Exile and Reintegration among Rape Survivors in the Democratic Republic of Congo: Factors Influencing Rejection and Acceptance
Abstract

The Democratic Republic of the Congo continues to be plagued by the systematic rape of women and young girls. With estimates suggesting that 200,000 women have been raped since 1996, the implications for the country and the society are profound. This study was aimed at understanding the unique cultural factors that influence exile and reintegration of women post rape by their husbands. As part of the secondary data analysis, 17 transcripts from female rape survivors were evaluated in order to identify themes that influence acceptance or rejection. The women were divided into five unique groups based on their marital status. From these interviews, 11 themes were identified. This study found that women who had testing positive for HIV, abducted by their aggressors, or had become pregnant from the rape were never accepted back by their husbands. Shame, living in fear, barriers to medical treatment and lasting medical complications were factors that influenced a women’s likelihood to face exile. Higher education, ability to conceive after being raped, husband trauma, mediation and optimism were associated with acceptance. By understanding the barriers to reintegration, specific programming and interventions can be developed to help women to transition back into their families. As the conflict in the Democratic Republic of the Congo continues, it is becoming increasingly important to address these barriers in order to preserve the families and prevent further disruption of the social cohesion of the communities.
Introduction

The Democratic Republic of the Congo (DRC) is a diverse nation, rich in natural resources including gold, diamonds and cobalt, bordered by one of the largest lakes in Africa, and home to a wide variety of biodiversity (Central Intelligence Agency [CIA], 2011). Yet, the DRC is also home to some of the most brutal human rights violations in the world. The International Rescue Committee (IRC) reported that the ongoing conflict had resulted in 5.4 million deaths, which makes it the “deadliest war since World War II” (International Rescue Committee [IRC], 2007, p. 3). Though the high death toll has caught the attention of the international community, the use of rape as a war tactic targeting women and families in the DRC is an even more disturbing development. In the DRC, rape is used as a weapon of war, aimed at destroying not only the individual, but the entire society (Trenholm, Olsson, & Ahlberg, 2011). In March 2009, the Secretary General of the United Nation Mission in the DRC reported that 1,100 women were raped every month, which means around 36 women are raped every day (United Nations Organization Mission in the Democratic Republic of the Congo [MONUC], 2009). The fighting and rapes continue to be heaviest in eastern DRC where studies suggest that as many as one in three women have been raped (Kwon, 2009).

Background and Significance

History of the Democratic Republic of the Congo

The DRC has had a very turbulent history which has led to today’s conflict. Its wealth in natural resources has proven to be both a blessing and a curse. The country was claimed as a Belgium colony in 1908 and was King Leopold II’s personal property for over 50 years (CIA, 2011). Under the control of King Leopold II, millions of Congolese were killed during Belgium’s exploitation of the DRC’s natural resources (Nzongola-Ntalaja, 2002). In 1960, the
DRC received its independence from Belgium. In 1965, a coup led by Joseph Mobutu, who later took the name Mobutu Sese Seko, was the beginning of another 32-year brutal reign that is characterized by exploitation and fear of its people (British Broadcasting Corporation News [BBC News], 2011).

The 1994 genocide in Rwanda, which resulted in the death of thousands of Tutsi at the hands of the armed Hutu group, called the Interahamwe, was the beginning of the conflict that continues today in the DRC. Tutsi refugees fled to the DRC, but the Interahamwe were also able to infiltrate the country. The Alliance des Forces Democratiques pour la Liberation du Congo (ADFL), was backed by Rwanda and Uganda and led by Laurent Kabila to protect the DRC’s border from the Interahamwe (Puechguirbal, 2003). In 1997, the ADFL, along with anti-Mobutu rebels, invaded the DRC and took over the capital city, Kinshasa, and Laurent Kabila became president. Disputes between the DRC’s former allies, Uganda and Rwanda, came to a head in 1998 when Kabila forced Rwandan troops out of the country. Uganda and Rwanda retaliated and invaded the DRC, which at the time was backed by Namibia, Zimbabwe, and Angola (BBC News, 2011). In total, eight nations and at least 25 armed groups were involved in the Second Congo War (Open Society Initiative for Southern Africa [OSISA], n.d.). In 1999, the Lusaka Peace Accord was signed and a ceasefire was ordered. The United Nation’s (UN) mission, Mission de l’Organisation de Nations Unies en République Démocratique du Congo (MONUC), entered to help supervise the transition, but violations on all sides continued to escalate. Laurent Kabila was assassinated in 2001, and his son, Joseph Kabila, took power. Under his leadership, a peace deal was signed in 2002 that signaled the official end to the war (BBC News, 2011). However, militia groups continue to wreak havoc in eastern DRC, which borders Rwanda. The Interahamwe, the Hutu armed group that originally entered the country after the Rwandan
genocide, along with the Mai-Mai, the Congolese army, other soldiers, as well as UN peacekeepers are often cited as the perpetrators of the rapes committed today.

**Rape in the Democratic Republic of the Congo**

The United Nations has dubbed the DRC the “Rape Capital of the World” (BBC News, 2010). Although the Second Congo War officially ended in 2002, the country, specifically the North and South Kivu regions in eastern Congo, continues to be an area that is crippled by further fighting. The Kivus are located on the border with Rwanda where the fighting originated in 1994. The weapon of choice in these continued attacks is rape. The systematic rape of women is often referred to as a silent or invisible war because it is nearly impossible to know the full extent of the practice (Trenholm, Olsson, & Ahlberg, 2011). Accurate statistics of the number of men, women, and children raped each year are difficult to find because survivors often do not report the crime and suffer at home, instead of seeking treatment due to the stigma associated with rape and other forms of sexual violence (Oxfam International, 2010). Furthermore, reporting and monitoring of the incidence of rape is hard to organize in an area that continues to be disrupted by fighting, further destroying the basic infrastructure in the area. The UN reported that more than 15,000 people were raped last year in the DRC (United Nations High Commissioner for Refugees [UNHCR], 2011) and that 200,000 women and children have been raped since 1996 (Drash, 2009).

**Rape as a Weapon of War**

In 2008, the UN voted unanimously to classify rape as a weapon of war (BBC News, 2008). It is described as “a tactic of war to humiliate, dominate, instill fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group” (BBC News, 2008). Since the start of the Second Congo War, eastern DRC has been plagued by the use of rape as a
weapon of war (Drash, 2009). It is an effective war tactic because it costs the perpetrator nothing, but the ramifications for the survivors, their families, and the community are devastating and long lasting (Mukwege & Nangini, 2009).

While the sheer number of women and children who have been raped is horrifying, the manner in which the rapes are perpetrated is unprecedented. The extremely violent nature of the rapes has demonstrated a new level of barbarity and dominance that has scarcely been seen in previous conflicts (Wakabi, 2008). Human rights workers have commented that “it [The DRC] is one of the worst places in the world to be a woman or girl” (Drash, 2009). Rape of the very young and the very old, sexual slavery, forced incest, genital mutilation and penetration with foreign objects are among a few of the characteristics that demonstrate the atrocious nature of the rapes in the DRC (Wakabi, 2009; Mukwege & Nangini, 2009). The perpetrators do not discriminate in terms of age; their primary goal being to disrupt social cohesiveness and to create terror in order to continue to profit from the vast natural resources in the area. The DRC’s ongoing conflict has enabled the perpetuation of rape and hindered the organization and implementation of programs to assist the survivors.

This continued conflict not only makes accurate data collection of rape incidences difficult, but also discourages the presence of international and local Non-Governmental Organizations (NGOs). Additionally, the continued instability hinders the survivor’s ability to feel safe and seek assistance. Little data is currently available about the social and psychological needs of the rape survivors in the DRC (Wakabi, 2008). Furthermore, stigmatization and ostracism of survivors have been widely reported throughout the region (Trenholm, Olsson, & Ahlberg, 2011). Isolation becomes a major barrier to the survivor’s mental and physical
recovery. Without resources or social support, their ability to reintegrate into society is detrimentally impacted.

This study examined the factors influencing exile and reintegration of female rape survivors, by their husbands, in the DRC. It is important to understand the culturally specific needs and the limitations inhibiting reintegration, as this will lead to successful planning and implementation of social and medical assistance programs. Despite international pressure, humanitarian workers in the DRC have reported that the rapes are becoming more common and increasingly violent (Wakabi, 2008). Failure to understand the factors that influence reintegration and exile may lead to the continued isolation of the survivors and destabilization of the community.

**Methods**

The purpose of this study was to explore factors that influence the exile and/or reintegration of women by their husbands following rape in the Democratic Republic of the Congo. This study was a secondary analysis of data collected in a larger study, consisting of 43 semi-structured interviews with rape survivors, men who accepted their wives, men who rejected their wives, health care providers, political officials, social advocates, prisoners convicted of rape, religious leaders, and child soldiers. For the purpose of this study, only the interviews from the female rape survivors were analyzed in order to identify factors that facilitated or inhibited acceptance by the women’s husbands.

**Procedure**

The University of North Carolina at Chapel Hill’s Institutional Review Board provided a waiver for the procedures carried out in the study as permission was obtained from Johns Hopkins’ Institutional Review Board for the primary study. Permission to use the data was
secured from the principal investigator, Dr. Nancy Glass, of the original study at Johns Hopkins University School of Nursing. For the purpose of this secondary data analysis, only the interviews of female rape survivors were analyzed. Transcripts from the female rape survivors were provided by the principal investigator, and coded to protect anonymity. The coded transcripts were used for the secondary data analysis and no access to the personal information was available to the researcher or advisor during the project.

Sample

The sample consisted of 17 female rape survivors that were raped between 1997 and 2008 in the South Kivu province of the DRC. Participants ranged in age from 16 years old to 65 years old and were interviewed between one and 11 years post rape. The women were primarily working as farmers and cultivators (59%), with 23% surviving on petty trade (selling fish, charcoal, vegetables in local markets), 6% employed as primary school teachers, 6% employed as midwives, and 6% unknown. On average participants reported having five living children. Women were slightly more likely to be attacked in their homes (53%) with the remaining 47% attacked in public spaces, including fields and places of employment. The majority of the women in this sample reported being raped by multiple attackers (88%), with the remaining 22% being attacked by a sole aggressor.

Analysis

The transcripts were analyzed to identify common themes and patterns. Concepts were identified by reading through each transcript and underlining important phrases. The transcripts were read multiple times to ensure that the full experience of the female rape survivors could be obtained. The phrases were then placed into a Microsoft Excel document and grouped into meaningful clusters from which the themes and patterns could be identified. Themes were
identified as contributing significantly to the experience of reintegration and without them the experience would not be the same (Polit & Beck, 2003). The themes were then reviewed by the honors advisor whose interpretation of the data was compared with the honors student’s for similarities and differences. Any discrepancies were clarified by returning to the transcripts for further analysis.

**Results**

The 17 women that were interviewed fell into five unique categories; 1) women who were not married; 2) widows; 3) women who were accepted; 4) women who were rejected; and 5) women who were initially rejected, but ultimately accepted. Women who were not married were defined as not having a husband to be reintegrated with because they had never been married (n = 2). Widows were defined as women whose husbands were dead, and thus had no husband to reject or accept them (n = 5). Women in the accepted group (n =2), were defined as women who were immediately accepted by their husbands. Women in the rejected group (n =5) were defined as women who were rejected by their husbands and not allowed back into their homes. Finally, women who were initially rejected, but ultimately accepted (n = 3) were defined as women who were originally turned away from their homes by their husbands, but after varying amounts of time were eventually accepted back into the home. For the purposes of this analysis, the women were separated into these categories for analysis because factors that influenced their reintegration or exile were specific to these defined groups. However, there were some overlapping characteristics among all the groups of women which warrant further discussion.
Overlapping Characteristics

HIV status, pregnancy from rape and abduction were common themes that overlapped between all five groups of women. Women who became HIV positive or pregnant as a result of the attack were never accepted back in to the relationship with their husband, regardless of group assignment. Additionally, no woman who was abducted was accepted by her husband, regardless of group assignment (Figure 1).

Figure 1: Overlapping Characteristics by Defined Groups of Women

HIV Status. HIV status was a common theme that was expressed by all five of the groups of women. Of the 17 women, six had been tested for HIV. Three (50%) of the women tested were found to be HIV positive. None of the HIV positive women were accepted back by their husbands. All of the HIV positive women cited their HIV status as a reason for rejection:

“Now I am HIV positive. My son from the rape is not. I think I was infected the second time [I was raped]. My husband abandoned me when he heard I was infected.”

All of the women who tested HIV negative were either immediately accepted or ultimately accepted back by their husbands. Two of the three women that were initially rejected but ultimately accepted were found to be HIV negative and they stated that their negative status was a reason for their reintegration:

“My husband chased me away. I went to my father who welcomed me. My father went to talk to my husband who said he was afraid to be infected. After medical tests he was convinced I was not sick and my family took me back to him.”
Pregnancy from Rape. Whether or not the woman conceived during the rape was another factor that was expressed throughout the five groups. Three women (17%) became pregnant as a result of the rape. Of these, one woman was unmarried when she was raped and two women were rejected by their husbands. The women identified pregnancy as the reason for rejection by their husbands:

“My life has changed because I don’t have a home, no house. My husband rejected me because I had become pregnant by a Hutu... In my community I’m stigmatized. Everybody ‘backbites’ [talks about me behind my back] me. They don’t like me because I gave birth to a Hutu child and they hate the child. I am scared. I ask myself, ‘How is this child going to grow?’ He often asks me, ‘What is a child of a Hutu?’ I don’t have any more value.’”

Abduction. Although abduction did not occur in every group, its occurrence had an effect on acceptance by the husband. Abduction was seen in the singles, widows, and rejected groups. None of the women who were abducted were ever accepted by their husbands. Eight women (47%) were abducted and held by perpetrators from a range of two weeks to two and a half years. Additionally, two women (12%) were abducted multiple times:

“The Interahamwe came to my house. I was there with my husband and children. They stole money and the cows my husband was selling. They abducted my husband, two of my daughters, and me and took us to the bush. After two days of being there, my husband escaped. They raped me. They raped my daughter who was five years old and she passed away after being raped. During an attack of FARDC [Congolese] soldiers, the Interahamwe escaped. Then the FARDC soldiers freed us and brought me to the health center of Walungu. I was raped a second time. They came back. There were three soldiers. They abducted me again, my daughter and four women from my village. They killed my daughter and two other women on the road. After two weeks in the bush, they sent a message to our husbands telling them to come with money to free us. They came with money. They obliged my husband to stay there. They asked me to go back home and look for money. I went to borrow money in my village I went back to the bush with money to free my husband. Unfortunately they asked me to return saying that my husband will come after me. After one month I heard that my husband was killed. I decided to leave the village to go to another one called Kaniola. I was raped a third time at Kaniola. There were five. They abducted us to the bush for a third time. That time I was only the commander’s wife. I did not belong to everybody as it was the case before.
One day the commander went to visit his relatives at Walungu. I profited and escaped then.”

**Women Who Were Not Married**

Two women had not been married at the time of their rape. Both were abducted at a young age, 12 and 15 years old respectively, and each was kept as a sex slave by armed combatants for more than two years:

“I was at home. Five Interahamwe came, they took my father and me to the bush. On the road they killed my father. Once in the bush they locked me up with other women I met there. Every day Hutu soldiers came to beat and rape us. After two and a half years with them, they recognized that I was pregnant. They freed me and sent me back to the village.”

At the time of the rapes, neither woman had a husband to be reintegrated with, so no themes affecting their reintegration could be identified. However, their unique set of needs will be briefly discussed in the discussion section.

**Women Who Were Widowed**

Five women were widows at the time of the interview. Of these four women had lost their husbands during the same event in which they were raped:

“It was evening. The door wasn’t closed yet. I had my child on my back and my husband was resting in the bedroom. Six Interahamwe came. They snatched my child from my back and threatened to throw him in the latrine. One of my sons was slaughtered in the living room. The Interahamwe entered the bedroom and stabbed a dagger into the back of my husband who died on the spot. They struck me and two of them raped me in the presence of my children.”

Since there is no husband to reintegrate these women with, no themes can be identified that impede or facilitate reintegration with their husband. However, the unique needs of these individuals will be briefly discussed in the discussion section.
Women Who Were Accepted

Two women were immediately accepted by their husbands following the rape. The participants identified two factors to this reintegration that were unique from the other groups. These themes are “Level of Education” and “Ability to Conceive.”

Level of Education. The women in this group had the highest level of education compared to the rest of the sample. They were the only two women in a profession other than petty trade and/or farming. One woman was a midwife who was attacked in the clinic she worked in and the other was a primary school teacher. Their higher level of education allowed them to bring in financial support for their family and this was reported as a factor that influenced reintegration:

“The women who have financial means are easily accepted back into the family of her husband.”

Ability to Conceive. Both of the women had undergone brutal rapes where foreign objects were inserted into their vaginas:

“I was with my brother, husband and my children going to the village center. We met Interahamwe who first killed my brother, bound my husband’s hands, and forced us to carry their things. They started raping me, having sex with me by force. There were seven of them. After that, they took a banana tree and pushed it into my vagina, raping me with the banana tree. It was really painful and I fainted.”

“I was a nurse on guard at the health center… Four Interahamwe came. They beat me up and intimidated me. I offered them the money that was at the center. They said no, what they wanted was to sleep with me. One of them suggested to the others that they should kill me and he put his dagger on my throat. Afterwards they undressed me and all four raped me. After the rape they introduced the barrel of their gun into my vagina and pushed it in several times. They left leaving me alone on the ground with my clothes in my mouth so that I couldn’t cry.”

Despite this trauma, both women were able to conceive with their husbands after they were raped:

“After being raped we had a child together and are living together.”
Women Who Were Rejected

All of these five women were rejected by their husbands and not allowed to return to their homes following the rape event. The themes identified from the analysis of this group included: “Medical Complications and Barriers to Health Care,” “Shame,” and “Living in Fear.”

Medical Complications and Barriers to Health Care. The women identified that they continued to suffer from medical complications including pain, bleeding, and infertility. While the health complications varied between the women, all of the women reported lasting health effects from the rape:

“I was in my home when they came and looted five cows and nine goats. They raped me and my daughter. I went with them to the forest. My daughter escaped on the way. I spent three days there, then fled when they sent us to look for firewood… Since that time I have had pains in my back. I go from time to time to the Centre de Sante [health center] but the pains weren’t stopping.”

Direct injury to the uterus can affect a woman’s ability to conceive and this was given as a reason for rejection:

“It was morning. There were eight of us women. We went together to collect firewood. Aggressors came and abducted us. They tied our hands and feet to a tree. They raped and beat us… They introduced a stick and gun into my vagina… My family-in-law rejected me and asked my husband to marry a second wife… My family-in-law knew that they destroyed my womb. They were unhappy because I could not help them in anything. I could not have kids”

All five women cited examples of barriers to access to treatment and barriers to adequate treatment. Two women listed money for transportation and treatment as the major barriers to health care:

“Since then [the rape] I am suffering. I have pains in my lower abdomen. I cannot afford treatment.”
Four women reported that clinics and medical facilities did not have adequate medications on hand at the time of the rape and thus they were unable to get the right type or amount of medication:

“Hospitals need to have materials and medicines to help us.”

Two women were able to get medication, but were unable to finish the prescription because it made them feel sick on an empty stomach:

“I went to the health center to have medicine that I didn’t finish taking because the medicine made me sick because I had nothing to eat.”

**Shame.** Shame was a persistent theme that was expressed throughout the interview by the women in this group:

“I was going to the market with other women from my village. We met Interahamwe in the bend who probably were waiting for us. They asked us to put whatever we had in their car... They bound our hands and raped us one after the other. One of us tried to talk to them and resist. They killed her. Back home I did not say anything to anybody. It was shameful for me.”

The women’s feelings of personal shame as a result from the rape were also identified in this group:

“I don’t have any more value.”

“The aggressors made me dirty.”

“They cut my life short. I ask myself if I am even still alive.”

In all of the interviews, the women reported that their husbands and communities became aware of their rape and of their medical status:

“One day, a woman who knew me found me in pain and suffering and brought me to the health center where I did a test. Unfortunately, I was HIV positive... At home they know what happened and they are also informed about my health. The day they were informed they chased me away with my two children.”
The women stated that the shame of having their medical status spread to their community often prevented them from seeking medical care where they would have to inform health care workers about what had happened to them:

“It was shameful for me. I used salt as a disinfectant because I was bleeding. I was afraid and ashamed to go to the hospital to be treated.”

**Living in Fear.** Among the women who were rejected, three of the five women also reported feelings of continued unease and the fear that they are still not safe. Three of the women reported continued unrest and insecurity, which served as a painful reminder of what happened to them. Flashbacks of the rape were reported by many of the women. These perceptions by the women manifested as the theme, “Living in Fear”:

“I remember the events when I see something related to the events.”

“I often see scenes again because I live in bad conditions.”

“Perhaps I would have forgotten, but I don’t have a house, or anything to eat. I have a child of nine years who has to be at school. All these worries just make me think about that often.”

“Everyday before I sleep I see the events happening. I have bad dreams… I can’t fall asleep.”

“I am afraid to relive the event. I feel jumpy at all times.”

**Women Who Were Initially Rejected but Ultimately Accepted**

There were three women who were initially rejected by their husbands but were ultimately accepted and allowed back into the family. After analysis of this group, three unique themes were identified. These themes are identified as “Husband Trauma,” “Mediation,” and “Optimism.”

**Husband Trauma.** A unique factor reported by this group was that the husbands had residual effects of also having gone through a trauma:
“I think my husband also has some psychological problems because he has become irritable. He couldn't sleep and was often complaining of these aggressors.”

They explained that when a woman is attacked in her home, the husband is often also attacked. He can be beaten or killed, and he is forced to watch as his possessions are stolen and his wife is raped:

“Three Interahamwe soldiers came home. They each raped me with my children watching. Some beat my husband while others were raping me. They stole everything and left me naked.”

This trauma is something the husband has seen and experienced firsthand and has been cited by the women as a reason for understanding and reintegration:

“My husband welcomed me back because he was beaten, too, and we both know it could happen to anyone.”

Mediation. Mediation served as a crucial factor in assisting with the reintegration of these women. All of the women in this group received mediation and identified it as a contributing factor to their reintegration:

“At first he [my husband] chased me away and only accepted me after four months of mediation”

The women reported that, following the attack, they were seen as collaborators with their attackers and that this is a reason for rejection:

“People from the village and others as well call me the Interahamwe's wife”

“Many men wanted to get rid of their wives when they were raped. They don't want to share anything with them because they collaborated with their aggressors”

The women in this group were aware that mediation is aimed at showing the men that the women did not choose to be raped and did not collaborate with their aggressors:

“The counseling aims to train men, to teach them that everything happening to women does not depend on their will.”
Mediation also points out that husbands are often humiliated and beaten during these attacks. Mediators can use this to show how both the husband and his wife were helpless during the attack and neither of them chose to have this happen:

“As men don’t want to be beaten and humiliated, also women cannot choose to be raped”

“They [mediators] explained to him that he was chained and he was incapable of defending himself and I too was unable to defend myself”

**Optimism.** All three women conveyed that they were still having some difficulties adjusting to life after the rape. These include no longer having a way to work because their tools were stolen or that they had no money to send their kids to school. However, two of the women reported that they no longer had any emotional or psychological troubles:

“I don’t have any problems. All the pains disappeared with the sensitization [mediation].”

One woman reported that she did still have lasting fears, but that it was not so debilitating as to keep her from functioning or enjoying everyday life. She reported still being able to love and looking to God for support in her future:

“Every day when someone knocks at my door, I’m afraid and ask my children to hide themselves… I still can enjoy myself. I can have fun without any problem… I love everybody, including my in-laws and my children. I do not know what will help improve my life situation, but I am praying God helps me.”

Two women showed signs of optimism and cited their mediation as helping them to move forward:

“My health is good. I don’t think about it anymore because I have been sensitized [had mediation]… I am no longer afraid of reliving these events… I no longer feel jumpy. At the beginning I was hiding myself, I was avoiding meeting people. I was just closed up. But now I can speak with them without any difficulty… I have recovered quickly because I’ve understood that with love there is peace. With love all will go well. With love one can endure, one can forgive.”
Discussion

Overlapping Characteristics

There were three overlapping themes that were identified once the transcripts for the interviews had all been reviewed: “HIV Status,” “Pregnancy from Rape,” and “Abduction.” Although these factors are non-modifiable in the sense that the women cannot prevent them from occurring, it is important to identify and discuss them as components of mediation programs as they serve as factors for whether the woman will be accepted or rejected by her husband.

**HIV Status.** There is a powerful stigma surrounding rape and HIV in the DRC. HIV is seen as a death sentence because access to treatment and HIV drugs are severely limited. Women who are raped are assumed to be HIV positive until they can prove otherwise. Stigma surrounding sexually transmitted infections (STIs) and HIV are prevalent and the DRC lacks the resources for testing and treatment in many rural communities (Trenholm, Olsson, & Ahlberg, 2011).

While the woman’s HIV status is a non-modifiable factor, access to testing is a potential intervention point. Among the women in our sample, those who were able to get tested and prove that they were HIV negative were all accepted back by their husbands. Therefore, access to HIV testing could be a powerful asset for these women in terms of being reunited with their husbands. However, more investigation is needed to develop programming for women who find out they are HIV positive. The results from our study show that women who were HIV positive were never accepted by their husbands. This could be due to the notion of HIV as a death sentence, which prevents the husband from accepting his wife. The husband fears that by continuing to have sexual relations with his wife, he is putting himself at risk for contracting HIV. Therefore, it is crucial that programming be developed for the women, their husbands and
the community to prevent stigma and identify prevention and risk factors for HIV. Programming needs to be designed to reintegrate survivors with their husbands and/or help them to become self-sufficient.

**Pregnancy from Rape.** If conception occurs as a result of the rape, this will increase a woman’s chance of being rejected by her husband. The data showed that no woman who became pregnant was ever accepted back by her husband. This may be because of the cultural stigma surrounding raising a child that is a product of the rape. The child is actually seen as the son/daughter of the aggressor. Pregnancy from the rape is another powerful weapon used to destroy the cohesion of the community. Not only are the women rejected because they are raped, but the child is often rejected as well. Children born from rape are considered to be a curse and many communities fear them and thus ostracize both the child and their mother. In the DRC, these children are often left on the streets and grow up in orphanages or as street children. If a woman is able to conceive with her husband soon after the rape, she may also face criticism and speculation that the conceived child is not the husband’s child, but the child of her attacker. The woman’s ability to conceive and produce children is highly valued in the Congolese culture. If a woman is not able to conceive following the rape then the woman may lose her value. This is a constant challenge and the reason why rape as a tool of warfare holds such power. Not only does it have initial physical and emotional consequences for the woman, but there are long-lasting implications felt throughout the entire society. More research into interventions is needed to help address both the women who conceive during the rape and women who are dealing with the accusations that linger after she conceives with her husband.

**Abduction.** Abduction is a common practice among the armed groups in the DRC. The practice is aimed at further destroying the cohesion of the community and stigmatizing the
woman. Every woman from this study who was abducted was rejected by her husband. This could be because the woman’s absence and the likelihood that she is being raped by the abductors is noticed by her husband and her community. When the woman returns to her community, whether she was released or she managed to escape, she has no way to hide the fact that she was abducted. Their continued absence often results in the husband taking another wife, or they may reject the wife upon return because she has been sexually intimate with another man. According to Congolese customs, a wife can never be intimate with anyone other than her husband (Trenholm, Olsson, & Ahlberg, 2011). Additionally, women are often accused of going willingly with their attackers or collaborating with them. Women who are kept for any length of time are also at an increased risk of becoming pregnant because they are often raped by multiple assailants on multiple occasions.

Women Who Were Not Married and Widows

More research is needed to address the needs of the women who were not married (single) and the widows. Although clear themes could not be identified from this study, these are important groups that warrant further research. The women who were not married at the time of their rape are culturally seen as “dirty.” Sexual purity is valued in the DRC’s patriarchal society (Trenholm, Olsson, & Ahlberg, 2011). Young girls who are raped must face the likelihood that they will never be married. Once the community learns of her rape, a woman’s chances of being married and having a family are limited (Mukwege & Nangini, 2009). The results from the sample show that younger, single girls are more likely to be abducted. This tactic of abducting young girls helps to further undermine the social cohesion of the community, not only in the present but also in the future. By abducting them, their sexual purity is called into question. Without the prospect of marriage, these girls will have to learn to be self-sufficient among a
community that stigmatizes them. Since this study focused on the factors that influence rejection or acceptance by the husband, no themes could be identified for this group as these individuals did not have husbands with which to reintegrate. However, more research is needed to understand their unique needs and to develop programming that will help integrate them back into society, empower them to be self-sufficient, and care for their physical and psychological problems.

Similarly, no themes could be identified for the women who were widows because they had no husband to reject or accept them. Many women lost their husband during the same attack in which they were raped. These women not only had to survive the stigma and shame surrounding their rape, but they were also forced to cope with the loss of their husband. In a patriarchal society like the DRC, the woman’s future is limited without her husband and her prospects of being remarried are slim. This group of women often has children, and must find shelter, food, and money to provide for their families. Further research is needed to address their specific needs and to develop programming to help them become self-sufficient.

**Women Who Were Accepted**

The woman’s level of education and her ability to conceive after the rape were factors for the woman’s acceptance by her husband.

**Level of Education.** A woman with a higher level of education in the DRC often means that she has a job that brings money to the household. While petty traders and farmers may bring in some extra income, women who have a job such as teaching or nursing are a powerful asset to their family. Their ability to financially contribute to the household makes the likelihood of their acceptance much higher. Further research and programming focused on educating girls and women could have a powerful effect on the society. If rejection still occurs, a job would also
help to provide a woman with a way to support herself and her family. A higher level of income also means that the woman will have money for transportation to and from a medical facility for necessary medical treatment and testing.

**Ability to Conceive.** The brutality of the rapes in the DRC is aimed at destroying the women emotionally and physically. By destroying her uterus, they are destroying her ability to have children (Mukwege & Nangini, 2009). Culturally, a woman’s ability to have children is very important and if a husband knows a woman is not able to reproduce, she will be rejected. Children are seen as a blessing in this society and having many children is seen as a personal accomplishment on the part of the mother and father. By destroying her ability to conceive, the rapist is destroying the family and community by impacting its future generations. Therefore, women who are able to conceive after the rape are more likely to be accepted. Equipped medical facilities with trained personnel are needed to help treat women who are raped. Many women continue to suffer from the medical complications of their rapes long after the attack occurs. Postponed treatment can result in permanent damage to the woman’s reproductive system (Mukwege & Nangini, 2009). Access to medical care can increase the likelihood of women being able to conceive after rape and thus increases the chances of them being accepted.

**Women Who Were Rejected**

**Medical Complications and Barriers to Health Care.** Surviving the attack is only the beginning for these women. The brutality of these rapes leaves women with physical injuries ranging from cuts and bruises to vaginal fistulas, sterility, and disease. Vaginal fistulas are “the rupture of the vaginal wall which can cause urine and feces to leak uncontrollably” (Wax, 2004, p.181.). These fistulas often require multiple surgeries that only a handful of physicians in the world have the expertise to perform. The physical injuries the woman receives may impair her
ability to have any more children. In a culture where productivity is highly valued by the husband and his family, a woman who cannot reproduce or have a sexual relationship with her husband is not likely to be accepted into the family.

Additionally, women are usually responsible for working in the fields, cooking, cleaning and child care. Rape and its lasting health complications can have a huge impact on a woman’s productivity and ability to carry out even simple daily tasks. If she is in pain and/or injured, she will not be able to complete tasks that are crucial to the daily workings of the household. This inability to be productive in the home due to extensive injuries or injuries that result in a chronic condition, often leads to rejection. Without proper medical attention, minor injuries can become quite serious. Women need to be educated about the importance of seeking treatment early, and medical facilities need additional medicines, equipment, and educated providers to be effective.

Panzi Hospital, located in Bukavu, DRC, is the only hospital in South Kivu equipped to treat women who are suffering from injuries due to sexual violence. Its two main surgeons are among the few that have expertise in “surgical repair of urogenital trauma, including urological-genital and rectal-genital fistulas, simple and diverse genital and/or anal wounds, diverse genital mutilation, and other complications” (Mukwege & Nangini, 2009, p. 2). However, the stigma surrounding rape often deters prompt treatment, and Panzi Hospital reported that only 12% of rape survivors seek treatment within the first month after the rape (Oxfam International, 2010).

There are many barriers to seeking treatment in addition to the stigma. Women need transportation to and from the facilities and a way to pay for treatments, food, and medications. Women who lack money for transportation are forced to walk to the nearest medical facility, which can take several days or several weeks. This also puts them at further risk, as they may be attacked on the road (Wakabi, 2008).
Without increased access to treatment, the women’s health conditions will continue to impede their ability to be accepted by their husbands. In addition to developing programming to encourage women to seek immediate treatment, programming designed to facilitate transportation to and from rape crisis centers and hospitals is also needed.

**Shame.** Despite having “one of the most progressive laws on rape in Africa,” the DRC, in reality a highly patriarchal society, leaves rape survivors at great risk for rejection and isolation. While being granted equal legal status, women in the DRC are culturally still expected to be submissive to men, especially their husbands (Puechguirbal, 2003; Mukwege & Nangini, 2009). This notion of submission may lead to shame in these women, which combined with the stigma of rape may lead to rejection by the society. In the DRC, men are the head of the household and have the right to reject their wives if they are displeased with them (Puechguirbal, 2003). For this reason, many women are afraid to report the rape or to seek medical treatment.

Shame may also delay a woman in seeking medical treatment. This can result in medical complications that can serve as a reason for rejection. Shame can also be a powerful emotion which affects productivity. Feeling “dirty” or “worthless” impacts how a woman acts and how she is seen by her husband and the community. The psychological impact of rape can hinder the woman’s ability to reunite with her husband; it may prevent her from wanting to be intimate with her husband. Shame can prevent the woman from wanting to interact with other people, which can lead to self-isolation. The stigma of rape is deeply rooted in cultural beliefs, but further research to understand the stigma may shed light on ways to help reduce it or ways to empower the women. Counseling and social support aimed at helping the woman to cope and to regain a sense of self will help her become more productive and, hopefully, more likely to be accepted by her husband.
Living in Fear. The psychological impact on the survivors impedes their ability to cope and reintegrate into society. Many suffer from symptoms consistent with post-traumatic stress disorder (PTSD) (Johnson, et al., 2010). The DRC continues to be a hostile place to live and the constant fear of attack continues to traumatize the women after they have been raped. The country’s continued hostility and instability also contributes to this theme because if a woman survives her first rape, she is still at risk of being attacked and raped again. Women are often attacked on their way to get household supplies, such as water, timber, or food to support and care for their families (Puechguirbal, 2003). The memory of their rape makes returning to these tasks difficult. Therefore, not only are the aggressors disrupting the present conditions of the area, they are creating and perpetuating a feeling of fear and unease for the future as well. A woman may be raped in a single act of violence, but every time she sees a soldier she may relive what happened to her and feel as if she is being raped all over again (Trenholm, Olsson, & Ahlberg, 2011). Without a government to prosecute the aggressors or to protect the people, these women will be forced to live in a state of continued fear.

Living in fear also greatly affects a woman’s productivity. For example, if a woman was attacked on her way to find firewood, she may fear getting firewood in the future. Without a stable environment and proper psychological treatment to help her develop healthy coping mechanisms, a woman’s life can be overrun by fear. This fear can be paralyzing and will affect her and her family. Safety should be a top priority; until the area is safe for the women, they will continue to be re-traumatized on a regular basis. Additional international pressure must be put on the government of the DRC to encourage the Congolese government to stop these rapes. Additionally, these women need psychological care and treatment. The horrific ordeal they have gone through will be something they need to deal with in order to live a productive life in the
future. Trained nurses, social advocates, mediators, religious figures, community leaders, and/or trusted family members can help to bridge this gap until psychological personnel and facilities can be put into place.

**Women Who Were Initially Rejected but Ultimately Accepted**

The themes identified in this group warrant further investigation because they provide insight into the factors that lead from rejection to acceptance.

**Husband Trauma.** Because much of the violence is perpetrated by men on women, the impact it has on men is often overlooked by the international community. Men are also victims of the violence that is sweeping eastern DRC. When a woman is attacked in her house, the husband is often forced to watch as his wife is raped in front of him. This study shows that the husband is often forced to watch as his possessions are stolen, his children abducted and he is often beaten. The impact that this violence has on the man is something that needs to be investigated further. The women in this group reported that their husband’s personalities have changed after the attacks and that they demonstrated emotional and psychological signs of trauma. The helplessness the man feels during an attack on his family and his home has been used as the foundation of mediation therapy between the couple. Further insight into the male experience will only help to increase the success of programming and interventions to help reconciliation.

**Mediation.** The results of this study indicated that mediation can be a powerful influence in the reintegration of women back into their families. All of the women who were rejected but later accepted underwent some sort of mediation. The mediation was aimed at showing the husband that despite the cultural belief that the woman may have gone willingly or collaborated with her aggressor, she was powerless. Mediation points out that just as he was
powerless to stop the attack on himself and his home, his wife was also powerless to the attack. This tactic is particularly effective if the husband was also present during the attack, but can also be used in instances where he was absent. Mediation has the potential to be a powerful factor in determining the status of the woman. Sex is typically seen as a taboo subject in the DRC and mediation helps couples to talk about what happened. Mediation has the potential to help decrease the stigma about rape and to facilitate a more accepting community. There are a variety of people who organize and run the mediation, ranging from local health care workers to advocacy groups and non-profit organizations. By understanding the cultural stigma surrounding rape, the mediation can be tailored to directly address the factors that have been shown to cause rejection. While mediation is not always successful, it does provide a foundation to initiate communication about the event. More research is needed to focus on improving mediation and educating members of the community to serve as mediators. Currently, mediators may or may not have had formal training and may be of either gender. Further research is also needed to explore the techniques used by the more successful mediators. One possibility is to involve local community advocates as they have a greater understanding of the culture and social norms specific to the area. By utilizing their knowledge, successful training programs can be developed to help increase the number of mediators in the DRC.

**Optimism.** One of the unique traits from the accepted group was that they displayed optimism in their outlook on the future. Despite continued unrest in the area and their traumatic attacks, these women have a positive outlook toward their future. With such strong themes of stigma and shame prevalent in the communities, optimism is inspiring. While these women are still surrounded by unrest, inadequate food, and poor living conditions, they have been able to find hope. Mediation was credited as playing a role in helping the women to overcome their
fears and motivating them to create a more positive future. These women have overcome adversity and rejection and as a result have an optimistic outlook on their future. This means not only have they been reintegrated into their families, but they have embraced their future. Further research to understand the role of mediation on optimism will lead to a more optimistic future for all the women.

**Implications and Further Work**

With 200,000 confirmed rapes and no end to the fighting in sight, continued research on the barriers to maintaining a cohesive community in the DRC is crucial (Drash, 2009). Further research into mediation skills, techniques, and interventions could have an enormous impact for the entire community. In this study, mediation between husband and wife was shown to lead to a higher chance for the wife to be accepted by her partner. Mediation provided an avenue to help the women cope with what has happened to them and to help them develop an optimistic outlook. It also provided a better framework for the husband to empathize more clearly with the trauma his wife had gone through. While mediation has not been successful in helping women who are HIV positive, pregnant with their aggressor’s baby, or were abducted, a better understanding of these factors may lead to more successful mediation.

More research into the trauma experienced by the husbands and other men and boys in the community is also needed. By understanding their experience, more effective mediation can be developed to help address their fears and needs. By combining the perspective of the husband with the perspective of the woman who was raped, mediation may be more successful.

Future work should also be aimed at addressing the impact of rape on children, especially if the child has also been raped or is the result of rape. Much work is needed to help the individuals affected by rape in the DRC, but understanding their perspectives and the factors
influencing reintegration is the first step to developing interventions aimed at improving the lives affected by this brutal and devastating crime.

**Conclusion**

Both the prevalence and the level of barbarity of the rapes being committed in the DRC are horrifying. Nurses, especially in the global health setting, need to be aware of the challenges these women are facing in order to better assist them in receiving rapid access to care, obtaining much needed resources, and advocating for social awareness and acceptance. With inadequate resources and continued unrest, nurses need to help educate and train local community advocates to address the stigma surrounding rape and help with mediation. Nurses are on the front line of primary care and are often the sole providers in rural areas. Nurses have the opportunity to help educate their communities about the importance of seeking care, to refer women to more advanced facilities for complex procedures, to begin the mediation process between husband and wife, to start the coping and healing process for the woman, and initiate culturally sensitive public awareness campaigns to encourage community acceptance and support of rape survivors. As communities reach the point where more women have been raped than not, it is increasingly important that nurses begin to help address issues around reintegration and social cohesion. By increasing awareness of the factors that influence the exile or reintegration of rape survivors, much need culturally specific interventions can be developed to address this growing population.
References


