzman et al., 1999).

The term gender-based violence is used interchangeably with the term violence against women, although the United Nations (UN) has narrowed the definition of violence against women to refer to “any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life” (UN, 1993). Gender based violence is an umbrella term that includes, at least, rape, attempted rape, sexual abuse and sexual exploitation. It involves “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work” (IASC, 2005).

According to UNESCO (1999: 53) GBV is defined as any act of violence that is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. It further stresses that violence against women is one of the crucial social mechanisms by which women are forced into a subordinate position (UNESCO, 1999:52). Contextualizing rape in times of peace, Cowling cited in Mukamana (2004:8) defines rape as an act of vaginal, oral or anal contact involving force or threat of injury, or when the victim is asleep, unconscious,

severely drugged or psychologically helpless. According to Gottschall, rape in war (unlike rape in peace) is identified not as a crime of sexual passion but as crime motivated by the desire of man to exert dominance over women (Gottschall, 2004). Other authors like Hayden (2000), however defines mass rape as “social action, by a coordination of a large numbers of rapists”.

Examining its causes, in line with the UNFPA (2005), gender-based violence is rooted in structural unequal power relations between men and women in society. It is the most direct form in which men can and are using their power over women. Furthermore, power inequalities between women and men and the masculine culture are the major causes of gender based violence.

1.2 Gender based Violence and HIV/AIDS

Looking at the risks of gender based violence, the evidence is compelling. Research conducted by the Pan American Health Organization (2007) shows a direct link between gender-based violence and HIV infection, as well as unwanted pregnancies. These findings are supported by studies carried out in Rwanda and Tanzania that indicated that the risk of HIV infection among women who are victims of gender-based violence is up to three times higher compared to women who have not been subjected to violent behaviours (UNAIDS, 2007). It has also been discussed that, just as rape against women increases their risk to HIV, it is also one of the main causes of unwanted pregnancies. According to Goodwin (2004):

“HIV positive women as a result of their status are more likely to face stigma, discrimination, and violation and rights violations from their intimate partners, families, communities and states. There have been cases reported of HIV positive women being denied their sexual and reproductive rights by health practitioners merely because of their HIV status. HIV positive women also face the possibility of disinheritance and dispossession from their families”.

Gender inequality and violence against women often inhibit women and girls’ abilities to take full advantage of crucial, even life-saving, services. A recent UNFPA (2006) and WHO (2005) report notes that in the context of AIDS, violence against a woman can interfere with her ability

to access treatment and care, and also maintain adherence to antiretroviral therapy or feed her infant in the way she would like.

It is important to indicate that gender based violence increases the risk of HIV/AIDS among women in the same way it does for unwanted pregnancies. For example a report from Amnesty International (2007), shows that among women who were identified as rape victims in the North and South Kivu alone, 40% of them were pregnant or have given birth to a child whose father will forever remain unknown. These however are not the only consequences that rape victims suffer. Holmes et al. (1996: 175) stated that: “in conflict situations, raped women are often traumatized and stigmatized. In many cultures, women can be abandoned, divorced, and declared unmarriageable if they have been raped. Furthermore, many raped women become impregnated; contracts sexually transmitted infections, and suffer gynecological injuries that require reconstructive surgery”. While in case of rape it is not easy or possible to use contraception, research indicates that in the DRC, the issue of contraception is still debated and contraceptives not easily accessed (Kayembe et al., 2006:15).

However, Amnesty International (2007) has shown that despite the large public attention that these rape cases received, the DRC is not the only nation in which rape during war time occurs. Goodwin (2004:5) testifies that it was also the case for Rwanda during the 1994 genocide when the report from Amnesty International and the Human Right Watch (HRW) estimated that at least 15,000 women had been assaulted and raped during the genocide. However, what makes the case of the Eastern DRC personal and unique, according to the report from Amnesty International (2005), is the fast spread of HIV /AIDS and the fact that it has tripled from the beginning of the conflict to date. Additionally, the report from Dr Denis Mukwege the director of Panzi General Referral Hospital indicates that out of the total rape survivors being treated at Lemera hospital 40% are HIV positive (Amnesty International, 2005).

It is clear that HIV/AIDS is often deliberately used as a weapon to infect women through rape. Experts estimate that some 60% of all combatants in the DRC are infected with HIV/AIDS (Amnesty International, 2007). It is by virtue of this that the journalist Jan Goodwin (2004) describes rape as a cheaper weapon than bullets, implying that soldiers use HIV/AIDS as

ammunition to demolish and devastate. The epidemic has become a weapon with which to continually harm the victims. The onset of the HIV/AIDS pandemic found a bosom friend in the pandemic of rape against women. The intersection of the two remains a testimony of the cost of ignoring calls to end violence against women (Goodwin, 2004). It remains a stark reminder that the violation of rights in one sphere leads to more serious violation in other spheres resulting in compounded situations.

Despite the establishment of the National Program on Reproductive Health (NPRH), which seeks to promote contraceptive use, the proportion of women of reproductive age who regularly use modern contraceptive methods remains consistently low in the DRC (Bertrand et al., 1985). The prevalence of the use of modern contraceptives among women of reproductive age generally does not exceed 5%, and the trend has not changed since 1983 (Bertrand et al., 1985). The DRC experiences both high fertility of 7.3 children per woman and a high maternal mortality rate of 1298 per 100,000 live births (UNICEF, 2002). These high rates demonstrate the need for specific and effective strategies to improve reproductive health that is being worsened by conflicts and wars leading to women being raped regularly in the eastern province of the country (Amnesty International, 2007). However, considering the definition of the term reproductive health, one can easily conclude that the DRC still has a long way to go in addressing and eradicating this problem. According to the WHO (2005) The understanding or meaning that people attach to reproductive health is the right of all women and men to be informed, to have access to safe, effective, affordable, and acceptable methods of family planning of their choice, and to have access to appropriate health care services that enable women to safely go through pregnancy and childbirth (2005:15). Furthermore, the Programme of Action of the International Conference on Population and Development ICPD (1994) defined reproductive health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”.

Existing evidence has also revealed that rape is the major way that increases the risks of unwanted pregnancies. According to HRW (2002), in a country like the DRC where abortion is forbidden by law, even in the case of rape the risks of unwanted pregnancy and unsafe abortion are very high. Carpenter (2000) documents the problem of unwanted pregnancies and the

findings reveals that, humanitarian policy documents and guidelines for the protection of children in conflict situations have failed to describe how to address the situation of children born to rape victims. The report suggests that “these children do not necessarily experience war in the same way as child soldiers; refugees, displaced children or war orphans do, but are rather victims of abuse and stigma during and after the war”. However, little research has been conducted into the living conditions of children born following rape and it can justifiably be assumed that so-called ‘rape children’ face high risks of infanticide, stigma, neglect and discrimination. A report by UNICEF (2005) indicates that, some children have been called ‘Interahamwe’ after the Rwandan militia who had crossed the border to DRC, and are thus stigmatized for life.

Furthermore, GBV may contribute indirectly and directly to unwanted pregnancies. Women who suffer sexual abuse during their youth may more often have unwanted pregnancies. The reasons may however be multiple: abuse has been associated with loss of control, anxiety, and fear -all of which can contribute to risky sexual behaviour. For example, unprotected sex or forced rape; impair a woman’s ability to use contraceptives consistently, or make it difficult for her to negotiate contraceptive use with the perpetrator. Women living in situations of sexual violence may also not be able to discuss contraceptive use. Moreover, since many cases of rape and incest go unreported, the number of resulting pregnancies can only be estimated. It may be assumed that many of these pregnancies are unwanted, because access to pregnancy contraception is unavailable or restricted in many places (de Bruyn, 1999).

This study focuses on two aspects of the consequences of reproductive health: the risks of unwanted pregnancies and the spread of HIV/AIDS. This with acknowledgement that Africa has the highest level of HIV, and there is a need to address and prevent the fast spread of the virus as well as unwanted pregnancies, which are dominating in this particular province of the country. This study aims to fill the knowledge gap in an under-researched country and was motivated by the fact that the burden of reproductive health is shouldered by women alone who face huge barriers and difficulties when it comes to their health needs, and recognizes that fact that they face additional violence during times of war.

1.3 Aim of the Study

The aim of this research was to explore the experiences of survivors of gender based violence (GBV) by:

- documenting the experiences of gender based violence of women in a conflict situation;
- determining the risks associated with gender based violence and how it impacts on reproductive health outcomes;
- ascertaining the risk of unwanted pregnancies and HIV infection among women survivors of gender based violence;
- examining the barriers to changing behaviour as well as the obstacles women face in protecting themselves against gender based violence

1.4 Theoretical Framework

In order to explore violence against women in the context of war, it is important to examine theories on rape in everyday settings. The theoretical approaches to gender based violence or specifically rape, have taken many different paths from biological theories to the control-theories. I will attempt to outline four major theories pertaining to rape: the biological theory, the developmental theory, the commodification theory and lastly the control theory. Although all four theories are considered in this study, the commodification and the control theory are most relevant to the study.

Biological Theory

Thornhill (1999) outlines the biological theory of rape in his book, “The biology of human rape”. Rape is viewed as an evolutionary concept, in that it promotes group and/or reproductive success. Thornhill (1999) asserts that rape increases male numbers and thereby the reproductive success of males. He also argues that rape is a “byproduct of men’s adaptation for pursuit of casual, non-committal, consensual sex.” Rape becomes a natural part of the male psyche, an adaptable feature. It is seen as something that innately exists within some males because of high levels of testosterone, therefore it is something that cannot be eliminated or destroyed (ibid).

Opposing theorists argue that, it becomes risky to attach a biological definition to rape implying that it is a natural process and, one that must be adapted to and accepted as a part of humanity. Thornhill (1999) citing Baker (2007:1) states “rape appears to have existed in human evolutionary history, as seen in women’s adaptations to deal with rape” (2007:1). When examining rape during times of conflict, this approach suggests that rape becomes a situation to adapt to because its existence appears inevitable. Perhaps women’s silence is their way of adapting to a situation that looks unchangeable according to biological theory.

Commodification Theory

The commodification theory argues that rape is a crime of property. Sex becomes a commodity, which is stolen from women by a rapist. Baker (2007), in an article, entitled “Once a rapist” states:

“For some, sex is a commodity, and if sex is a commodity, then taking it is theft...we live in a culture that rarely discusses sex as anything other than a commodity....Instead, young men are bombarded by a culture that sexualizes commodities and commodifies women’s sexuality. Companies sell products by selling the sexuality of the women endorsing the product. The product and the sex are purposefully conflated. Sex is also purposefully commodified... what motivates rapists may not be substantively different from that which motivates men who go to prostitutes or purchase tickets to peep shows. None of these acts requires mutual enjoyment or emotional intimacy and they are called sex. Thus, men are able to satisfy a desire for sex without having to incorporate the complexities of sexually intimate communication...This cultural endorsement of marketing of sex as a commodified good leads to an increased desire for, and sense of entitlement to sex...Thus it is not surprising that one study found thirty –nine percent of convicted rapists were caught in the course of robbery. As many of these men conceded, they raped her because she was there” (Baker 2007).

In this excerpt, Baker (2007) points to rape stemming from a societal push of making sex a commodity. A commodity is something that can be easily exchanged and made readily available. Sex is no longer something sacred, shared between two individuals; it has become mass marketed, publicised. Then sex becomes something that can be easily acquired and sexual desire something that needs to be satisfied by any means necessary. Rubin (1975) points to the ways in

which women's bodies and sexualities have been exchanged and commodified, which adds to the inequalities in society. Women are given in marriage, taken in battle, exchanged for favors, sent as tribute, traded, bought and sold (Rubin1975:118). Therefore, because sex, sexuality and women's bodies are treated as objects some men find it justifiable to take, sell, and destroy.

Development Theory

Malamuth and Hellmann (1998) propose a development theory which describes rape proneness among men as not caused by genetic variation rather by developmental events over the course of their lives involving learning. Their analysis suggests that men who rape are more likely to come from an extreme developmental background that involves "impersonal and short-term social relationships and backgrounds in which manipulation, coercion and violence are valid ways of conducting social relationships (1998:2)". The theory thus attempts to create a correlation between a person's background and their rape proneness. In the end they assert that rape is related to an insecure sense of masculinity, hostility, distrust, and a desire to subordinate women (ibid).

Control Theory

The last theory views rape as a mechanism of control. The assumption of gender roles plays a large role in this theory. In the eyes of the rapist, women are viewed as submissive and obedient to men who are the aggressive and dominant partners. There have been numerous studies concluding that there are no sexual functions fulfilled in the male brain whilst raping. Rather what gives him satisfaction is the humiliation and degradation of the victim and a sense of power and domination over women (Seifert, 1996:36).

Elaborating on the above, it has been suggested that in control theory, the destruction of a culture is the ideal goal (Seifert, 1996). Marie-Madeleine Kisoni, a Congolese counselor who works with raped women and children, comments about these rapes not being just an individual act. "Why do they rape a child... we don't understand there's spirit of bestiality here now. I've seen 2-and 3year olds raped. The rebels want to kill us, but it's more painful to kill the spirit instead" (Goodwin, 2004:18). Kisoni draws upon the effect these acts against women and children have on the community. It would be quick and easy to kill people, but to destroy their mental and spiritual wellbeing, is a destruction that lasts forever (Amnesty International, 2006).

The question arises, how applicable are these theories in explaining violence against women during times of conflict? The biological theory does not really fit the pattern. During times of conflict there are sharp increases of sexual violence against women with negative effects on their reproductive health (Moffett, 2006:1310). Thus if the biological theory was true there would be no difference between instances of rape during war and during times of peace. But if women are being used instead of other methods such as destroying land or animals, then the commodification theory is applicable. Women are viewed as representations and objects during times of war, they are seen as representations of the nation that can be easily destroyed and humiliated. The third theory relies on the assumption that only a certain type of soldier would commit these atrocities; one that has a serious delinquent background and lack of significant relationships. Unfortunately, because rapes in times of war are virtually undocumented, it is not possible to know the personality type of the rapist and the diversity between rapists. Therefore the developmental theory is more applicable in individual cases, rather than mass systematical rape.

The control theory becomes applicable because in the case of mass rape during times of war, the act of rape is no longer about fulfilling the sexual needs of the rapists. It is about control, domination and humiliation of the opposing side. Scarry (1985) argues that sexual torture and rape are vehicles for exertions of power. Seifert (1999:40) states: “this structure may be in part premeditated, seems for the most part unconscious, and is in either case based on the nature of pain, the nature of power, the interaction between the two, and the interaction between the ultimate source of each—the body, locus of pain, and the voice, the locus of power. Sexual torture is used to control the power of women and therefore transfers that power to the male perpetrator” (ibid).

Koo (2002) states that, rape is always used as a form of torture and a tool of political power. Rape and the threat of rape are used to “gather information from women, to instill urgency into ransom-payers, as a means of punishment and as a tool of intimidation and humiliation to ensure civilian compliance” (Koo, 2002:528). Seifert cites Pohl’s (1992) argument that rape displays an unconscious disrespect for women that exists in western culture. Pohl argues that even in times

of peace, evidence for the disrespect of women is evident in the arena of socially accepted pornography and desensitises the physical violence of men against women (Seifert, 1996:38). Pohl states that: “war becomes the vehicle in which men can play out their unconscious beliefs about women in the form of rape” (ibid). Campanaro (2001) asserts by virtue of their gender alone, women become victims of one of the most appalling forms of war tactics.

Littlewood (1997:8) claims that “sexual violence has been argued to be the depersonalisation of women, a conscious process of intimidation by all men which keeps all women in a state of fear”. Amongst soldiers at war, there already exists a dehumanising mechanism which is carried over onto their view of civilian women during times of conflict. In most wars, a tactic among the combat teams is to view the enemy as less than human, which makes it easier for them to fight them without a conscience. The enemy is no longer referred to as human; rather they are given nouns as names. For example, during World War II, The Japanese were called “Japs”. The mind must first eliminate any human characteristics attached to the enemy. Consequently, the same defense mechanism is used among civilian women. They are no longer viewed as women but as a physical representation of a nation. They are merely seen as vehicles to devastate and humiliate a nation as is the case in both the neighboring countries of the DRC and Rwanda during the war times. However, rape attempts to achieve humiliation, not only on a personal level but on a national scale. Cherie (2006) describes rape and other sexual acts of violence as warfare; as a means to humiliate shame, degrade and terrify an entire group (2006: 10). This displays the unfortunate success of mass systematic rape and the effect it can have on its victims. For example in Rwanda during the 1994 genocide, militia and the military frequently preferred to sexually abuse women in front of their families or in front of the entire village (Shanks, 2000:154). Rape is no longer a personal act between the rapist and the victim; it becomes a publicised defamation of a woman’s sexuality. Her sexuality and body are put on display and abused publicly as means of warfare. She becomes minimised to a body, something which can easily be destroyed to never reproduce again.

Linking the above to feminist theories, it is argued that rape against women in African countries is perpetuated by patriarchal power. Weedon (1987:2) concurs: “this power relation takes many forms, from the sexual division of labour and the social organization of procreation to the

internalized norms of femininity by which we live”. Furthermore, feminists and other writers want to see an end to this endemic act, and they encourage people to be able to envision a relationship between the sexes that involves sharing, warmth, and equality of the social system in which these values are fostered (Thornhill 1999; Weedon 1982; Baker 2007 and Seifert, 1996).

Studies conducted by Landes (1998:11) emphasise that “feminist theory aims in part to overcome the gender hierarchy that gives men more power than women”. Cohen in Schwartz, (1997:84) describes feminist theory as our tutor, which broke open the convenient, conventional understandings that, blanketed in denial, had masked any meaningful opportunity for knowledge and understanding of the central condition of many women’s lives: “that they are ruled by male violence”. Therefore, for this study the power debate will provide insight as to why rape occurs and its long-term effects. In the context of feminist discourse, Mackinnon argues that in the male system, rape of women is an act by which some men are against other men, in other words it may be a sign and a form of expression to men, a way men communicate with another, but to women it is real violence (Mackinnon, 2006:171).

However, the point here is not to provide a definitive response to this title of this study, but to show that this theoretical framework helps us to gain a deeper understanding of the context of GBV during times of war in the eastern province of the DRC and the consequences of this act on the reproductive health of women in this province as well as in the country at large.

1.5. Organization of the Dissertation

This study is made up of six chapters. Chapter one is the introduction that comprises; the background of the research, the definition of terms, the objectives and aims of the study, the intersection between gender based violence and HIV/AIDS, and the theories informing the study. Chapter two reviews the literature and looks at various elements such as; the causes and consequences of gender based violence, HIV/AIDS, unwanted pregnancies, contraception and the general aftermaths. Chapter three outlines the methods used for data collection and data analysis. Chapter four presents the findings of the study and the implications of the results. Chapter five presents the discussion of the results, the recommendation and the final conclusion.

CHAPTER TWO

LITERATURE REVIEW

2. Introduction

The literature review aims to synthesize the findings from evidence-based interventions, and to review previous studies on gender based violence. It is structured around two components namely: the causes and consequences of gender based violence. In line with Terre Blanche and Durrheim (1999), this literature review involves more than merely citing as many sources as possible, but highlights pertinent literature and contributes to the field by providing a novel and focused reading of the literature.

2.1 Causes of Gender Based Violence

Examining the causes of gender based violence, Taslitz (1999:25) argues that, “for most men, aggression, whether physical or verbal, is instrumental, a way of controlling others, attaining social or material benefits, dominance, and self esteem”. In other words, aggression is central to a man's behavior. And men are central to society's institutions. Therefore, male aggression creates the atmosphere for rape because society grants men the role of control over women in all institutions. Lefkowitz (1999) supports this view indicating that, what he has observed in life are too often stories about military bases, big business, universities, professional sports organisations where women are humiliated and abused by men who think that they have license to do whatever they want to them.

In war, rape has been used as a strategic weapon to destroy and demoralise the civilian population. A report from HRW (1998) indicates that by systematically targeting women, the symbolic life-source of the community, the enemy aims to attack the family structure. Furthermore, if a woman is impregnated, it grants a victory to the enemy because of the humiliation of being forced to carry the seed of the enemy. The rapists in this conflict are men from armed groups including Rwandan soldiers, Rwandan Hutus, Burundian rebels of the Forces

for the Defense of Democracy, the Mai-Mai, the Front for National Liberation, and the combatants of the Congolese army (Jefferson, 2004). However, in patriarchal societies like the DRC in general and South Kivu in particular, women do not have adequate economic resources to survive. Their subordination to men is a byproduct of their economic deficiency and the fact that men own all economic opportunities (including their women). This subordination of women finds expression in the fact that some women victims choose not to come forward to report their ordeals. For traditional women, to report a crime committed by men against them, is to have subscribed to the 'alien atmosphere of foreign inspiration' (Narayan, 1997:6).

2.1.1 Global overview

Resick (1998) stresses that in armed conflicts sexual gender based violence is often used as a tactic in ethnic cleansing or as part of a strategy to destroy community bonds. The United Nations (1995) observes that women may be viewed as trophies and are forced into sexual slavery and kept to provide domestic services to the armed troops. One of the root causes of sexual violence is the subordinate status of women and girls in many countries. Itano (2009) claims that discrimination and unequal power relations lie at the heart of women's greater vulnerability to gender based violence and that addressing the inequality that is deeply entrenched in all societies must be central to their responses to the issue. As discussed above, many factors can contribute to the vulnerability of women in a Congolese society and are thus major causes of GBV. However, this is not unique to the DRC only; additional reports have shown similarities in most African countries such as South Africa, Zimbabwe and others. Research conducted in South Africa suggests that it has one of the highest rates of rape in the world, where about 50,000 rapes were reported in 2001 alone, although women's groups say this is just a small percentage of the total number. They estimate that a woman is raped every 26 seconds and a child every 15 minutes (Itano, 2009). The South African police service gives a slightly lower estimate of one woman every 36 seconds (Jewkes, 2007). Other activists say that the rape problem in South Africa is due largely to the lack of power of women, which is both a legacy of apartheid and of traditional African beliefs about the role of women. Ultimately, many observers say that one of the main reasons rape is so prevalent in South Africa is because the justice system is so ineffective in dealing with rape. Most rapists walk free. Of the more than

50,000 rapes reported to police across the country in 2001, only about 5,000 resulted in convictions (Itano, 2009).

According to Jewkes et al. (2003) many people in South Africa have been extremely brutalised by the political violence in the country's past, the disruption of families and communities, high levels of poverty, and very high levels of violence of all forms. The direction of much of this violence at women and girls might be explained by sexual inequalities, a culture of male sexual entitlement, and a climate of relative impunity for rape (Jewkes et al., 2003). Pitcher and Bowley (2002) suggest the myth that having sex with a virgin will cure a man of the HIV infection, is an important cause of women rape and that of child rape in particular. Furthermore, research in South Africa suggests that the high rape levels are due to ideas about masculinity based on gender hierarchy and that the sexual entitlement of men is rooted in an African ideal of manhood (Jewkes, 2007).

Certain community and societal-level risk factors are associated with higher or more severe rates of sexual violence. WHO (2003a) identifies the following factors that support male superiority and entitlement; social norms that tolerate or justify violence against women; weak community sanctions against perpetrators; poverty; high levels of crime and conflict in society generally. All these factors have been presented above and apply both to the case of the DRC as well as South Africa.

Research conducted in different countries indicated that, traditional gender roles prescribing female submission and male dominance are linked to rape. In Australia, Germany, and Japan, rates of violent sexual offenses were related to national levels of dominant masculinity (ibid). Neapolitan (1997) argues that rigid gender roles and promotion of an ideology of male toughness are related to violence against women.

This supports the statement made by Muehlenhard, Danoff-Burg, and Powch (1996) that, different rapists commit rape for different reasons, and any one rapist may rape for different reasons at different times. However, many cultural factors seem to contribute to rape, and the following commonly held myths contribute to date and marital rape:

“a man must have sex to prove his masculinity; when women say no to sex, they really mean yes, so men should ignore women's refusals; if a woman engages in kissing or petting, she is obligated to engage in sexual intercourse; what goes on between a husband and a wife is no one else's business, and the man should be head of the household. These are dangerous myths that can lead to rape” (Burt et al., 1991).

2.1.2 Women's Status in Congolese Society,

Women are traditionally seen as second-class citizens in the DRC. In Congolese society, there exists an old set of rules called the Family Code that subordinates women by requiring them to obey the husband, the recognised head of the household (HRW, 2002). While the family code has been abolished and replaced by equalising reformed family codes, this tradition is deeply rooted, and the status of women remains subordinate to men. The old code dictates that a woman must live wherever her husband chooses to live and that she requires her husband's authority to bring a case to court (Jefferson, 2004). Furthermore, the management of wealth is to be entrusted to the husband. The fact that women have been relegated to lower status in society does not necessarily imply lesser importance. It could instead be an attempt to protect women because of their reproductive importance to the community (Galleguillos, 2007). A virgin-whore dichotomy is created, such that society holds virgins in the highest regard and tries to protect them. If a woman is defiled, she is seen as a whore and worthless.

Due to their lower status, women are reluctant to ask their husbands to use condoms to protect themselves against HIV/AIDS and other sexually transmitted diseases. Additionally, women tend to have large families, especially in rural areas, thus limiting a woman's options for independence from her husband (HRW, 2002). This inequality extends to all facets of daily life, including the opportunities for girls to get an education because educating boys is considered more important, and thus a higher percentage of boys attend school than girls in the DRC (Kirchner, 2007). This enduring cultural norm is known by the perpetrators of GBV and is specifically used to destroy the society psychosocially by targeting its most protected members.

2.1.3 Construction of Masculinity

Rape is also a result of the construction of masculinity that armies offer their soldiers, and the idolisation of masculinity. It is a confirmation and strengthening of masculinity (Hong, 2000). The construction of masculinity and its confirmation has its roots in everyday life. In his research conducted in Sub-Saharan Africa, Baker (2007:5) writes that the chief mandate or social requirement for achieving manhood in Africa, in other words to be a man is to achieve some level of financial independence, employment or income, and subsequently to start a family.

The role of culture is evident in the DRC, where custom and tradition dictate that young men who are circumcised are men who are entitled to sexual relations. In many places uncircumcised men are not awarded the same respect nor are they actually regarded as having achieved manhood. Baker (2007:25) points out that at a basic level, boys involved in the most brutal of armed insurgencies become 'big men' by being in control of a given setting and being able to exert violence on those around them. Young men who become combatants in these settings are often bombarded before becoming combatants and after, with violent images of manhood, whether in the form of Rambo films, gangster rap, or the idolisation of 'big men' such as Charles Taylor (ibid). As a result the rape of women by these newly empowered young men becomes a confirmation of their newly acquired male status.

This social construction of masculinity has consequences for young soldiers when they return to normal civilian life. They fear that they are no longer men. A study conducted in 1998 by the Center for the Study of Violence and Reconciliation in South Africa highlights this tragedy, showing that "those who participated in the front lines with the African National Congress (ANC) in South Africa perceived themselves as relegated to second –class status once returned to civilian life (CSV, 1998). A similar study by Peters, Richards and Vlassenroot and Raeymaekers (2003:114) also asserts that such men who have wielded power in settings of war are reluctant to return to normal life where they perceive themselves to be subordinate again. This problem is of significance to the Congo conflict, for it may be argued that some soldiers do not want peace and will continue to fight in order to carry guns and pursue behaviors that are equated with being men, even if peace has been agreed upon.

2.1.4 Cultural rejection of women

Women are socially and culturally perceived as ‘the other’, mostly as irrational, unpredictable, unreliable, and feeble minded by men (Hodgson and Kelly, 2004:102). Furthermore, Congolese institutions are patriarchal, ruled and governed by rules that are familiar to men and conducive to “defining, controlling, and regulating women” which according to Hodgson and Kelly (2004: 102) are so infused with male domination that sexual violence can be defended, perpetuated, and condoned. Anderson (2004) adds that, culture exerts such a powerful force on defining what a man is and how he behaves, that the entire society needs to change in order to end gender based violence. Because women lack such power and dominance in society, they hardly ever challenge the fact that rape is a part of their existence, they just modify their behavior in order to minimise the chances of being raped.

Orgies of rape therefore originate in a cultural hatred of women that is acted out in extreme situations. This literature advances that rape remains an extreme act of male violence against women which would not be possible without general feelings of hostility towards women. According to Seifert (1996) however, the ‘enemy’ concept, is problematic in this context as enemies usually know that they are enemies to each other. Women do not normally expect to be attacked on a massive scale. Seifert (1996) invites us to face the fact that in our societies there are varying degrees of hatred towards women. Making reference to Graham and Dworkin’s (1981) views, these feelings of hatred and contempt manifest themselves in the socially accepted pornography that celebrates the physical violence of men against women in peace time. Evidently, many men and many women come to regard these hate filled images as normal. She adds that it is against this background that war becomes an exploration where fantasies of destruction are encouraged and acted out (ibid).

Pornography style brutality against women came to be perceived as normal practice since women could not defend themselves and therefore became the prey of anyone. The pornography –style atrocities against women, were also witnessed during the rape of Muslim and women during the war in Bosnia and Herzegovina as well as during the 1994 Rwandan genocide (Henri,

2005). A similar situation was also witnessed during the Second World War where Jewish women were raped by the Nazi mob. When the Russians passed through Germany, Russian soldiers are reported to have raped German women in what came to be viewed as revenge rape. Back in 1914 for example Henri (2005:67) notes: “German troops systematically raped Belgian women in an attempt to persuade the British and Americans in entering the war. Similarly, during the occupation of China by Japanese troops, the systematic rape of Chinese women took place”

2.1.5 Patriarchy

Some researchers suggest that patriarchy is a root cause of rape. According to Connell (2003) patriarchy gives men power and an excuse to control and dominate women. That is why rape occurs to such an extent that it appears to be an acceptable and inevitable part of human existence. Good et al. (1995) point out that rape is such a culturally and socially accepted phenomena in that the very behaviours that society values and perpetuates as inherently male are, in fact, at their most extreme, the behaviours that lead to rape.

Although the Congolese culture considers itself progressive and open minded, certain ideals and assumptions regarding gender roles persist. Specifically, a man should be strong, dominant, decisive, aggressive, and controlling as the head of a household and his wife should be subservient, quiet, nurturing and passive in his custody and charge. These roles are prevalent throughout the culture and include all interactions between men and women. They are also, unfortunately, fundamental in creating an environment conducive to rape (HRW, 2002; CEDAW, 2006; Good et al., 1995; Connell, 2003; UNICEF, 2001). The acceptance and perpetuation of traditional male and female roles carries clear indications for rape. Thus, the literature reveals that men who endorse more traditional male gender roles have greater participation in GBV (Good et al., 1995).

2.2 Consequences of Gender based Violence

Social, economic, and gender issues are increasingly recognised as significant factors behind the HIV epidemic, and increases the likelihood that sex will not be safe, voluntary, or pleasurable.

Violence against women and children, of both sexes, has gained international recognition as a serious social and human rights concern affecting all societies. But epidemiological evidence shows that GBV is a major cause of ill health among women and girls, as seen from death and disabilities due to injuries, and through increased vulnerability to a range of physical and mental health problems (Mugawe and Powell, 2006). Female survivors of GBV not only sustain physical injuries, but are more likely than other women to have unintended pregnancies, to report symptoms of reproductive tract infections, to have multiple partners, and less likely to use condoms and other contraceptives (IFPP 2004; Campbell and Self, 2004). Violence and the fear of violence severely limit women's contribution to socio-economic development, thereby hindering the achievement of the Millennium Development Goals and other national development goals. Rape and domestic violence account for 5-10% of healthy years lost by women (WHO, 2001).

If one wishes to fully comprehend and appreciate the consequences of sexual assault for the victim, Combrinck and Skepu (2003) advise it is important that rape and other forms of gender based violence be understood as a traumatic event. The authors perceive rape not just as unwanted sex but also as a highly traumatic experience. Combrinck and Skepu (2003) state that in the aftermath of rape, survivors complain of insomnia, nausea, and nightmares as well dissociative or numbing symptoms. It is worth noting that there are a number of other consequences of rape which are listed below.

2.2.1 Physical consequences

Sexual GBV can lead to serious physical health consequences. Physical consequences may include injuries such as fistulas or vaginal bleeding, infections, unwanted pregnancies and sexually transmitted diseases including HIV/AIDS and many other STIs. In many countries, women who become pregnant as a result of having been raped are forced to bear the child or risk their lives through unsafe abortion-practices (Goodwin, 2004). Selina, 12 years old who was raped and whose scars of the ordeal are still visible struggles to tell her story:

“When I was fetching water, I felt someone come behind me, ‘she recalls’. I saw that it was somebody in military uniform. He took a stone and stuffed it in my mouth and carried me off into the bushes, my cries were not heard at the nearby road and the soldier proceeded to rape me. When people finally came to my aid, he had fled” (Amnesty International, 2005:12).

Selina’s story is shocking, but it is not rare. It is believed that hundreds of thousands of women and children have been raped in the DRC and each one has her own story to tell. According to Amnesty International (2005), most of these women raped in such ways are being diagnosed HIV positive and carrying the virus and have no one to blame except the rapist who remains unknown.

Lewis (2002:21) agrees that every rape is different and survivors have different reactions to the experience of rape. A woman’s reaction to rape is shaped by many factors, such as: who the rapist is, what kind of person he is and how he behaves during and after the rape, the woman’s age and experience of life, who she is, what and how her life was before the rape, how she behaved after the rape and what happened afterwards, the circumstances of the rape and the woman’s relationship with the rapist.

Physical symptoms may result from crime, injuries, pregnancy and sexually transmitted diseases. Post et al. (2002) found that factors such as vaginal tearing and other injuries which often occur during rape could increase the risk of HIV transmission in cases where the rapist is HIV positive. These physical problems interact with psychological symptoms and may complicate recovery from the trauma (Root, 1996). Moreover, McFarlane (1995) argues that beyond the immediate effect of the violence, the prolonged stress reaction of victims may take a toll on their health. Research has shown that women who have been raped report more symptoms of illness and view their health as worse than non-victims and visit their physicians more frequently (Davis et al., 1997).

2.2.2 Psychological Consequences

Resick (1998) reports that each rape victim responds in her own way to being raped. Some women respond immediately in an emotionally upset and tearful manner. Others react in a more calm and controlled way with little expressed emotion as if nothing dramatic has happened, often claiming that they feel distanced from the attack or that the whole thing seems unreal (1998:8-9). Additionally, physiological effects frequently follow a rape. Victims may change in their sleep patterns (insomnia, early awakening and nightmares), change in eating patterns as well as report reduced sexual satisfaction and sexual activities. Many women also report withdrawing from any sexual contact (Ellis, 1999).

Psychological consequences include anxiety, anger, depression and post traumatic stress (PTS). Women, who experience sexual assault, are more likely to attempt or commit suicide. In addition, victims face stigmatization and social exclusion. Heger and Emma (1995:13) state that psychological effects have been investigated from different vantage parts and these effects are emotional, cognitive and interpersonal. Emotional effects include depression, anxiety, somatization, hostility, substance abuse, confusion, suicidal ideation, and self destructive tendencies, negative self evaluation, guilty, perceived helplessness and distrust of others.

There are also a personality change which Tsai cites in Mckendrick and Hoffman, (1990:125). There is overwhelming evidence that a victim of rape experiences negative long-term effects in the quality of personal adjustment and inter-personal relationships. Sometimes a victim may show signs of sadness and social withdrawal which is different from her personality, self-destructiveness and aggressive behaviours towards other people. She may also suffer from lack of confidence, feelings of helplessness, a sense of isolation, and an inability to form heterosexual relationships.

Various sources have witnessed the increased cases of rape in the Eastern DRC. Girls as young as three and women as old as seventy-five have been raped and mutilated in Eastern Congo. "Women are dying two types of death," says Christine Karumba the Country Director of Women for Women International in DRC. "The two types of death are the physical and the emotional death. The physical death is where you are no longer alive to walk the earth, and the emotional

death is where you no longer see signs of hope and are dead inside although living” (United Nations, 2006). Karumba has vivid recollection of growing up in the DRC and witnessing the trauma of living day by day not knowing if it was going to be your last which became an everyday occurrence for many. The intensity and frequency of rape as a weapon of terror is worse than anywhere else in the world. “Women are raped, mutilated and kept as sex slaves, and then turned away from their families and left with no hope to rebuild their lives. Without hope, women cannot survive,” says Karumba reporting to Amnesty International (2007).

2.2.3 Social Consequences

The literature suggests that it is very important to understand how people view victims of rape. Such attitudes are frequently characterized by victim blaming. Attitudes towards rape seem to be linked to traditional gender role stereotypes, in particular those related to sexual behavior (Acock and Ireland, 1993 cited in Fresse et al., 2004). Social tolerance of rape has several extremely important consequences for the victim, as she is more likely to blame herself for the assault, which then has an important impact on her recovery (Everstine and Everstine, 1989).

In some cultural settings, women are blamed for being raped, and subsequently lose their function within their community and society or are repudiated by their families. This often leads to poverty and exacerbates existing gender inequalities (WHO, 2005). The literature continuously reveals that women who are victims of GBV are ostracised from society and condemned as damaged goods that are no longer worth anything. Amnesty International (2004) has revealed that the exclusion these women experience is born out of enduring cultural stigmas, heavily influenced by the rigid Roman Catholic religion predominant in the DRC. Other religions include Islam, which also maintains conservative and traditional family values. The sexual virtue of women is heavily valued in traditional rural societies (Shanks et al., 2001). A woman who is raped, and therefore is no longer a virgin, will not receive a dowry and will not be able to find a husband (Pratt and Werchick, 2004).

The Human Rights Watch reports that a married woman will often be rejected by her husband and abandoned by her family, leading to economic hardship for the woman as her husband

generally controls the finances (HRW, 2002). If the woman becomes pregnant after being raped, this generates even more shame since Roman Catholicism forbids abortion even for rape victims, and the woman is forced to carry the enemy's child (HRW, 2002: 84). Victims of sexual violence are also marginalised for possibly being infected with HIV/AIDS. Families do not want the burden of caring for a person who is infected, and the presence of HIV/AIDS in the community frightens people and sparks tension (HRW, 2002). This is a very serious concern since it was found that there was a twenty-seven percent chance of being HIV-positive among rape survivors compared to a three to six percent HIV positive rate found in pre-natal clinics (Pratt and Werchick, 2004).

2.2.4 Medical Consequences

The medical consequences of GBV going on in the DRC are vast because of the uniquely brutal character of the rapes. According to Pavlish (2005), gang rape and sadistic mutilation of women lead to adverse medical conditions such as fistulae (holes in vaginal tissues), and a wide range of sexually transmitted infections, including HIV/AIDS. These medical effects and other resulting injuries impact on the victim's ability to do daily work; women have trouble with daily tasks that are critical for survival, including securing and preparing food and water, collecting and carrying wood, caring for children and maintaining the household.

The issue of HIV and AIDS as well as other sexually transmitted diseases, cannot be ignored in any study of war and gender based violence as they are inextricably linked. The report of the Joint United Nations Programme on AIDS (UNAIDS) at the 2002 AIDS conference noted that there is strong evidence that war is a factor in the rapid spread of the virus. The consequences of war included the collapse of health and education services, and dramatically increased instances of rape and prostitution which only fuelled the pandemic. This report notes that throughout the world military personnel are among the most susceptible populations to HIV and AIDS, and these are the alleged perpetrators of rape in the DRC (Amnesty International, 2004).

Relating the above report to the situation of the DRC during the 1996-2009 conflicts, Brackaman (1999) recalls that Rwandan and Ugandan troops have on several occasions enacted reprisals

against local people (women and men), leaving thousands dead in south Kivu, and north Kivu and that there have been numerous reports of rapes by men involved in fighting, many of whom were HIV positive. Although HIV /AIDS remain a reality even in peace time in this millennium, north and south Kivu, represent a case of grave concern. Highlighting the issue of health with a specific focus on HIV /AIDS in these two provinces, the United Nations (2001) states that:

“Two million people are infected with the AIDS virus twice as many in 1999. The eastern provinces have the highest rates , with the number of people infected having increased fivefold (from 4 to 22 per cent) over the two years in towns such as Uvira, Bukavu, Goma ”.

Added to trauma and despair resulting from their rape experience during these conflicts, many raped women victims who were mutilated and shot in their vaginas have often been diagnosed with fistulas. Goodwin (1997) and Amnesty International (2005) stress that for these victims; their capacity for reproduction was destroyed. Similarly, those living with HIV/AIDS as a legacy of rape during these conflicts have shattered lives. Apart from the inhumane acts against them, many other victims have been deliberately displaced from their land and forced in hostile refugee camps. Gingerich (2005) argues that militaristic tactics like these are an effective tool to create a sense of fear in the civilian population and to restrict their freedom of movement and economic activity.

However, the DRC is not the only country where violence against women is increasing the risks of HIV infection. The research reveals that in some other African countries such as South Africa the percentage of HIV positive women is higher than that of men (Gilbert and Walker, 2002). The prevalence of abuse is between 20-30 percent with one percent of women being raped each year (Jewkes, 2000). Furthermore, many researchers in this field indicate that gender inequalities and intimate violence directed at a female partner have already been established as risk factors in contracting HIV (Ackermann and Declerck, 2002; Walters et al., 2000). Many abused women fear contracting HIV (Wingood and Raj, 2000). A study in the United States found that of the 68% of women who reported experiencing abuse during their lifetimes, 65% had already been abused before they were infected, and 33% experienced abuse after they were infected. Interestingly, the severity of the abuse led to an increase in the number of women

reporting their HIV-sero-positive status (Sowell et al., 2002). McDonnell and Faden (2001) also found that 63% of HIV positive women had been sexually or physically abused at least once. The research finally indicates that GBV is certainly one of the important causes of HIV infection. A study found that women fear immediate violence more than possibly contracting HIV and therefore often resign themselves to sexual demands and violence (Gilbert et al., 2000). The above raises the question what has been the response of the government.

2.2.5 Economic Consequences

Economic exclusion is another consequence of gender based violence. The livelihoods and prospects of women following rape are drastically limited due to abandonment by the family and the loss of related income. Medical repercussions can also prevent the victims from performing the physical work that would usually earn them an income. Women who work in agriculture and trading often cannot return to the fields because they have been physically weakened by the injuries caused by the rapists, and thus lose out economically. They may also fear that they may be targeted again if, for example, it was in the fields where the rape took place (Amnesty International, 2004).

Chemiack (2007) after conducting the study amongst these women in the DRC has recommended in this regard that a woman who is ostracised from society, suffering from medical consequences of rape and is economically excluded needs to be medically and psychosocially rehabilitated and reintegrated into society. Instead, a status of pariahs is created, permanently keeping raped women on the fringes of society.

2.2.6 Secondary Victimization

Holmstrom and Burgess (1978) cited in Combrinck and Skepu (2003) claim that rape does not end with the departure of the perpetrator. The processes involved in reporting the case, the medical examination, follow-up counseling, and court procedures can be equally devastating for the victim. Combrinck and Skepu (2003:11) describe this phenomenon of secondary victimization as: “the unsympathetic, disbelieving and inappropriate responses that victims of sexual assault experience at the hands of society in general and at each stage of the criminal

justice process”. Such responses which are based on stereotypical perceptions of rape and of how rape victims should behave, serve to exacerbate the effects of sexual assault on the victims. Williams (1984) cited in Campbell and Raja (1999), defines secondary victimisation as “a prolonged and compounded consequence of certain behaviours; it results from negative, judgmental attitudes directed toward the victim, which results in a lack of support, perhaps even condemnation and alienation of the victim (1994:67). The authors indicate further that when service providers become insensitive and start blaming victims; these attitudes are also considered as traumatizing the victims again. Moreover, the subjugation of the needs and the psychological boundaries of rape victims to agencies’ needs make survivors feel violated again (ibid). For example, Campbell and Raja (1999) prove this when they conducted a survey with the mental health professionals and 84% of the total surveyed agreed that contact with social service providers re-traumatizes rape victims.

2.2.7 Conclusion

The literature review was an important and integral stage in this study’s research process. It discussed the key concepts of the study namely the causes and consequences of GBV. It illustrated and demonstrated the different types of effects of gender based violence on women. It also examined the consequences of rape for this group of women. Furthermore, the intention of this literature review was to explore the interconnection between the rape of women in the DRC and the reasons for these rapes. It is clearly evident that there was premeditated planning of gender based violence in this province during war time. Interestingly however, the literature review has revealed that hypotheses which postulate sexual violence against women as a tactic of warfare have proven to be of little use when applied to the case of neighboring Rwanda. The social construction of masculinity; the Congolese woman’s status in her society; patriarchy in armed conflicts can be drawn upon to shed light on the some of the causal social roots of gender based violence in wartime, which has negative implications on women’s socio-economic status and their reproductive health.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The methodology used in this study guided the researcher to follow certain procedures in order to be able to analyse data. According to Marlow (1998) the qualitative methodology focuses on the underlying meaning and patterns of relationships, enabling one to obtain rich in-depth information. This motivated the researcher to use a qualitative approach for this study. Women survivors of rape who participated in the study were encouraged to relate in-depth their experiences of rape during the conflict in the DRC.

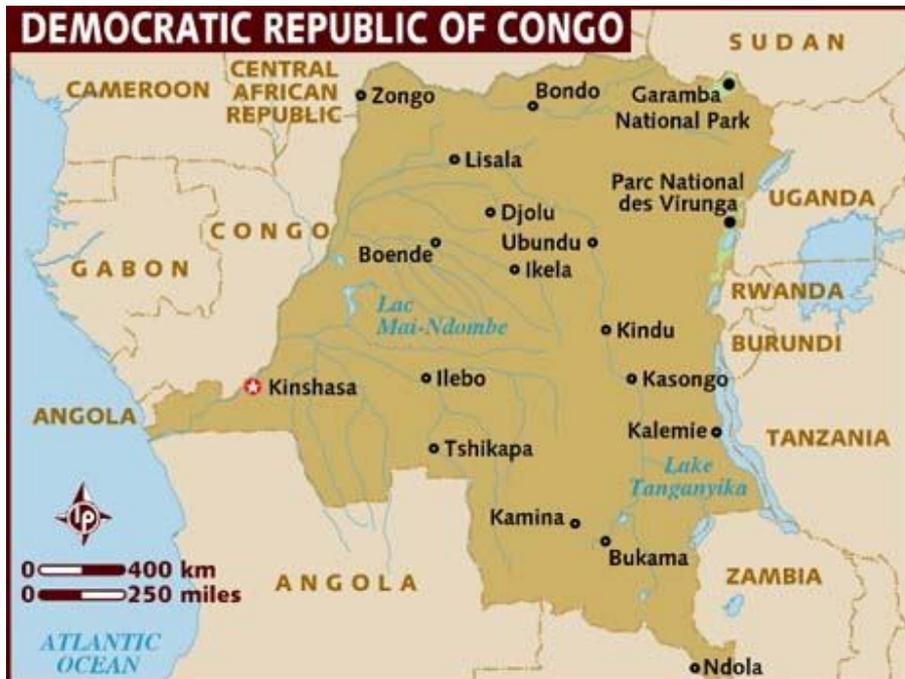
3.2 Geographical Situation

The Democratic Republic of the Congo is situated in central Africa. It is the third largest African country after Sudan and Algeria, with a land area of 2.345.000 km². The DRC was formerly variously known as the Congo Free State, the Belgian Congo, Congo-Leopoldville, Congo-Kinshasa, and Zaire. The nation is economically and regionally affiliated to Southern Africa as a member of the Southern African Development Community (SADC). It borders the Central African Republic and Sudan on the North, Uganda, Rwanda, and Burundi on the East; Zambia and Angola on the south, the Republic of the Congo on the west; and is separated from Tanzania by Lake Tanganyika on the East. The country enjoys access to the ocean through a forty-kilometre stretch of Atlantic coastline at Muanda and the roughly nine-kilometre wide mouth of the Congo River which opens into the Gulf of Guinea.

The country is vast and rich such that neighboring countries are all turning their eyes to the DRC for their prosperity. The eastern province which is close to the border of Rwanda, Uganda, Burundi and Tanzania has suffered the consequences of war. Armed men from the above cited countries emerged in the country from 1996 and embarked on war and violence. A report from Amnesty International (2005) states that women have been the most frequent victims of GBV and are most likely to be suffering its consequences. The survivors after the massacre are kept at the Panzi referral hospital in the eastern province, under control of the French medical doctor

Denis Mukwege. The study was conducted to understand the experiences of the women at the hospital. In-depth interviews were conducted with women who live at this centre plus two key informants.

Figure 3,1: Map of the DRC



Source: The world facts book, (2007)

Brief History: Established as a Belgian colony in 1908, the Republic of the Congo gained its independence in 1960, but its early years were marred by political and social instability. Colonel Joseph Mobutu seized power and declared himself president in the November 1965 coup. He subsequently changed his name - to Mobutu Sese Seko - as well as that of the country - to Zaire. Mobutu retained his position for 32 years through several sham elections, as well as through the use of brutal force. Ethnic strife and civil war, touched off by a massive inflow of refugees in 1994 from fighting in Rwanda and Burundi, led in May 1997 to the toppling of the Mobutu regime by a rebellion backed by Rwanda and Uganda and fronted by Laurent Desire Kabila. He renamed the country the Democratic Republic of the Congo (DRC), but in August 1998 his regime was itself challenged by a second insurrection again backed by Rwanda and Uganda. Troops from Angola, Chad, Namibia, Sudan, and Zimbabwe intervened to support Kabila's regime. A cease-fire was signed in July 1999 by the DRC armed rebel groups, Angola, Namibia,

Rwanda, Uganda, and Zimbabwe but sporadic fighting continued. Laurent Kabila was assassinated in January 2001 and his son, Joseph Kabila, was named head of state a month after. Unfortunately, Kabila's death and the takeover by his son did not result in the regulation of GBV; on the contrary, the situation has become much worse and until today there are still reports of women being sexually abused in the DRC (Amnesty International, 2007).

Lemera Hospital or Panzi General Referral Hospital:

The study was conducted at the Lemera (or Panzi General Referral) Hospital. This hospital was established by the French Doctor Denis Mukwege who grew up in Bukavu, where he first became aware of the need for better medical care in the region while visiting sick parishioners with his father, a Pentecostal minister. After studying medicine in Burundi, Mukwege returned to the Congo and worked at a hospital in the village of Lemera. Though initially interested in pediatric care, he switched his focus to obstetrics and gynecology after observing the harsh circumstances that many rural women faced while giving birth. He pursued further studies in Angers, France, and in 1989 established an obstetrics and gynecology service in Lemera in Uvira.

After the hospital in Lemera was destroyed during the civil war that erupted in the country in late 1996, Mukwege resettled in Bukavu. His original goal in founding the Panzi Hospital was to provide maternity care that was lacking in the area, but soon the hospital began to receive large numbers of sexual-assault victims, some as young as three years old and many with extreme injuries and mutilations. He then created a staff to specialize in the care of such patients, hoping to use prize money that he had received to establish services aimed at helping survivors of sexual violence rejoin society. Since then, this hospital has been receiving women survivors of rape in large numbers, and they have been treated while staying at the centre until full recover or healing. Some have been there between 5 to 10 years.

3.3 Methodology

This research largely utilises qualitative research methods. The study is based on in-depth interviews. Holloway (1979) states that: "each approach in qualitative research has its own underlying principles and procedures". Grinnell (1988:186) agrees with the above statement that; "the qualitative method focuses on describing and comprehending the subjective meaning of the

events to individuals”. Therefore, this research uses an exploratory descriptive design because it provided evidence of how women who have been victims of gender based violence suffer the consequences of this endemic practice and its aftermaths.

Qualitative research is a generic term for investigative methodologies described as ethnographic, naturalistic, anthropological, field, or participant observer research (Baily, 1997). It emphasises the importance of looking at variables in the natural setting in which they are found. Interaction between variables is important. Detailed data is gathered through open ended questions that provides direct quotations. The interviewer is an integral part of the investigation (Weseen and Wong, 2003:46). This differs from quantitative research which attempts to gather data by objective methods to provide information about relations, comparisons, and predictions and attempts to remove the investigator from the investigation (Smith, 1983). According to Baily (1997) the significance of qualitative research consists in placing stress on describing and understanding complex phenomena. It investigates, for instance, the relationships and patterns among factors or the context in which an activity happens. It is concentrated on understanding the multi-dimensional picture of the subject of investigation.

The researcher used a qualitative method in this study for different reasons because the methods are helpful not only in giving rich explanations of complex phenomena, but also in creating or evolving theories or conceptual bases, and in proposing hypotheses to clarify the phenomena. Baily (1997) indicates that beside its value, qualitative research consists in validating the information received. People are interviewed one after the other so that the obtained data can be taken as correct and believable reports of their opinions and experiences.

However, although the methodology is advantageous for this particular study, it has also some disadvantages. The primary disadvantage of qualitative research methods is that they are unreliable predictors of the population. That is, they can expand the list of possibilities, but they cannot be used to identify the best possibilities (Woodlife, 2004). Many researchers such as Monet et al. (2003:40) agree that:

“Researcher bias can bias the design of a study. Bias can enter into data collection. Sources or subjects may not all be equally credible, hence some subjects may be

previously influenced and affect the outcome of the study. Background information may be missing; study group may not be representative of the larger population; analysis of observations can be biased”.

This implies that any group that is studied is altered to some degree by the very presence of the researcher. Therefore, all data collected is somewhat skewed. It takes time to build trust with participants to facilitate full and honest self representation. Short-term observational studies are at a particular disadvantage where trust building is concerned (Fine et al., 2003).

3.4 In-depth Interviews

The study was qualitative in nature using in-depth interviews as the main method of data collection. This refers to a naturalistic, interpretative approach concerned with understanding the meanings which people attach to actions, decisions, beliefs, values etc, within their social world, and understanding the mental mapping process that respondents use to make sense of and interpret the world around them (Ritchie and Lewis, 2003). It concentrates on words and observations to express reality and attempts to describe people’s natural situations (ibid).

Therefore in-depth interviews were used as the main method of data collection in this study. In total twenty-one interviews were conducted, out of which 19 were survivors of rape and 2 were key informant interviews. In-depth interviews are used to explore conceptual issues at an early stage in the development of a questionnaire. Punch (2005) agrees that they can look at how respondents' answers to questions relate to their actual experiences. This technique can also be used to explore topics in their own right, to provide more depth about a subject or individual cases than a quantitative survey, or to complement quantitative enquiry. Issues can be explored in detail with participants. In-depth interviews involve open-ended questions asked by a researcher to an individual. The interviewer uses a topic guide but does not rely on a structured question set. Probing techniques are used to encourage respondents to give the fullest answer possible. According to Punch (2005), interviews are a very good way of accessing people’s perceptions, meanings, definitions of situations and construction of reality. Furthermore, they are one of the most powerful ways of understanding others. The primary advantage of in-depth interviews is that they provide much more detailed information than what is available through other data collection methods, such as surveys. They also provide a more relaxed atmosphere in

which to collect information and people may feel more comfortable having a conversation about their programme as opposed to filling out a survey questionnaire.

However, there are also limitations to using in-depth interviews as they can be a time-intensive because of the time it takes to conduct interviews, transcribe them, and analyze the results. Additionally, Punch (2005) argues that interview responses are likely to be biased because of the influence exerted by the interviewer.

3.5 Sample

Congolese women who survived the massacre during the 14 years of war and who were raped during this period in different parts of the Congo and living at Panzi hospital, constituted the population of this study and the study was conducted only at Panzi hospital.

The director of the centre with two others health professionals identified the potential participants and they were personally approached by the researcher to invite them to willingly participate in the study. At the first meeting with the potential participants, the researcher explained the purpose of the research, the objectives and the ethical considerations. There was no age limits for the participants as most of them were affected and the act caused similar consequences on their reproductive health. However, the researcher together with the health professionals used purposive sampling to select participants. Polit and Hungler (1999) justify the advantages of purposive sampling as allowing the researcher to select the sample based on knowledge of the phenomena of the study. According to Blaxter and others, there is a wide range of sampling strategies that can be utilised. Blaxter et al. (2001) divide them into two groups, viz, probability and non-probability sampling. Sampling saves time labour and therefore money by reducing the numbers of cases involved. It allows for a concentration of effort on high quality information about the smallest number of cases involved (Mann, 1985). In a random sample, each person in the universe has an equal probability of being chosen for the sample (Bailey, 1982) and is chosen indiscriminately and not favoured by personal choice. The sampled group stands in good stead however as they are representations of a [wider] group which will be studied, and as such their characteristics are added together to present the general picture of the group itself (Mann, 1985). So to narrow down the sampling frame, the population target was women survivors at Lemera hospital.

As indicated in the previous chapter, this study was made up of 21 participants. The researcher used the participants' proper names, after asking them if they would like to use pseudonyms instead of their own names, and almost all of them replied:

“We have nothing to hide anymore, after we have been raped, destroyed, despised, tortured and undressed in front of our children, husbands and neighbours. In fact it is better to show our real names so that the world and our government in particular will know that this is real we are really suffering, we have to show it and let it be known”.

3.6 Methods of data collection

In this study, trust was established before the data collection stage started. This was done at the time the researcher went to the Panzi General Referral Hospital to ask for permission to conduct the research, and explained the purpose, the main aims and what was anticipated and expected by the researcher. Permission to collect data was obtained. The researcher explained the objectives and significance of the study to the staff that assisted in identifying the prospective participants. Aspects such as inclusion criteria, ethical considerations, and questions to be asked during the interviews were discussed beforehand. Time spent on each interview and the number of interviews conducted varied from one interviewee to another. A semi-structured interview schedule was used to collect data. In such interviews according to Marlow (1998) the interviewer is generally required to ask a certain number of specific questions, but additional probes are allowed and even encouraged. Mann (1985) adds that semi-structured interviews may use both closed and open-ended questions. For this research, a semi-structured interview schedule that was used was first translated from English to French and Swahili. Some people from the Northern Province could speak only French and some from the southern only Swahili.

In order to establish a trust relationship with the participants, the researcher conducted the first interview in which he explained the purpose, objectives and the significance of the study, and any question from the interviewee about the study or the researcher was answered in the first meeting. During the second interview when the researcher was meant to collect data, he found that the subject of rape was too sensitive, given that sexuality is a taboo topic in Congo culture.

To overcome these biases, the researcher chose to ask each woman to talk about her history as a survivor of war in the DRC rather than focusing on the causes and consequences of rape as it was stipulated in the interview schedule. The researcher realized that when the participants were discussing their histories in general, they inevitably included their experiences of being raped, and then questions were asked in line with the scheduled interview.

3.7 Data Analysis

Data was obtained from interviews which were conducted with 19 survivors of gender based violence and two key informants. All the interviews were tape-recorded and transcribed. Translation was done by the researcher alone who could speak the same language as the participants'; in fact Swahili is the researcher's mother tongue. Therefore, the researcher spent time listening to the tapes and translated the scripts from Swahili and the others from French to English. After this stage, all 21 transcripts were used for the analysis of the data. This was the stage where the researcher was finally able to understand the victims' experiences of GBV. Holloway and Wheeler (1996) argue that in data analysis of phenomenological enquiries, the researcher aims to uncover and produce a description of lived experience. This was described through verbatim interviews and then analysed, using thematic analysis.

After transcription, the researcher went through an intensive process of repeatedly reading and reviewing the transcripts and audiotapes. The main purpose of reviewing the transcripts was to identify fundamental thematic content in each transcript based on the words of the participant's accounts. To facilitate the analysis done manually, the seven stages of phenomenological analysis outlined by Colaizzi (1978) were used. That is, data was organized according to the research questions which related to the objectives of the study. The words and sentences relating to the consequences of GBV were highlighted. Themes with the same meaning were grouped together and sub-themes were developed. Themes with common characteristics were identified, and defined until six principal themes that represented the consequences of gender based violence on women's reproductive health were retained.

3.8 Ethical Considerations

The University of KwaZulu-Natal provided the researcher with the ethical clearance to conduct this research, and the director of the Lemera hospital also granted him the permission to conduct research in the hospital. Each participant filled in an informed consent form and the participation in the study was voluntary. The interviewees were well informed and well aware that they could withdraw from the study at any time they felt uncomfortable or not willing to continue with the interview, and that their withdrawal would not affect the treatment they received at the hospital. The director of the hospital provided the researcher with a space for the interviews and this was very private. Once more, the purpose and objectives of the study were explained to the interviewee and this was tape-recorded with the written consent of each participant. Participants were guaranteed confidentiality and promised that the tape-recordings would be destroyed after the completion of the study. Finally, confidentiality was maintained throughout the research process, although in the interviews all the participants agreed that their names should appear as they are in the report.

3.9 Limitations of the Study

The limitation of this study is that it consisted only of a limited number of women who are part of those raped living at Lemera Panzi Hospital in Bukabu Kivu. The other limitation is that the sample was not truly representative of all women who had been raped. Additional members were contacted because they live at the place and may have additional information that was crucial for this research project. Therefore, due to the time constraints and limited resources a total of 21 interviews were conducted. The other limitation was the sample size of the respondents. The researcher did not have enough time to conduct interviews with a large number of survivors. The sensitivity of the topic was another limitation, because rape is a sensitive issue and in countries like the DRC, it is culturally taboo to discuss sexuality. Also, social desirability and self reporting were other limitations, as the researcher could not go beyond what the respondents wished to reveal. Furthermore, given the small sample size the results of the study are not generalizable to all women in the DRC.

CHAPTER FOUR

RESULTS

4.1 Introduction

The researcher has organized the findings of the study into themes and sub-themes, which after being identified, are discussed in-depth, aligning them with existing literature. Then, at the end of the chapter, a short conclusion is drawn.

4.2 Sample Characteristics

Table 4.1 presents the socio-demographic characteristics of the sample of the study. In total, in-depth interviews were conducted with 19 women who were victims of rape. In addition, two key informants were interviewed. All these women reported experiencing some form of gender based violence. The youngest woman was 13 years old and the oldest was 50 years old. Most of the women who were interviewed belonged to the Mushi ethnic group. A few of them also belonged to other ethnic groups including: Nande, Batembo, Babembe, Bahavu and Bifulero. The majority of the women were married, however many of them had been divorced by their husbands after they were raped.

Table 4. 1 Sample characteristics

| No | Names of survivors | Age | Marital Status | Ethnic Group |
|-----------|---------------------------|------------|-----------------------|---------------------|
| 1 | Charline Buhendwa | 16 | Single | Mushi |
| 2 | Tulinabitu Rushingwa | 27 | Divorced | Bafulero |
| 3 | Machozi Muunga | 44 | Married | Babembe |
| 4 | Benita Katindi | 15 | Single | Barega |
| 5 | Aline Munguakonkwa | 20 | Single | Mushi |
| 6 | Chele | 25 | Married | Bahavu |
| 7 | Mazabuka M'Rudahindwa | 28 | Married | Mushi |
| 8 | Madame M'Rujwejwe | 50 | Divorced | Mushi |
| 9 | Bayongwa Kahusi | 47 | Divorced | Bahavu |
| 10 | Agatha Bisimwa | 14 | Single | Murega |
| 11 | Verdiane | 45 | Divorced | Mushi |
| 12 | Zawadi | 13 | Single | Batembo |
| 13 | Chibalonza Muka | 22 | Divorced | Mushi |
| 14 | Asira Ponga | 45 | Divorced | Mukute |
| 15 | Kabisuba Matenda | 43 | Married | Barega |
| 16 | Mapendo Nyamise | 30 | Married | Babembe |
| 17 | Sifa Mirindi | 14 | Single | Mushi |
| 18 | Nadia Tumaini | 13 | Single | Banande |
| 19 | Pendo Ngeranya | 29 | Widow | Batembo |
| 20 | Maman Cecile | 33 | Married | Nande |
| 21 | Viviane Bafakulera | 25 | Married | Mushi |

The analysis of the data shows here that, women who come from largely disadvantaged and vulnerable social groups are the main victims of rape in the DRC. Here the emphasis is placed more specifically on women who come from the deep rural areas and villages where the principal activities are: cultivation, trade and farming.

Table 4.2 Level of Education

| Educational Level | Numbers of women | Occupation | Numbers of women |
|--------------------------|-------------------------|-------------------|-------------------------|
| University | 0 | Unemployed | 6 |
| Secondary School | 3 | Students | 4 |
| Primary School | 1 | Farmers | 6 |
| Never been to School | 15 | Traders | 3 |
| N | 19 | | 19 |

Table 4.2 presents the level of education and occupation of the women in the study. It suggests that the level of education is very low. Most of the women interviewed had never been to school. Only a few of them have attended tertiary education, while only one had attended primary school and three had attended secondary school. However, this is not strange in the DRC. The surveys carried out by UNICEF (2001) revealed that the illiteracy rate among Congolese women is 46%. The report further indicated that, the literacy rate is even lower in the rural areas, and the further the distance from towns, the less likely the children are to attend schools. This explains the reasons for low levels of education among women in the villages of the DRC.

An analysis of sample characteristics reveals that unemployed women and farmers accounted for the largest number of women. This implies that, the main victims of gender based violence in the eastern province of the DRC are mainly farmers and the unemployed. All the women live in the rural areas where according to Boute and Moulin (2003), 65% of the DRC population live and the main tasks of women include cultivating the fields, harvesting, gathering firewood for cooking and fetching water. One has to note that most of the above mentioned activities are carried out in isolated places; hence women are exposed to assaults of all kinds when they go out in search of food in the fields or to collect firewood. They often meet with their abusers and rapists in these isolated places.

The majority of women were either married or divorced. Among the single women, some of the rape victims were under 19 years of age, so they were still expecting to get married. Unfortunately, the act of rape and for some becoming mothers of unwanted children has

destroyed their dreams of getting married in the future. For example, Sifa, a 14 year girl stated that:

“I have no more hope for life anymore, I am neither a boy nor a girl, and cannot desire even being alive since I was told that I am carrying the virus which I did not want”.

However, the reason for the predominance of married women in this area is the low rate of school enrolment in rural areas and the custom of early marriage for young girls. This is partly due to the law which fixes the minimum age for marriage at 15 years for girls and 18 years for boys (RFDA 2003). Given this situation, the main preoccupation of a young girl is, from the age of 15 onwards is to get married and start her own home. In most poor families, the education of boys is given preference over that of girls. In this context, boys are socialized from an early age to become a ‘real’ man. This aligns with the argument by Connell (2003) that in patriarchal communities, males are raised differently from females and this makes them feel different and powerful compared to women, hence the sense of domination.

Table 4.1 contains the list of distribution of interviewees by ethnic group. It shows that, the interviewees came from eight different ethnic groups. These ethnic groups are mostly found in the Eastern province of the DRC, and occupy the four main territories which are geographically near to Rwanda and Burundi as well as the Ugandan border. The territories are namely: Mwenga (inhabited exclusively by the Barega) Walungu, Kabare (inhabited exclusively by the Bashi) and Plaine de la Ruzizi (Inhabited particularly by the Babembe and Bafuliru). As previously discussed, these territories are covered by a great forest rich in flora, fauna, minerals and are the hideouts of the Rwandese and Congolese armed groups, thus increasing women’s exposure to gender based violence and other assaults.

4.3 Types of rapes

The acts of gender based violence and rape were committed with unprecedented cruelty, the perpetrators having devised the most humiliating and degrading treatment they could inflict on their victims. In most cases and in this study particularly, rapes occurred in public places and in

the presence of family members, community members and witnesses. Five types of rape were identified: planned rape; forced rape; individual rape; gang rape and rape involving objects being inserted into the victims' genitals. In many cases, the rape victims were tortured some were murdered, married by force or if the victim resisted, was killed.

4.3.1 Planned rape

Richters (1998) defines planned rape as an act of committing pre-meditated sexual violence. Aligning this definition with that of Raison de Femme pour la Defence de Droits et la Paix; RFDA/P (2003), planned rape is when the rapists seem to have a specific aim in mind, for example, they may terrorise, loot, rape, then live with the goods that they have stolen. Such rapes seem to have been well planned and coordinated. Lining up this definition with what is happening in the DRC and after the researcher has gone through the respondents' answers, it was observed that in most cases, rapes were planned in advance by the rapists. Take for example the case of the Ninja village in the year 2007 where Bayongwa one of the respondents describes her experiences:

“The interahamwe and other rebels who live in the mountains around the Ninja village, broke into our area at around 08:30, divided in groups, some entered the houses to rape women and kill every man that was in the houses, while others were busy packing every single stuff that they could eat or sell in the house, and when they were finished, they forced many young men to carry their stuff and some women who had become their wives there in the forest by force”

She went on to explain:

“We have reported this matter to the local chief who told us that this was beyond his control and may also be killed if trying to protect us, so now you see, when the leaders fail to protect us, how can we be saved? Maybe they are also part of the deal and this is what makes me feel that this was a planned mass rape”

In most cases, the rapes were reported to occur in forests and fields where the rapists could not be identified as they were wearing masks that concealed their faces. This is an indication of the state's failure to protect its own population. In this situation, the survivors have shown mistrust

in their leaders and have even suspected that they may be part of the group attacking them, since they did not react to their situation. Some men, who insisted on protecting their wives from rape, were killed or buried alive, while the process of pillaging and looting was continued by other group members. This had devastating consequences for the village and more particularly, the women.

4.3.2 Forced rape

While there is no precise definition of forced rape, some researchers have attempted to describe the meaning of the word. According to RFDP (2003), forced rape is described as an act of attackers forcing members of the same family to have incestuous sexual relations with each other, after having gang raped them. Many respondents reported that they were forced into sexual intercourse with their attackers. In this case they were not in a position to refuse or negotiate safer sex. Furthermore, when they tried to protect themselves they were subjected to serious torture and humiliation which resulted in death:

“I was coming from the field with my husband when we met them, they tied my husband’s hands and legs on a tree next to where they were standing, then they started pulling me next to my husband, then they started taking my clothes off. When I tried to protect myself, they hit me with a machete on my head, I fell down and did not know anything that happened after that, because when they finished raping me they all left me thinking I was dead, and they killed my husband at the same time, until Dorcas came to my rescue and transported me here for treatment”.

Many other cases were similar to this. Often, after having committed forced rape, the attackers would force members of the same family to have incestuous sexual relations with each other: e.g., between mother and son, father and daughter, brother and sister, aunt and nephew. According to Medecins sans Frontieres (2002) families were forced to watch the gang rape of one of their members, usually the mother or sisters. They were then made to dance naked, to applaud, and to sing obscene songs, while the rape was going on. Likewise, sons were forced to hold their mother or sister to prevent them from struggling while they were being raped. Although this type of rape happened all over South Kivu, the largest number of testimonies came from some of the DRC villages of Shabunda, Ninja and Kalehe.

In their study conducted in the DRC, Medecins sans frontieres (2002) reported that forced rape was the most dominant form of violence. They suggested that, these acts have been ongoing in the DRC for a long period of time. The common theme that emerged was the cruelty of the acts committed by the perpetrators. Bayongwa, one of the respondents who were raped in 2008 in the same village describes the trauma she was forced to experience in her testimony:

“They came into my house, speaking Kinyerwanda and asked my husband to rape his daughter, when he refused, he was shot twice in the head and died, then they called my first son and asked him to have sex with me, he could not either because it is not in our culture, they tortured him until he died, then came my young children who they asked to hold my hands and watch while I was being raped. I felt ashamed and very humiliated”.

She was forcibly raped while her children held her down. The rapist forced members of her family to participate in the rape and those who refused were tortured and eventually murdered. There were a number of similar cases, and in many cases, the perpetrators were identified as Kinyerwanda speakers. But the problem is that, most of the population in the Eastern province can speak this language, especially those who were in the army since 1996. It is therefore hard to confirm whether the rapist was truly a Rwandese, or Congolese, or even Burundian because there is no difference between Kirundi and Kinyarwanda.

4.3.3 Gang rape

The researcher considered gang rape as a form of rape where a woman is raped by at least two rapists, who may have sex one after the other or even simultaneously. In this report, out of the 19 respondents who were victims, 15 were gang raped and only 4 of them were raped by a single rapist. And for those raped by many, it happened one after the other or concurrently. This is graphically illustrated in the following comments:

“Early in the morning of Tuesday, I was in the field, busy cutting wood, when four armed men suddenly appeared at the other end of the field. They forced me to undress and to volunteer myself to one of them. I refused. Then they took me, spreading my legs out and tying them, one to the bottom of a tree, the other to another tree trunk. They stuck my head between two sticks held

diagonally, so that I could not sit up without strangling myself. I stayed in this position and one of the attackers penetrated me forcefully from behind in the vagina, and the other pushed his penis into my mouth, right into my throat... I was eventually found by some neighbours who had watched my ordeal from a distance. When they found me I had fainted and was covered in blood...they could not come to my rescue earlier as they also feared to be raped or killed”

“.....after the first one finished raping me, he called the other one to carry on. They all did the same thing until all of them were satisfied, while I was terrified and very exhausted after being raped by more than 10 men in less than an hour”

Some women reported that they found the experience not only emotionally but also physically exhausting. There have been many reports like this throughout the whole interviews. Some other survivors indicated that, after one rapist finished having sex; the following rapist did not mind inserting his penis right away into their vagina, not even allowing the survivor to rest or clean herself. It is obvious that most of the reports are relatively similar because the perpetrators used a similar modus operandi. This is evident in the testimony of Asira Ponga who observes:

”We went to gather beans from the field. We were 13 people but they chose the young girls amongst us then returned the old women and stayed with us. They were questioning us and if we responded that we want to live, they then took us to the bush and asked us to sleep with them until they were satisfied sexually. But if you say no, they kill you automatically. When they took us there, after using us for sex, they called our relatives to pay money for us to be freed, and every one of us had to make sure we satisfied at least 5 men sexually every day, mornings and nights”.

There were a number of women who were raped at the same time. In many cases they preferred young women. Many women were forced to submit because they feared for their lives. Women who refused to submit to the sexual demands of the men were killed. However, a number of respondents were raped by as many as 12 to 15 rapists. Asira Ponga who was raped in front of her son and husband while returning from the field stated that:

“The group of rapists started beating my husband with the gun on the neck, while asking me to kneel down.....”

“.....They asked me to kneel down and 12 men one after the other had sex with me”

Survivors who reported being gang raped said they had lost control after the second or third time and hence they could not remember the actual number of men who had sex with them. Many remember how it started when they met with the rapists but what happened after that remained unknown to them as it was for most of them a time of pain, torture and beatings. Charline says:

“I was going to the field, they met me there, and they raped me and left. The second time, they took me with them, in that time, if you do not smile, they beat you to death. They cover your eyes with cloth, and then they all rape you, and so they did it to me, I do not even know how many they were because after the fourth rapist, I lost control”

“.....I was taken by force by five men who took me to the forest where I spent a month being raped day after day by these men and others who we met there in the forest”

From the reports of many respondents, such situations of not identifying the rapists and losing control during the rape were common, and this was not a once off event but rather it happened continuously. However, as indicated above, most of the reports of gang rapes looked similar, appearing that they were planned. It was clear that this was very traumatic as many of the women felt helpless and powerless and were unable to resist their attackers.

4.3.4 Individual rape

There were cases where an individual rapist rapes a single woman. However, although most cases of rape were reported as gang and mass rape there were a few cases of individual rapes. Out of the sample of nineteen survivors interviewed four were victims of individual rapes. Nadia was raped by a single rapist. She reported:

“A man used to come to my house, stepped in while there were no one at home, he called me inside the house. I met him, he immediately started taking off his clothes, he took mine off as well, then started raping me. He was a family friend and used to come to my house”

Another respondent stated:

“The man was a Congolese not even a Rwandese, who pretended he was lost and wanted me to show him the way out from the area, while I was coming from school. He then took me to the forest where he lived and there he raped me and had been abusing me sexually for the last two month, just like his wife”.

This respondent’s report suggests that, not only the rebels raped women but also members of the Congolese army, and sometimes people they knew. Beside the many acts of cruelty by the rebels, rape seems to be dominant even in the city where cases such as these were reported.

4.3.5 Insertion of objects into the victim’s private parts or shooting into them

Some other survivors have indicated that after the rapists had finished raping them, they would then insert some objects into their private parts or just shoot bullets in the vagina. However, out of the 19 interviews, only two survivors reported having been victims of such acts.

“I was in the field and getting ready to go home when these men came out of their hiding place. They tied me to a tree trunk that was lying on the ground. They tied my legs, spread out, to two other tree trunks. All of them, one after the other, raped me. Then they took one of the unripe bananas that I had gathered and pushed it into my vagina, moving it about, several times, claiming that I had been acting like a whore but that I had rejected the advances of one of them. They mocked me in Kinyarwanda saying that five men were not enough for me, that I needed more than ten. My attackers spoke Kinyarwanda very well among themselves. I was bathed in blood when my friends untied me. I am still suffering bad pains in my lower abdomen. I do not know when this will ever end, because the state of my vagina has totally changed since then”.

“After they all finished raping me, one of them took my bottle that contained my cooking oil, and he pushed it into my vagina, ordering me to sit down. One of them held me down with all his weight and holding my hands, to make it easier to push the bottle in. I bled a lot, because my vagina was torn and the whole part around it. This bleeding has not stopped until today”

The consequences for the women were long-term and the use of extreme violence was clear. This type of rape has left many of the victims with a number of physical and medical consequences and pains which may never be healed. Moreover, most of this form of rape was accompanied by torture and beatings, especially when the survivor tried to protect herself. Machozi explains:

“In December we were hunted by soldiers, I was caught by them, they started torturing me, beating me and wanting to rape me, then a man from CEPAC came to my rescue, took me to the church for prayers where they told me to go to Bukavu to meet with Dr Denis Mukwege at the Panzi General Referral Hospital for him to treat my pains”

Some other victims of gang rape and planned rapes suffered the same trauma of insertion of objects in their vaginas which has left them with wounds and problems in their vaginas. Moreover, not only objects were inserted in the survivors’ private parts but also in other parts of the bodies. Mapendo reports:

“When the interahamwe hit me with a machete in my head, I fainted and I was taken to the hospital. Things started growing on my skin due to the rape, until we decided to leave the hospital to Nyabibwe because of hunger. However, I did not know I was raped at all because I lost conscience after being hit by the machete, until I then came here and got tested, but I found that I was not HIV positive, and did not have syphilis. The doctor said that I am only pregnant and my vagina and stomach are wounded”

In the DRC many women are tortured, beaten and badly humiliated after being raped (RFDA 2003). A number of rapes are accompanied by torture, especially if the victims resist. These acts of GBV have left the victims with profound physical, psychological and emotional trauma. All of them said that the manner in which they had been assaulted and raped constituted the most

degrading and humiliating experience they had ever lived through. They said that they had lost their dignity, their honour and their self-esteem. Their sense of self and their spiritual sensibilities had been seriously damaged. Several women interviewed in the DRC, and particularly in the Kivu province said that, they felt profound regret at having been forced to have sex by men who were not their husbands, which was contrary to their religious convictions, a finding consistent with other studies (UNFPA, 2006). According to the report from interviews previously conducted by RFDA in 2003, this trauma was exacerbated by the fact that many women who had been raped were stigmatised and ostracised by their spouse, families and communities

4.4 Changes in womanhood

4.4.1 Loss of identity

During the interviews, many survivors indicated loss of identity since the rape took place. Many of them expressed a feeling of distress and despair especially those who had not previously been sexually active. The loss of their identity was linked to the loss of their virginity and being raped. This is explained by the declaration given by many participants in this study that, losing their virginity and being raped led to the loss of their identities. Some others even went further stating that they had no reason to continue living anymore. One of the interviewees declared:

“I am worried that when I go there I will be given names, because myself I do not know whether I am a man now or a woman now, young or old, these things have confused me. I do not think I will ever get married anymore, and cannot study, so I am no one. In my culture having a child at my age and not being married, it means you are not to be married or even sit together with other girls in the community. I cannot also sit with old women because I am not also a mother.....for us a mother is a married woman.”

This testimony explains the implications that the rape has on a woman's integration in her community. Many of the women felt isolated and lost. They did not feel as if they belonged to their communities. They were particularly afraid of being ostracised by their community.

4.4.2 Changed intimate relationships

Out of the 19 survivors interviewed, 13 were affected by changes in intimate relationships. Out of these 13, six have been married and divorced after the rape. The remaining were never married while four of them were in relationships but these relationships broke down. Some of the respondents explain;

“I was married, living in good relationship with my husband for more than 23 years. But one day I went through a lot of troubles that I cannot easily explain. I went out looking for food for my children. Along the way I got caught by soldiers and taken to the forest, where they had sex with me. When I returned, my husband just said that “in my culture a wife cannot sleep with another man...””

Another adds:

“..... He then said he cannot marry me again, after he saw me being raped in front of his eyes by twelve men”

Yet another one states:

“My husband chased me from our house because I was raped by other men”

The rape had severe implications for their relationships. In most cases, it led to the termination of their relationship. Some married women were abandoned by their husbands. They were indirectly blamed for the rape. It was not acceptable for a woman to have sex with another man even if it is against their will. Bayongwa’s statement explains further:

“My husband denied me insisting that until I go for a test then he can only share a bed with me. The whole body of mine has changed since then, and in my house we had started living just like single people and not a married couple”

In addition to the pains that these survivors went through, some of them reported a greater problem. They indicated that after a husband divorced his wife because she had been raped, he leaves all the family responsibilities in her hands, including care for the children, school fees

payments and other expenses; even though he knows that the wife is not employed. Tulinabitu's case explains this:

"My husband separated himself from me after this, and he left me alone with all children. I have two here and one left back with his grandparents".

However, some husbands and boyfriends showed some considerations. After the rape, they encouraged their wives and/or girlfriends to undergo the HIV test and pregnancy test before they would consider staying together. Verdiane testifies:

"My husband said: go to the doctor first if you want to stay with me, so they can test and confirm if you are not HIV positive. We went, bought cards then I was tested negative"

Other survivors who were not in a relationship, for example Charline, who is single tells her sad story. Her family did not want to have anything to do with her after she was raped.

"My parents heard about this, but they do not just care about me anymore"

Some of the women had never been involved in any form of sexual relationship. Some women faced rejection by their husbands, the same way single females were rejected by their own families and friends. Only a few survivors did not experience any changes in their intimate relationship. Some of the women had never been involved in any form of sexual relationship. Some of the women who were married, and in relationships, were not rejected by their partners nor their community and families after the incident. This is clear in the following statements by the respondents:

"Community members had no problem with me, although they knew we were taken in the forest by the rapists for so long"

"My partner was influenced by his relatives to reject me for that cause but he did not agree with them, he still considers me and said he loves me still".

“My partner took me for a test, and he agreed to always support me despite what has happened, and especially after I was diagnosed HIV- negative”

“When I came back my parents were so happy, members of the community rejoiced when they saw me”

The report above reveals that from the sample interviewed, many survivors reported changes in their intimate relationships. Of the 19 survivors interviewed, only three did not experience any changes.

4.4.3 Loss of hope for marriage and childbearing

While in Congolese community marriage is highly valued and strong emphasis is placed on having children; some of the survivors reported feeling hopeless as they do not see themselves having children in the future. The fear of not producing children is high due to damages caused by the rapists to the survivor’s reproductive system. Some of the women reported that they will not be able to have children because of the violence they were forced to endure and the damage it has caused. In the study, two respondents, Benitha and Tulinabitu give a clear picture of the survivors’ sufferings:

“I gave birth properly but felt hungry after delivery that was after a short while, then I decided to go to the forest searching for something to eat, there I met those rapists, they raped me then I started feeling pains. I met some men who gave me the direction to the Lemera hospital then I came. Since then I have had two operations here at this centre and the doctor said I will not be able to conceive a pregnancy any more, due to the severe damage in my vagina”.

“I have only one problem now, I can never get married anymore, because in our tradition, it is very impossible for a 15 years old girl like me to have a child. They call us names which can never allow any man to marry us. So my future is now destroyed. In the communities we are being called wives of Interahamwe or rebels”.

In the DRC and in the eastern province particularly, women as young as 15 years old are no longer able to bear children and have no hope of getting married either. Furthermore, women

who bear children out of the wedlock are likely to face stigma and discrimination and there are limited opportunities for them to get married.

4.5 Survivors of Rape

The most frequently reported acts committed against the survivors before or after rape are: humiliation, destruction of culture and torture.

4.5.1 Humiliation

Many survivors indicated that they felt very humiliated by the acts of the rapists especially those who were raped in front of their family members or forced to rape each other, irrespective of family relationships. However, although rape has always existed in the traditional society of the DRC, it has been regarded nevertheless as a deeply reprehensible act and an extreme humiliation for the victim and her family, especially her husband. The testimonies from two of the respondents, Chibalonza and Madame demonstrate their humiliation:

“They came into the house when we were sleeping, knocked and said they wanted to tell us something. They were interahamwe; they came in, started beating us, took everything in the house then raped me in front of everyone including my children. I felt so humiliated with my husband”.

“When they raped me, I was with my husband and he saw all these men raping me one after the other, and they forced him to stand there watching them...I felt very bad and humiliated. I wished I had died that day”.

This respondent explained that she was not alone in feeling humiliated. It was also a humiliating experience for her husband who was forced to watch her being raped in front of all their children. Many participants also explained how humiliated they felt when raped in front of their community and family members. Sharon (1994) points out that, for a woman being raped involves the loss of many things, including the loss of control of her own body and her dignity and values. This is also clear in the statement by one respondent, Verdiane:

“I came here because of those enemies from the forest that came in our house, locked my husband and raped me. After, they asked my son to have sex with me as well, then insisting that my husband also should sleep with his daughter. I cannot be able to explain the sort of humiliation that I felt since then”.

One can observe that in most cases the reasons for women or their husbands feeling deeply humiliated, is due to the fact that, the rapists forced the husband and children to watch them raping their mother or wife. Furthermore, in the case of Verdiane, after she was raped by the men, they ordered her son to rape his mother. Richters (1998), states that rape is not an act of pleasure but of extreme violence implemented by sexual means. He added that the source of satisfaction for the rapist is the humiliation and degradation of the victims.

4.5.2 Destruction of Culture

During her interviews with Amnesty International (2005), Marie Kisoni indicated that, the destruction of culture which is an integral part of every society; is the main aim of rapists in the DRC. She further stressed that, raping a child or a young girl of less than 15 years, “is just destroying our culture”. Furthermore, destroying young women’s virginity and forcing family members to have sex with each other is not part of Congolese culture. Consider the testimony of Agatha the 14 years old young girl who was raped by many young men:

“I got raped by a group of men, but by then I had not known a man, so it was very hard for me, because I was bleeding too much”.

The rapist must be aware that the Congolese community places a high value on virginity, so they decide to destroy it, in ways that dishonour women and the whole community at large. For example, raping a young virgin like Charline in the Congolese community is not only humiliating but a full violation of the country’s culture, which regards virginity as a sign of purity. Moreover, the act of family members raping each other is not part of the country’s culture. These acts are unspeakable in the DRC.

4.5.3 Torture

The report suggests that, out of the 19 survivors who were interviewed, 13 of them reported being tortured, before or after being raped. Most women reported that they were tortured when they tried to protect themselves or their partners. The testimonies suggest the use of extreme brutality by the rapist. A number of women were raped by one or several individuals, with objects such as sharpened sticks or rifle barrels, and subjected to sexual humiliation. They were raped after being forced to watch the torture and murder of their families, as well as the ransacking of their houses. Many women were killed after being raped. Asira Ponga gives her testimony:

“The reasons of me being here, since 2002, I was going to the field with my husband. We met a group of soldiers, and they let us go, but when we were coming back from the harvest, they stopped us together with my child, and asked us to give them some US dollars. They searched the two of us, and found 5000 Franc Congolais in my pocket. When my husband came, he saw his son already tied to a tree, and I was being tortured, beaten and forced to have sex in front of my son. They then started beating my husband, hitting the gun on his neck, while others were busy raping me”.

This describes the level of violence women were forced to endure. They felt completely helpless and defenceless, and there was nothing they could do to protect themselves. The victims stated that for them rape was an ultimate physical, psychological and social violation. Herman (2001) explains that the purpose of the rapist is mainly to terrorise, dominate and humiliate his victim, by rendering him or her completely helpless.

Based on the survivors’ testimonies in this report, women in this study were publicly raped, and forced to watch others being raped, while also witnessing the tortures and killings of their loved ones. The torture that the survivors were subjected to, led to the loss of the will to live. Some of the survivors indicated during the interviews how they wished to die rather than being raped. Kabisuba says:

“They used me badly until there is no way to defend yourself and I don’t have a way to explain the way I felt that day. I so wished to die because my life has lost its meaning”

In support of this testimony Resick (1998) states that in the case of extreme violence, the loss of hope to live and consciousness is a dissociative response. He argues that, this may have a survival value because it allows the individual not to consciously experience or remember the overwhelmingly traumatic event, resulting in symptoms of dissociation.

4.6 Main causes of women rape in the DRC

During the interviews, respondents were asked whether they are aware of the main causes of rape in the DRC. Almost, every respondent said that, the real cause of these acts remain unknown, except that the aims of the rapists is to continuously humiliate, torture, and destroy women's reproductive lives. However, some causes were identified throughout the sub-themes and they are supported by the existing literature in this field.

4.6.1 Socio-economic status of women in the DRC

In addition to the data collected a review of the literature suggests that in order to understand why these acts of GBV are taking place in the DRC, it is necessary to take into consideration the socio-economic status of women in the country and particularly in the province of south Kivu. An awareness of the way gender relations are perceived, and, above all, men's attitudes to women's bodies in times of peace in the DRC and in the neighbouring countries where some of the perpetrators of this violence come from, makes it easier to understand how such atrocities could have occurred.

HRW (2002), reports that, the war has had a devastating effect on women's economic and social activities. The report suggests that the already meagre resources and revenue of grassroots women's organizations, as well as their means of production, have been destroyed. In addition to the volatile security situation, women also face basic structural problems that exacerbate their impoverishment. Firstly, it is difficult for them to have access to land because of the over-exploitation and overpopulation of fertile lands, and because of patriarchal traditions. In addition to this, the economic infrastructure that would have enabled them to carry on productive

activities has been destroyed. For example, Sifa and Nadia when asked how they are surviving replied:

“Currently, we are relying on the food that we receive from lemera hospital because no one can go in the forest to look for food or collect firewood. If you go, obviously you will not come back. We cannot go to the market as well because they wait for us there”.

The war in the DRC has produced a large number of widows and displaced women who have become heads of households without them having had any preparation for this role. Most live below the poverty line and depend largely on food aid for their survival. War and poverty have forced many women and girls into prostitution as a means of survival, and this makes them particularly vulnerable to sexual violence. This has been described as ‘survival sex’ and creates conditions “in which abusive sexual relations are more widely accepted and where many men, both civilians and combatants, regard sex as a service that is easy to obtain by means of coercion” (Turshen and Twangiramariya 2001).

4.6.2 Women’s Place in Congolese Society

Women in Congolese society occupy a low social status. An analysis of the characteristics of women, show that their level of education is relatively low, because in many families boys still get preference over girls when it comes to schooling. Moreover, a large number of girls from the most disadvantaged communities drop out of school because of marriage or early pregnancy. It is difficult for women to obtain access to the means of production such as land, property or credit. Moreover, certain aspects of Congolese legislation still discriminate against women. For example, a married woman must obtain her husband’s permission before undertaking certain initiatives such as opening a bank account or asking for credit. Traditionally, women cannot inherit from their fathers or from their husbands. In the rural areas, women produce and manage 75% of food production, process their produce for family consumption, and sell 60% of their output at local markets, yet often they get nothing back from the proceeds, which tend to go directly into the pocket of their husbands (International Monetary Fund 2002).

Further reports reveal that, the province of South Kivu has almost no mechanisms in place for the advancement of women. Various international instruments for women's advancement, such as the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), and the Beijing Platform have rarely been applied because of lack of adequate funding. A survey carried out in 2001 by the DRC government and UNICEF across the whole of the Congo produced a damning assessment of the situation of women and children, revealing that it had deteriorated on almost all counts since 1995 (UNICEF 2001).

4.6.3 The Rapist

The respondents stated that, in most cases, rapists went unnoticed and not punished after the action. This can be explained by the fact that the perpetrators are Burundians and Rwandan troops, who have lived through experiences of the 1994 genocide when rape was committed at its highest level. For these troops, rape has become common practice.

Nevertheless, although GBV in the DRC has worsened due to the war, all evidence suggests that it was also occurring, albeit on a smaller scale, in peacetime. In fact, in both countries, (Rwanda and Burundi) as pointed out by HRW (2002), domestic violence has always been widespread. In the private sphere, many women are subjected to sexual, physical and psychological violence. In Burundi, it is often members of armed groups who are blamed for sexual violence, but according to Dushirehamwe (2003), they are not the only ones to commit these crimes. Incest is being committed within families, with fathers sexually abusing their daughters. There have also been reports of children, and even babies being raped by people employed in the home to look after them. The situation in Rwanda is the same: the rural areas have experienced cases of domestic violence and of rape committed against women and young girls following the war and the genocide. All these facts strongly attest to the correlation between the domestic violence that takes place within the privacy of the home, and the violence perpetrated against women in the public sphere by soldiers and members of militia groups during times of armed conflict.

4.7 Long-term consequences of being raped

This report has revealed that survivors of rape in the DRC have become victims of various health, psychological, and physical consequences of rape. Apart from this, the survivors are also

victims of infectious diseases such as HIV which always appears in these women's testimonies. In addition, there is the problem of unwanted pregnancies and other social impacts.

4.7.1 Health consequences

Amongst the survivors interviewed, 8 out of 19 respondents were already HIV positive, as a result of the rape. Post et al. (2002) point out that factors such as vaginal tearing or other injuries which occur during rape could increase the risk of transmission in cases where the perpetrator is HIV positive. Furthermore, it is estimated that nearly 60% of combatants involved in the war in the DRC are HIV-positive according to the HRW (2002) which means that there is a high risk of infection. It is known, moreover, that the risk of HIV/AIDS being transmitted during forced and violent sexual intercourse is much higher than in the case of consensual intercourse. Also, the protective vaginal secretions that are present during normal sexual intercourse are absent in the case of rape. Girls who have not yet reached puberty run a high risk of HIV infection, in that they are more liable than older girls and adult women to suffer vaginal injuries during rape (ibid).

The fact that a substantial number of women were raped by different men and raped more than once makes it inevitable that many contracted the virus as a result (African Rights 2004). Some respondents have however not been able to disclose their status because of the stigma attached to HIV/AIDS. There are some women who are living with HIV/AIDS. They contracted it from their rapists. According to some of the respondents:

“I am already diagnosed HIV positive...for me I am already dead”

“I am HIV positive, and I live on my own, so I have no hope to live any longer, no one will care about me”

“I can only tell you that I am HIV positive but I will not tell it to people in my community because they will all hate me. They will assume I wanted to carry the virus myself”

Women who are HIV positive feel a sense of hopelessness. They regard it as a death sentence. In the DRC anti-retroviral treatment is not widely available, and few women will have the opportunity to access the treatment. After hearing all these testimonies accompanied with fear and lack of HIV education, the researcher referred them to the social worker and the psychologist for further counseling.

4.7.2 Physical and reproductive health consequences

Based on the survivors' testimonies alone, they suffer ongoing physical problems as a result of their experiences of rape. The table below summarises the number of survivors suffering from one or more rape related physical or psychological effects

Table 4.3

| Sufferings | Number of survivors |
|---|---------------------|
| Asthma | 4 |
| Fear and Shame | 4 |
| Phobia about soldiers | 17 |
| Pregnancies following rape | 7 |
| Diagnosed HIV/AIDS due to rape | 8 |
| Pains when having sex with husband following rape | 3 |
| Vaginal discharge (blood & abscess) | 6 |
| Vaginal discharge (urine, water or faeces) | 5 |
| Pain in lower abdomen | 6 |
| Headaches | 4 |
| Stomach aches | 5 |
| Insomnia and nightmares | 3 |
| Injuries caused by blows with machetes | 5 |
| Vaginal tearing and can't walk properly | 5 |
| Fistulas (Genital malfunction) | 5 |
| None | 0 |

Table 4.3 summarizes the health consequences following rape. It suggests that almost every survivor has been the victim of not less than five afflictions. Many of the women suffer serious medical problems. One of the women Kabisuba testifies:

“They used me badly until there is no way to defend yourself, and I don’t have a way to explain the way I felt that day. In fact after having sex with these many people, then when I had it with my husband I felt bad, then I started urinating every hour, that I could not stay in front of other people because they look at me very strangely, and start laughing when I go to the toilet every minute”.

Other respondents who returned to their husbands after rape and did not divorce their partners indicated:

“After the rape, I felt a strange pain in my body, I went home, and there at home most of the time when I sleep with my husband I feel more pain”.

“After this action I started bleeding seriously and since that day I can no longer walk properly. After two months, I realized I was pregnant, and when my husband heard this, he denied me”

“I was here in August 2009 for an operation, that time I was pregnant and bleeding seriously”

Some women reported that they experienced severe side effects after rape. Some reported experiencing pain during intercourse, others reported severe bleeding. Some women reported that they fell pregnant, and others only found out about their pregnancies at the hospital. Others indicated:

“After the rape, I started feeling very bad, and since then I felt big changes in my body, until I discovered I was pregnant. I became sick; I was pregnant and gave birth here”.

“I felt very bad and started bleeding and feeling a strange pain in my lower abdomen. I started crying, every day I felt different pain, and now I am having a problem of fistulas asthma and insomnia”.

Resick (1998) points out that every rape victim has her own way of reporting the incident and that it happens differently for every victim. Some women suffered psychological trauma that was evident in reports of extreme exhaustion, headaches and sleepless nights. Mazabuka who could not stop crying during the interview gave this testimony:

“I can spend up to two month bleeding and since I was raped sometimes my tummy grows bigger, but the doctor also sometimes says he does not see that sickness. I also have regular headaches and asthma. Every night I have bad dreams about what happened to me, causing me to not want even to see a soldier during the day”.

Asira gives a closely related testimony:

“This caused other problems because July this year I was admitted at the hospital again. The same thing happened again, where I started bleeding, every morning I will realise that I have wet the bed. The doctor tried to repair my Fistulas but it could not work, they then referred me to Lemera Hospital to meet with other gynaecologists, and right know I am only waiting for another operation because I have met with them already”

Some women have suffered fistula which are holes in bladders, vagina and rectum caused by rape or attack using bayonets, wood, and even guns (UNFPA, 2005). The *Economist* magazine recently estimated that 80% of the fistula cases in the DRC were the result of sexual violence (UNFPA, 2006). These fistulas have caused women much embarrassment because they are constantly passing urine and they come to the hospital to repair their wounds. In most cases the interviews were interrupted and it was clear that the survivors could not continue, because they became very emotional.

At the end of the field work, the researcher had time to go through some interviews with the psychologists and the social worker, who is a nurse by profession. These interviews were conducted in the form of conversations, aiming at getting some additional information that might have not been reported by the survivors in traditional surveys. The psychologist reports:

“We do not understand this situation at all; when they come here, some of them look dead already. And on our side we are overworking and since this is the only centre that takes care of such victims in the whole province, this puts us in big trouble. I even remember one woman coming here last week with a one year girl raped seriously. She is still under medication and this is so hard. If only the government could do something...look at they way they are walking, many of them have become mentally disturbed, especially those now living with HIV/AIDS, they do not speak to us politely anymore. They are tired of life they said. The others can never be able to fall pregnant because their reproductive system has been destroyed by the rapists. According to my view, the rapists were envisaging to destroy the women’s reproductive life and the culture of our country”.

The experiences of the survivors are not only shocking to themselves but even to the service providers. The testimony of the psychologist at the centre makes it easy to understand that these atrocities are inhuman. After this declaration, in which she has shown her incapability and failure to understand the reasons for these acts, the social worker added:

“I do not know how I can explain the experience of being raped. When they first come to the centre, we fail to understand the aim of the rapists, because after having sex with them they could at least allow them to go freely and not shoot, or insert objects in their vagina. The most serious problem with them is that of being refused by their partners, and we fail to deal with this. So the numbers keep increasing since after medication they have nowhere to go. Look at those with children, they come pregnant, now after delivery the hospital director has allocated some funding to start educating both the victims and their children. We do not know where the government is in all these. If these NGOs were not assisting, this centre would have been closed already and no one would be alive amongst them by now. Especially, those living with HIV, and those who gave births here, and who are under age. I believe whatever they told you is their real story because this time they are no longer afraid of telling their stories, like before. They said they were tired of living and they have nothing to hide anymore. The only thing is that they live with fear, not only of the soldiers but of their families left behind. Some of them do not believe they will ever see their families and are worried who is taking care of them now”.

The declarations of the services providers above do not differ much from that of the survivors. The psychologist and the social worker have demonstrated their concern about the destruction of other services facilities in the province. This according to them causes a big challenge and they are worried that if these acts do not stop, this unique centre will not be able to absorb all the survivors. The number of entrants per year is much higher than the releases, in fact they indicated that they may receive up to 3500 survivors per year but only 1700 will leave. The rest will stay, admitted or referred to other provinces to find doctors and other experts in the field related to their sufferings.

4.7.3 Aftermaths

This paragraph deals only with the general aftermaths of rape. While conducting the interviews, the researcher realized that there were many other challenges faced by the survivors but these remain unnoticed, for example, the future of the children born out of rape, the survivor's rejection from their communities and their wants addressed during the interviews. Out of the 19 survivors interviewed, seven had already tested pregnant, and 4 out of them had given birth and were living with their children. The others may have been pregnant but because they were still waiting for this particular test, nothing had been reported about them. Benitha was asked about her pregnancy during the interview and said:

“Yes, this pregnancy that I am carrying is from that man who took me for two months. I left him in jail because I reported him and left”

It was clear that the main concerns for the survivors near to recovery are now concerns about the future of their children. Mapendo says:

“I thank God because I was not diagnosed HIV positive, but some complications may occur during delivery if at all. The other main problem that I am faced with now is that of my children at school, my husband was helping carrying people's good on his head from one destination to another, and earned some amount for fees, but now he can no more, so there is no way to get money to pay for their school fees. Three of my children go to school but I cannot afford it. Even

this pregnancy I am not sure about my delivery since I still have four month before this. We went there in search of life, and the whole money that we had saved already was taken off our hands”.

Other respondents were very concerned about HIV infections after being raped and expressed their worries and feelings. Their fear was exacerbated by the fact that, treatment for the virus is hard to access and that they experienced denial in their relationships and communities;, and; more importantly by the stigma attached to the sickness. Zawadi explains;

*“I have realised that I can have HIV/AIDS without notice, that is why I came here for **the** test and see how far I will go”*

Apart from this problem the survivors were concerned about the reactions of their communities. Many of the respondents reported being laughed at and given names when they returned to the communities. This according to some of the survivors has been another barrier for them to return home although they are feeling better. During the course of the interviews, 17 out of the 19 survivors reported being given names when they returned to their communities after rape. Most of them also indicated having a phobia about soldiers.

“Everyone seeing me in our area laughs at me, they point fingers at me, and all these are because my husband insisted that I should not tell anyone that I was a victim of rape”.

“People of my area call me wife of the interahamwe, and everyone who has been raped is called that name in our area”.

“You know, at home it had become a habit, at home, in the field or elsewhere, some would laugh at us and others do offer counselling. The other problem is the children we gave birth to after rape; no one wants them in our communities. They are calling them fruits of the killers”.

Many respondents have been forced to adapt to this situation. They do not see it as strange any more, although it hurts and stigmatises the survivors. The other concern regarding these children born following rape is that, as reported by the respondents, they remain living reminders of the

acts posed by the perpetrators. This makes it hard for the survivors to forget what has happened to them. Research conducted by Wax (2004) reveals that; in Rwanda children of rape were a source of conflict amongst their families because they were permanent reminders of what happened during the genocide. Some mothers named them little killers because they were born from the militia who had killed their family members. All the participants in this study were very happy and reported to the researcher that they did not believe they are considered people, until the researcher came and shared his research with them and comforted them. Finally, they extended their thanks to the director of Lemera hospital.

“Although our family members and community members do not consider us no more, we are happy that at least the researcher and the hospital are concerned with our situation”.

“We are happy because this report will be read by other people outside and they will definitely be informed of the situation women are going through in the Democratic Republic of Congo”

During the preliminary interviews, almost all the women held this view believing that this research, if published, will bring awareness and consideration of their situation. Furthermore, the table above shows that women of all ages have been subjected to rape and sexual abuse, especially those of reproductive age from age 15 to 49. The main victims were women farmers and women of childbearing age, so the socio-economic consequences are disastrous on two counts. Firstly, women farmers are the main producers and the driving force behind the whole subsistence economy of the region; therefore attacks on them have led to a considerable reduction in incomes and increased poverty in the community. Secondly, the victims who are of childbearing age have developed serious reproductive health problems which have impacted negatively on their quality of life.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

5.1 Discussion

The present study aimed at examining the consequences of gender based violence on the reproductive life of women. It has used the case of women survivors of rape who are living at Lemera hospital in the eastern province of the DRC. The data for the study was collected using in-depth interviews with the above mentioned survivors at the general referral hospital. This chapter presents a discussion of the main research findings.

A number of studies have been conducted in an attempt to understand the main causes and consequences of GBV. These studies are often aimed at uncovering the real causes and consequences of GBV in peace time and in some cases in times of war. The present study was interested in only exploring the consequences of gender based violence or rape in times of war. The aim was to document the experiences of GBV of women in a conflict situation and to determine the risks associated with it and how it impacts on their reproductive health.

However, as with most studies, the present one has its limitations. The sample was relatively small and the interviews were conducted over a limited period of time and therefore the conclusions of the study may not be generalizable to their population. Nevertheless, it is important to note that the key findings in the study are in most instances consistent with existing research literature.

This report suggests that the main causes of rape in the DRC are due to the status of women in the society, the views about and consideration of her body, the cultural detestation or rejection of women, the construction of masculinity and patriarchy. Moreover, the results indicate that the main consequences of GBV or rape in this particular conflict zone are: unwanted pregnancies and HIV/AIDS, including many physical, psychological and socio-economic consequences. It is significant to indicate here that, the most dominant consequences observed during the interviews

were the physical, medical and psycho-social. These in addition to the above-mentioned ones have been documented by more than a few studies (UNAIDS 2006; Pavlish 2005; Amnesty International 2007; McDonnell and Faden 2001; Pratt and Werchick 2004; WHO 2006; Mukamana 2004).

The findings of this research concerning the reasons why women are victims of rape in the DRC are consistent with the existing literature and evidence which explain that many ethnic groups retain traditional practices that perpetuate the subservience of women by reducing them to the status of private property. In DRC the custom of levirate remains very much alive even today, thus depriving women of the right to freely choose a new spouse (SFVS, 2006: 9). Furthermore, the research findings reveal that some traditional gender roles prescribing female submission and male dominance are linked to rape. Neapolitan (1997) points out that in Australia, Germany, and Japan, incidents of violent sexual offenses were related to national levels of dominant masculinity. Moreover, studies in several countries have suggested that rigid gender roles and promotion of an ideology of male toughness are related to violence against women (Heise, 1994; Sanday, 1981).

The findings of this research concerning the consequences of rape on the reproductive health of women are consistent with the existing evidence earlier documented by a large body of researchers and medical practitioners. For example, most of the problems mentioned are damaging to women's reproductive health, and this is particularly significant as the majority of women interviewed are of childbearing age. Leucorrhoea (heavy periods), for example, immediately suggests the presence of a sexually transmitted infection. Dysuria (difficult or painful urinating), pains in the lower abdomen, and irregular periods can also all be symptoms of vaginal infections. These medical conditions can lead to primary sterility in women who have never given birth, or secondary sterility in those who have already had at least one baby (HRW, 2002). If they do not receive appropriate treatment in time, the infection can travel up the vagina and uterus and infect and block the fallopian tubes, thereby rendering fertilisation almost impossible and thus compromising a woman's future childbearing prospects. The same is true for prolapse of the womb and for vaginal tearing, which requires surgical repair, especially in the

case of women of childbearing age (RFDA 2003; Medecins sans Frontiere 2002 and Mukamana, 2004).

These authors further indicated that urine flowing from the vagina are an indication of fistulas, which also need surgical intervention. Women suffering from this have to wear sanitary towels constantly or in most cases, because of the poverty in which most of them live, just a piece of cloth, which they have to wash frequently. Women with vaginal fistulas often live apart from the rest of the community, because of the bad smells they give off and this may lead to their isolation from other members of their community. While all these problems affect the survivors interviewed; this report suggests that rape has led to the survivors' reproductive life being destroyed.

The findings of this research are also consistent with the existing evidence that the immediate effects of rape are changes in womanhood, identities, humiliation, torture, unwanted pregnancies and other aftermaths. Moreover, the long-term consequences include; phobia about soldiers, HIV/AIDS, stigma, many physical as well as socio-economic problems. These align with the main descriptions of the survivors experiences of being raped as sexual torture. However, many of the respondents were reluctant to talk about their experiences of being raped because they feared that no one could believe them. Wilson and Raphael (1993) point out that the integral part of the rapists' choice of torture methods is to ensure that, if the story is told, no one would believe it. In line with Wilson and Raphael (1993) explain that the objective of rape as sexual torture is to manifest aggression and deliberately cause physical and psychological damage to the victim. This is also directed to the women's sexuality, seeking to destroy their future sexual function. Most of the survivors interviewed reported suffering from reproductive health problems and the destruction of their sexual functions.

The finding of this research also suggests that shame and humiliation were the main expressions used by the participants to describe their experiences of being raped. According to Herman (2001) shame is explained as a response to helplessness and indignity suffered in the eyes of another person. The feeling of humiliation and shame in this study was explained by the public rape which the interviewees were subjected to.

The findings in this research concerning victimization suggested that rape may lead to stigmatisation in cultures with strong customs and taboos regarding sex and sexuality. For example, a rape victim especially one who was previously a virgin may be viewed by society as being 'damaged'. Victims in these cultures may suffer isolation, be disowned by friends and family, be prohibited from marrying, and be divorced if already married, or even killed. This phenomenon is known as secondary victimization (Rennison, 2001). Survivors in this study have reported being divorced and being considered damaged goods. Even those who were not married before the rape reported the fear of never getting married because society will not accept their marriages after the rape, because the act is considered taboo. Further literature in this field reveals that secondary victimisation is the re-traumatisation of the sexual assault, abuse, or rape through the responses from individuals and institutions. Types of secondary victimisation include victim blaming and inappropriate post-assault behavior or language by medical personnel, communities or other organisations with which the victim has contact (Campbell et al., 1999). This again aligns with the survivors' testimonies concerning the way they were blamed for allowing the rapists to take control of their bodies, although the community knew that they had no power to resist the perpetrator.

The respondents also indicated physical, psychological and social problems in addition to the above. Some of the survivors suffered from post traumatic stress disorder (PTSD), some with continuous fear and others with mental problems. Other research suggests that in comparison to the victims of other serious crimes, female victims of sexual assault experience the most traumas in response to the event (Markesteyn, 1992). In support of the above, Resick (1998) identifies rape as the trauma which is most likely to cause post traumatic stress disorder, which was explained by the fact that, during rape, the exposure to violence is high. Gobodo-Madikizela and Foster (2005) explain this further stating that responses to rape trauma are increasingly associated with post traumatic stress disorder (PTSD). Many of the women according to the psychologist are suffering from post traumatic stress disorder.

The finding of this research also revealed that many survivors are faced with the problem of stigma associated with rape. This was addressed by the social worker and psychologist when the

survivors first came to the centre, but after they were diagnosed HIV positive, the problem became worse. According to the existing literature, a few authors indicated that in developing countries such as DRC, this stigmatization can be related to the information delivered in the early days of HIV/AIDS epidemic, which associated the epidemic with prostitution and concurrent sexual partners (Issiaka et al., 2001).

Most of the women reported HIV/AIDS as the main source of their fear and worries because it caused psychological, physical as well as sociological problems. The situation of affected women was further worsened by having children who were not accepted in the community, and were referred to as children of the rebels. This made their social integration very difficult (Wax 2004). However, these mothers although HIV positive, have not stopped doing everything they can for their children. Finding it hard to explain the motive behind HIV positive people caring so much for their children, a research conducted in Canada by Antle et al. (2001) revealed that: “mothers affected with HIV/AIDS focused on finding ways to create a happy and secure life for their children”. These authors suggest that the survivors may be motivated by their potentially shortened life span and a desire to protect and prepare their children for their possible loss, as they know they may not be there at any time soon. The responses also reveal that these children are exposed to many other problems which include educational and financial problems as well as difficulty to integrate in the community as the fruit of rape (ibid).

The findings of this research were also consistent with the evidence that there occurs a change in the view of womanhood for survivors of rape. This change is evident in the difficulties that these women face when they try to explain how they were raped. Rape not only changes their view of womanhood but also affects their intimate relationships and their social interaction within the community. Young girls explained the fear they had of not getting married in the future, due to the loss of their virginity which they associated with the loss of their identity of being girl. In this regard Lebowitz and Roth (1994) explain that it is sexuality which defines the woman, and not the woman who defines her sexuality. Moreover, a few of the married women testified how they were refused by their husbands because they were raped or could not perform any better sexually, and others because they were affected with HIV/AIDS. Golding (1996) supported these

experiences stating that the long-lasting sexual difficulties which many rape survivors experience are well documented.

Based on the findings of this research alone, it is suggested that rape can increase the risk of transmitting HIV. Jenny (1999) points out that, in forced vaginal penetration, abrasions and cuts commonly occur, thus facilitating the entry of the virus through the vaginal mucosa. Adolescent girls are particularly susceptible to HIV infection through rape, and even through unforced sex, because their vaginal mucous membranes have not yet acquired sufficient cellular density to provide the effective barrier that develops in the later teenage years (ibid). This review supports this report finding which revealed that half the total number of survivors who were diagnosed HIV positive after the test were adolescent girls. Forced sex in childhood or adolescence, for instance, increases the likelihood of engaging in unprotected sex, having multiple partners, participating in sex work, and substance abuse. Sexual coercion among adolescents and adults is also associated with low self-esteem and depression factors that are associated with many of the risk behaviors for HIV infection (Wingood and DiClemente, 2000). However, although this research did not include rape with an intimate partner, the findings suggest that some survivors were raped and abused by people they knew before, and this created low self-esteem and depression which exacerbated the risks of infections.

Survivors also report feelings of intense fear, depression, sexual dysfunction, lowered self-esteem and difficulties in social adjustment (Burt and Katz, 1991). Aligning this with Table 4, 2 in the report, seventeen out of the total of nineteen survivors interviewed reported having at least three or four of these feelings accompanied by distress. Foa and Rothbaum (1998) point out that in comparison to other crimes, survivors of rape appear to suffer from higher levels of distress both in the immediate aftermath of the event and for an extended period thereafter. Heise et al (1994) elaborate on this indicating that coming face to face with a rapist is a terrifying experience and hard to forget.

The findings of this research concerning unwanted pregnancies align with the existing body of literature which reveals that pregnancies may result from rape. The rate varies from different contexts and depends particularly on the extent to which non-barrier contraceptives are used. A

study of adolescents in Ethiopia found that among women who reported being raped, 17% became pregnant after the rape (Mulugeta et al., 1998). These findings are further supported by a longitudinal study in the United States of over 4000 women followed for three years which found that the national rape related pregnancy rate was five percent among victims aged 12–45 years, producing over 32 000 pregnancies nationally each year (Holmes et al., 1996). Moreover, it is less likely that an adolescent girl who has been forced into sex will use condoms or other forms of contraception, increasing the likelihood of her becoming pregnant (Jewkes et al., 2001; Boyer and Fine, 1992). Drawing some similarities; a study of factors associated with teenage pregnancy in Cape Town, South Africa, found that forced sexual initiation was the third most strongly related factor, after frequency of intercourse and use of modern contraceptives (Jewkes et al., 2001). Forced sex or rape can also result in unintended pregnancies among adult women. In India, a study of married men revealed that men who admitted forcing sex on their wives were 2.6 times more likely to have caused an unintended pregnancy than those who did not admit to such behavior (Martin, 1999). Heise et al. (1994) adds that one of the most serious consequences of rape is the risk of unwanted pregnancy. As victims, women pay a high price in both physical and psychological implications for unwanted pregnancies.

The finding of this research concerning the consequences of GBV on the economics of reproductive health is consistent with the existing evidence. Martin (1999) indicates that an important dimension of GBV that is yet to be fully recognized is the extent to which treatment of the symptoms of abuse impose additional demands on the already limited resources of most national public health care systems. The growing body of knowledge based on research findings, clinical reports and advocacy activities all point to the widespread prevalence of gender-based violence across class, cultural and geographical boundaries in all regions of the world (WHO, 2005). With this increased awareness has come the recognition that violence against women and girls represents a 'hidden' health burden which has not yet been fully grasped, particularly in its implications for the financial cost to the health-delivery system. According to the UNFPA (1998) the serious reproductive health consequences of gender-based violence translate into an even higher demand for curative care in the reproductive health services sector. This means that the culture of secrecy and silence concerning the causes of injury and pain suffered by many women and girls results in an inefficient use of available services, because treatment will provide only

temporary reprieve unless the root causes are directly addressed (ibid). The two key informants in this research have indicated the problem of shortage of utilities and trained health workers. They raised concerns about the existence of only one centre in the province, and worry that in the near future this may not be able to absorb the number of survivors who come in every day.

Among the most disturbing findings in this study was the fact that the villagers have lived with the knowledge of the possibility (and even the probability) of gang rape and the murder of co-villagers, including children, but they were unable to prevent its occurrence, or escape the situation in which they as civilians were caught up. As the discussion of the findings and those of other similar reports indicate, many women who have been gang raped during the war in the DRC are without family or financial support. They are in no position to care for the child resulting from the rape, or to access AIDS treatment should this be necessary.

5.2 Recommendations

Research is designed to solve particular existing problems so there is a much larger audience eager to support research that is likely to be profitable or solve problems of immediate concern. It is therefore important to understand how research impacts decision making and problems solving. In order for the voices of these victims to be heard, there is a need for their cries to be written and read by the outside world. Furthermore, the problem of the perpetrator going unnoticed or unidentified can only be dealt with if these issues are documented. It is therefore imperative to recommend that, more research be conducted in the DRC on GBV, both for times of peace and times of war.

Out of the 19 interviews conducted with the victims, 11 raised problems concerning their children. These are the children they had before rape and those born following the rape. The respondents have recommended that the government should consider this issue and bring a solution to it. Given that many of the children are of school age, and no one cares about them; this was viewed as a state failure to protect these children. Therefore, they should be taken back to school where possible, in order for them to prepare for a bright future (UNICEF 2001).

The victims of rape, many of whom are very young, seemed desperate and discouraged about life. It is recommended that these traumatized victims receive trauma counseling and that the victims who have not been diagnosed HIV positive, be informed about and also receive HIV/AIDS counseling. Lastly, the government and the United Nations should make available anti-retrovirals for those affected and contraceptives for the rest of the women.

5.3 Conclusion

The study was conducted in the DRC with women living in Lemera hospital. It has used a qualitative methodology. With regard to the aims and the objectives of this study, the findings have shown that, women survivors of rape are highly exposed to the risks of unwanted pregnancies and HIV/AIDS infection. It has also shown that, amongst the survivors, many women are divorced following the rape and they therefore have to live on their own, while taking care of the children born following their rape. These children had been refused by the community and given names, because they are not considered belonging to their community. However, despite the care they receive at Lemera hospital where they are guarded, many of them live with fear about their future and that of their children, especially those living with HIV/AIDS.

Moreover, the women's stories provide a harrowing glimpse of their experiences and treatment and that of their women in their villages. They also capture the experiences of the survivors' kinsmen, male co-villagers and particularly husbands, fathers and sons who were forced to watch the rape of women in their villages. The report suggests that many of these men were brutally killed while or after attempting to defend wives and daughters to no avail. It is also the case that, in general, the victims of gang rape come largely from deep rural areas where the principal livelihood activities are small scale agriculture and petty trading. Here again, their injuries may affect their ability to continue earning a living successfully. Therefore, the picture painted of the future facing the survivors of this form of gender based violence is bleak.

The findings have also revealed that, many survivors suffer a number of medical problems and they have the constant phobia of soldiers since they were raped. Many other survivors had been told by the doctors that they will no longer be able to reproduce because their genital parts were destroyed during the rape. This conclusion suggests then that the main consequence of gender

based violence on women is the destruction of their reproductive lives and also, has put them at risk of HIV/AIDS and unwanted pregnancy.

Concerning the study's limitation, one might question the validity of the findings of so limited number of interviews were it not for the adequate supporting documentation from similar studies undertaken by a number of reputable international organization. Although the number of interviews conducted seemed not much (19 interviews), these were intensive and produced rich data. As the literature suggests, one of the hallmarks of good qualitative research is the depth and variety of the data it produces. The researcher was also limited by time and funds as well as the sensitivity and highly emotional context and topic of this dissertation would have precluded standard quantitative methodologies.

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Appendix 1



8^e CEPAC
Département des Œuvres Médicales
HOPITAL GENERAL DE REFERENCE DE PANZI
hgrpanzi@hotmail.com
B.P. 266 BUKAVU RD CONGO

INVITATION

To whom it may concern,

We are very pleased to invite Mr. ZIHINDULA GANZA MUNGU THEOS, Student at the University Kwazulu Natal, to the site visits at Panzi General Referral Hospital in Bukavu/DR Congo.

We hereby, allow Mr. ZIHINDULA GANZA to conduct his research at Panzi hospital in the project of victims of sexual violence. All expenses will be in charge of the student.

Bukavu, July 15th, 2008

Panzi General Referral Hospital

Dr DENIS M. MUKWÈGE
Medical Director



Appendix 2

QUESTIONNAIRE (SURVIVORS)

A. interview details

Authorizing officer:
Position:
Date and time:
Facilitator (s):
Mood of the victim prior to interview (if applicable):

B. Biography

Name:
Gender:
Age:
Ethnic group:
Number of children prior to crime:
Date of crime:
Marital status:
Address/origin:

C. Related Questions

What is your reason of being at this hospital?/ *sababu gain imefanya ufike hapa kwa hii hospital?*

How did you come here?/ *umefikaje hapa ao umeletwa na nani hapa?*

How long have you been at this place?/ *umekuwa hapa yapata muda gain?*

Have you had any experience of violence? If yes what form did it take? If no do you know of any? /*Je umeshaka patwa na tatizo ya kukamatwa kwa nguvu? Kama ndiyo ilikuwaje; na kama hapana je, unajuwa mtu ambaye hii hali imeishaka mufikiya?*

Can you spell out what was your immediate reaction after being a victim of sexual violence?/ *je unaweza nieleza namna gain ulijisikiya baada yaw ewe kubakwa?*

According to your own experiences, what was the immediate reaction of your partner after he/she knew that you were a victim of rape?/ *kufuatana nay ale yaliokupata binafsi, mme ao mke wako aliposikiya hi habari yako ya kubakwa aliipokeya namna gain?*

What was the reaction of other members of your community after they heard that you were a victim of rape?/ *ndugu jamaa na marafiki walikupokeya namna gani baada ya kusikiya kama ulibakwa ao kukamatwa kwa nguvu?*

What do you think is the major cause of gender based violence in this province/country?/ *unafikiri ni nini sababu kubwa ya kubakwa kwa wanawake katika upande huu wa inci?*

What are the risks associated with gender based violence?/ *ni hatari gain ambayo unafikiri inaweza kutakeya kisha kumatwa kwa nguvu?*

Have you ever experienced an unwanted pregnancy? / *je umeisha pata mamba ambayo haukuweza kutarajiya?*

Have you ever thought of your own risk of HIV infection? / *je umeishaka fikiriya ajili ya ugonjwa wa ukimwi?*

Do you consider yourself at risk of HIV infection? Why or why not? / *je unajifikiriya kuwa kwa hatari ya ugonjwa huo? Kama ndiyo ao hapana ni sababu gani*

What are the obstacles that women face in protecting themselves against gender based violence in this province/country? / *viziwizi gain ndivyo wamama wanakutana navyo wanapotaka kujizuiya kutokubakwa?*

Do you think that in these conflicts men were also raped? / *unawaza nieleza kama wanaume nao walikuwa wanabakwa katika hii vita?*

If yes, why do you think men were also raped? / *kama ndiyo kwa nini unafikiri wanaume nao walikuwa wakibakwa?*

In your own experience, do you think this mass rape was ethnically motivated? / *je unafikiri haya mambo yaliyokufikiya yalikuwa yanafanyika kikabila?*

If yes, what is the ethnic group you think was the most affected? / *kama ndiyo ilikuwa zaidi imebakwa?*

If both men and women were victims, what do you think are the likely factors that contributed to this crime? / *Kama wote wanaume na wanawake walikuwa katika hii hatari ya kubakwa, unafikiri ni nini sababu kubwa ilifanya hii itendeke?*

Can you state the reaction of the local authorities when a case of rape is brought before them? / *je unaweza nieleza kama umeisha ona mtu aliyeshitakiwa kwa kubakwa anafungwa ao huachiliwa tu hivyo?*

Now as you are here at the hospital, is there not any other place were these victims are accommodated? / *je ulivyo hapa hospitali, je hakuna mahali pengine ambako watu hawa waliobakwa wanachungwa?*

Are you satisfied by the services rendered at this hospital? If no would you suggest something more to improve the service? / *Je unatosheka na jinsi munavyo chungwa hapa? Kama hapana, unaweza kunieleza mawazo mengine unakuwa nayo ajili yah ii kazi hapa?*

Do you have any recommendation to other women (unraped), to the Government and to the NGOs around? / *Ni ushauri gain ambao unaweza kutowa kwa wamama ambao hawakubakwa, kwa wakubwa wa serikali, ao kwa hawa wanaotowa misaada kwenu?*

Informed Consent Form

(To be read out by researcher before the beginning of the interview. One copy of the form to be left with the respondent; one copy to be signed by the respondent and kept by the researcher.)

My name is Ganzamungu Zihindula (student number 206520999). I am doing research on a project entitled:

“The consequences of gender based violence on reproductive health: A case study of women in Lemera Hospital, Democratic Republic of Congo”

This project is supervised by Dr. Pranitha Maharaj at the School of Development Studies, University of KwaZulu-Natal, in Durban, South Africa. I am managing the project and should you have any questions or concerns my contact details are:

School of Development Studies, University of KwaZulu-Natal, Durban 4041, South Africa
OR *Alternatives-Democratic Republic of Congo*
Mobile: +243997744475(Congo)
Tel: +27-769918940 (South Africa)

Email: aganzetheos@yahoo.com or 206520999@ukzn.ac.za

Thank you for agreeing to take part in the project. Before we start I would like to emphasize that:

- Your participation is entirely voluntary;
- You are free to refuse to answer any question;
- You are free to withdraw at any time.

All interviews will be recorded. The interview will be kept strictly confidential and will be available only to members of the research team. Excerpts from the interview may be made part of the final research report. Do you give your consent for: *(please tick one of the options below)*

| | |
|--|--|
| Your name, position, and organisation, or | |
| Your position and organisation, or | |
| Your organisation or type of organisation <i>(please specify)</i> , or | |
| None of the above | |

Please sign this form to show that I have read the contents to you.

----- (signed) ----- (date)

----- (print name)

Write your address below if you wish to receive a copy of the research report: