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'If your husband doesn't humiliate you, other people won't': Gendered attitudes towards sexual violence in eastern Democratic Republic of Congo

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More than a decade of fighting in the Democratic Republic of the Congo (DRC) has resulted in extensive human rights abuses, of which sexual and gender-based violence (SGBV) is one of the most salient and disturbing features. This paper uses qualitative data, based on 10 focus groups with 86 women and men to better understand gendered community perspectives on SGBV and its consequences in South Kivu. We conclude that for many survivors, rape has consequences far beyond the physiological and psychological trauma associated with the attack. Respondents say sexual violence has become a societal phenomenon, in which the community isolation and shame experienced as a result of the attack become as important as concerns about the attack itself. Male focus group participants explain their own feelings of shame and anger associated with knowing their female relatives were raped. These findings highlight the complexity of community reintegration for survivors and identify a number of programmatic and policy implications, such as the need for counselling for survivors of sexual violence with their families as well as individually; the importance of income-generating training; and the need for improved justice mechanisms to bring perpetrators to justice.

Keywords: sexual violence; conflict; Democratic Republic of the Congo; stigma; rape; focus groups; qualitative research

Introduction

More than a decade of fighting in eastern Democratic Republic of the Congo (DRC) has resulted in a devastated government and healthcare infrastructure. The United Nations Development Programme (UNDP) ranks DRC 168th out of 169 countries evaluated for human development indicators (UNDP 2010). Attacks on the civilian population and their social and economic foundations are a distinctive feature of contemporary warfare (Nordstrom 1991). Sexual and gender-based violence (SGBV)

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is one of the most salient and disturbing features of the ongoing fighting in DRC. Research indicates that it is used as a weapon of war (Human Rights Watch [HRW] 2002) in which women and sometimes men are strategically targeted in order to destabilise entire communities (Gingerich and Leaning 2004, Reid-Cunningham 2008). A 2010 population-based study found that of 998 respondents from Ituri, North Kivu and South Kivu, 39.7% of women and 23.6% of men reported to have experienced sexual violence during their lifetime; of those who were exposed to sexual violence, 74.3% of women and 64.5% of men experienced conflict-associated sexual violence (Johnson *et al.* 2010). The sexual violence perpetrated by many of the rebel groups has features rarely seen in peace-time sexual violence, including abduction, gang rape, and forced incest (Wakabi 2008).

Previous research conducted by the Harvard Humanitarian Initiative (HHI) in South Kivu suggests that rape has consequences beyond physiological and psychological trauma. In a 2007 clinic-based survey undertaken in South Kivu, 29% of sexual violence survivors reported family rejection after SGBV and 6.2% reported community rejection (HHI 2009). This survey's findings are consistent with a figure reported by the Réseau des Femmes pour un Développement Associatif (RFDA), which reported 26% of married survivors were rejected by their husbands (RFDA, Réseau des Femmes pour la Défense des Droits et la paix, and International Alert 2005). There is, however, limited understanding of the impact of rape on families and communities, and a lack of data on the barriers that exist for survivors who seek to reintegrate into their communities.

This paper addresses the wider social consequences of sexual violence in conflict through the use of qualitative research methods, thereby forming part of the growing field of research that seeks to understand the differential consequences of large-scale social violence for men and women (El-Bushira 2000, Pillay 2000, Sideris 2003). To date, there has been little research comparing men's and women's attitudes towards sexual violence against women. Understanding the experiences and perceptions of men and women allows us to begin to decipher the complex dynamics that characterise community responses to destructive violence.

Methods

Focus group design

Focus group discussions were conducted in Swahili, the language of general communication in eastern DRC. Groups consisted of between six and 11 participants and lasted between 90 and 120 minutes. All focus groups occurred in Bukavu, South Kivu. Recruitment was conducted at a local NGO, Centre d'Assistance Médico-Psychosociale (CAMPS), and at Panzi Hospital in Bukavu, South Kivu – a general reference hospital that provides OB/GYN, paediatric, internal medicine, surgery, dentistry, and nutrition services. The hospital treated 17,701 new cases in 2009. Of these, 3376 were admitted to the 'Victims of Sexual Violence' (VSV) programme.

One female nurse from Panzi Hospital and one male psychosocial worker from CAMPS were trained on focus group methodology and acted as focus group moderators. All groups were recorded with permission of the participants. To avoid

making participants talk about their own possibly traumatic experiences, questions centred around societal responses to violence. The focus group questionnaire consisted of open-ended questions followed by prompts from moderators to further explore important issues. All Panzi focus groups were moderated by the female nurse at Panzi. The men's focus groups conducted outside of Panzi were moderated by a male moderator.

Focus group sample selection

Five women's focus groups were conducted. Participants were recruited from women seeking services from the VSV programme at Panzi Hospital in Bukavu during the month of January 2008. Women waiting for follow-up services from the VSV programme were told about the research in a group meeting. Women who did not have conflicting appointments and consented to participate in the research were enrolled and asked to present at one of the five discussions. Up to 12 women were enrolled for each discussion.

Five men's focus groups were conducted. Participants for two focus groups were recruited from men accompanying family members seeking any type of medical service at Panzi. In order to gain the perspective of a wider range of men, participants for three more focus groups were recruited from the wider Bukavu community. A social worker from CAMPS recruited men from a Protestant church to participate in a focus group. In addition, men who visited CAMPS were recruited over the course of two days to return the same week to participate in focus groups. These men were accompanying female relatives seeking psychosocial counselling services related to sexual violence, so were familiar with the issue of sexual violence and its effects on families.

Qualitative data analysis

A translator native to eastern DRC translated focus group audio files and two team members open-coded the transcripts. Team members generated codes first independently then refined them collaboratively; this process allowed them to identify key unifying themes, explore complexities in the narratives, and generate hypotheses where appropriate. Codes identified as important by two or more team members defined categories; consistent variations within a category were captured as subcategories. Axial coding was used to examine relationships between categories. Data was analyzed using NVivo 8 (QSR International, Cambridge, MA).

Human subjects' protections

The study was approved by the institutional review board of the Harvard School of Public Health Human Subjects Committee. Research approval was also obtained from Panzi Hospital. Research participants gave verbal informed consent, which was witnessed and documented by trained study staff. Participation in this research was voluntary. Participants were informed of their right to refuse to answer any question

or to discontinue their participation at any time. All focus group participants were older than 18 years of age.

Research findings

Participant demographics

In total, 45 women participated in five focus groups with an average of nine women per group. Women's focus groups were conducted from 24 to 28 January 2008. The average age of women participating was 37.5 years (Table 1). In total, 41 men participated in five focus groups with an average group size of 8.2 men. Men's focus groups were conducted from 29 to 31 January 2008. The average age of men participating was 35.6 years (Table 2).

Sexual violence in eastern Congo: 'Psychological and mental destruction'

Nearly all participants in the focus groups identified the first Congo war in 1996 – and the associated influx of foreign armed actors into the region – as the starting point of the epidemic of rape in their experience. Participants stressed that rape had not been a Congolese problem until large numbers of foreign militias in the area 'brought' the problem to DRC. In particular, groups such as the *Interahamwe*[1] were feared for their reputation of carrying out brutal attacks.

While the majority of participants defined rape as sex without the consent of one partner, many also defined rape as 'destruction' – associating it with the spread of disease, the drop in value of a woman as a wife or prospective wife, and the

Table 1. Women's focus group demographics.

Date	24 January 2008	25 January 2008	25 January 2008	26 January 2008	28 January 2008
Place	Panzi Hospital	Panzi Hospital	Panzi Hospital	Panzi Hospital	Panzi Hospital
Moderator	Female nurse	Female nurse	Female nurse	Female nurse	Female nurse
Ages	32	27	48	46	22
	43	26	37	33	45
	32	50	40	42	52
	42	32	42	50	35
	37	62	44	46	22
	18	38	46	40	38
	19	20	37	27	33
	50	18	25	21	45
		44	42	40	
			50	50	
Average age	34.1	35.2	41.1	39.5	36.5
Number participants	8	9	10	10	8
Total number of participants	45				

Table 2. Men's focus group demographics.

Date	29 January 2008	30 January 2008	30 January 2008	31 January 2008	31 January 2008
Place	Panzi Hospital	Centre de Assistance Medico-Psychosocial	Centre de Assistance Medico-Psychosocial	Church 8ieme CEPAC Carmel Irambo/ Bukavu	Centre de Assistance Medico-Psychosocial
Ages	31	38	45	57	26
	21	36	24	50	20
	68	27	50	50	40
	47	41	34	32	20
	24	42	36	47	25
	23	25	25	38	25
	29		54		32
	23		53		43
	27				20
	35				48
	27				
Average age	32.3	34.8	40.1	45.7	29.9
Number participants	11	6	8	6	10
Total number of participants	41				

breakdown of communal and familial relations and social structures. For example, many women spoke of their children losing respect for their mothers as a result of having witnessed them being raped. When asked to define rape of women, one man summed up the way in which many focus group participants described their experiences:

> The problem is destroying our households and families, foreigners are coming and raping our wives, destroying them. Since you are not God or an angel, you will stop loving her. That is why we say those people are destroying our communities.

Participants also suggested that rape has become a norm for many men who have grown up in the recent decade of intense fighting. Men and women spontaneously noted that Congolese men were increasingly prone to raping. When questioned as to why this occurred, participants described how rape evolved from what they characterised as a problem caused by 'foreigners,' to one that is now commonplace in civilian society. One man described this theme emerging from the data. He argued that over time, foreign militias forced young Congolese men to rape and pillage on their behalf, and since then:

> [Congolese] have copied that form; those people who raped your wife or your sister in front of you, or required you to sleep with your sister. Witnessing such incidents can affect you emotionally. Then, those who have witnessed those incidents sometimes repeat them because they start to think it is normal to behave like that.

Community responses: 'You feel like you are nothing'

Focus groups emphasised that women who were raped are often blamed for what happened to them. A woman's ability to begin recovery is often influenced by whether she blames herself for being raped (Campbell *et al.* 2001) and whether she feels that others blame her. There is a perception that women who are assaulted may have somehow 'asked for it' or were responsible for instigating the attack (Koss and Harvey 1991). Indeed, some male participants in the focus group interviews suggested that women might 'provoke' rape by wearing revealing clothes, travelling at night, or being far from their community. The majority of focus group participants agreed that women were not to blame for being raped, although they nonetheless recognised that blame of the rape victim was the basis for many of the negative community reactions of rejection and stigmatisation. One woman explained:

> If you are a girl [who has been raped], your parents will start mistreating you, they can't understand that you have been forced and that it was not your fault. You will never get married. They will throw you away because you are not worth anything; you lose all your value because nobody will marry you.

One of the most prominent themes that emerged in focus group discussions was the role that gossip and ridicule played in characterising community responses to rape. Women emphasised that gossip was one of the most hurtful ways in which communities contributed to the stigma and humiliation rape victims experienced. One woman described how rape can make women feel 'ashamed and unable to sit where other people are, you feel like you are nothing.' Another woman explained:

> When [other women] see you walking, if it is two of them, they start gossiping and they say: 'Do you know that this woman has been raped?' They can behave like that because they have never experienced such a situation. When we see that, we are heart broken because everyone is talking about what happened to us – then they start finger pointing at us, and you start crying. We are not even able to go to church to pray.

Discussion in women's focus groups made it clear that some of the greatest challenges women faced were navigating the shame, humiliation, and ostracisation arising from negative community perceptions of rape survivors. Men agreed that these were the greatest challenges survivors faced, making rape not only a physical and psychological problem, but also a problem of social isolation. At its most extreme, the stigma forced rape survivors to leave their own families and communities. Women's narratives expressed how rapes resulted in enormous *haya* (the Swahili word for 'shame'). One woman described:

> If you are a married woman, you will have problems with your husband. He will be ashamed because he has shared his wife with the *Interahamwe*, and maybe you have been contaminated by them.

Two female focus group respondents noted that their communities did help them by taking them to the hospital and counselling them. 'The most important thing they do is provide us with counselling; they encourage us, telling us that we should not worry because it can happen to anyone.'

The reactions of husbands: 'How can you feed yourself spoiled food?'

Women outlined a certain dichotomy in men's reactions to sexual violence. Men seemed less likely to reject a female relative, such as a sister or daughter, who had been raped compared with a wife. When asked about the reason for the difference in men's reactions, participants noted that male relatives may truly love the victim because of their 'consanguinity,' while the husband may only see his wife as a burden once she has been raped – particularly if she has suffered debilitating injuries. The fear of disease arose in almost every discussion of rejection, both men and women repeatedly cited fear of 'contamination' as a reason why husbands abandon their wives. This concept was often used by participants to describe being infected with HIV/AIDS or other sexually transmitted infections (STIs), but also a greater sense of moral contamination. Men's narratives repeatedly brought up HIV/AIDS as the reason a man 'must' reject his wife. As one participant said when speaking of maintaining marital relations with a survivor of rape, 'how can you feed yourself spoiled food?'

Other reasons cited by participants for a husband's rejection of his wife after rape were: reluctance to raise children born of rape and pressure from his family to leave his wife. Women did note that the fear of STIs provides a potential intervention point. Testing negative for disease was often cited as a first step to being able to reintegrate into one's family or community. As one woman said, 'If those organizations [that test for STIs] know your husband, they can invite him for advice. They can show him documents you got from the hospital proving that you are not infected. In that situation he can accept to take you back home.' Only women who test negative for STIs and HIV were seen by participants as likely candidates for reintegration. We consider the implications of this in the discussion.

Men's trauma: 'You lose your pride'

Participants from the men's groups emphasised that husbands of women who have been raped experience stigma and *haya* too. While men were quick to acknowledge women's suffering, they also repeatedly stated that they were also affected. As one participant put it, 'You can't live with that woman because sometimes when those aggressors come they will tie you and give you a torch to help them have light while they are raping your wife.'

One man explained that if one's wife is raped it also deeply affects the husband:

> [Men whose wives have been raped] feel ill at ease; they have lost their dignity and self esteem. If your wife belongs only to you, you feel proud and you think you have something that others don't have. But if she is raped, you lose your pride and you are worth nothing in the community.

Men also stated their inability to defend women from rape is traumatic. This inability to protect one's wife can lead not only to shame and stigmatisation in the community, but to discord in the home. Men explained that these feelings of impotence lead to the loss of the man's traditional role. 'The husband will lose his power in the family because the wife will be implying that he is weak and unable to protect her.'

Men's role in responding to rape was perceived differently by men and women. Women believed the most valuable thing a man could do for a survivor would be to accept her into the household and assist her in seeking medical care. In contrast, men saw themselves primarily in a protective role, with a duty to prevent rape. If they failed at this, they often saw rejecting the woman as justified. There were two specific mentions of a husband accepting his wife after rape. As one woman noted, this is the best possible outcome for the whole family: 'There is a woman who was raped but her husband didn't reject her . . . As he accepted to take her back and to be assisted by the church, their family is happy, and their children are still alive.'

However, men and women also described how trauma associated with the rape can lead to serious consequences within a marriage even when couples stay together after an attack. Sexual relations may end and husbands might become abusive towards their wives. Women agreed that staying together would not guarantee a return to a normal life. One woman described the cycle of blame and anger that can develop. 'The husband and the wife will be quarrelling every day. The man will blame his wife because she didn't resist, and the woman will blame her husband because he didn't protect her.'

Men as pivotal intervention points: 'If your husband doesn't humiliate you, other people won't'

A consistent theme in women's focus group discussion was how a husband's response to his wife's rape was central in shaping her ability to recover. As one woman said, 'We don't care about what the community thinks if our husbands agree to take us back.' Women stressed how important the relationship with their husbands is in determining the community's response to rape. Another explained, 'They can also help [survivors] to get respected from other people, because if your husband doesn't humiliate you, other people won't.' Discussions with women made it clear that the husband also plays the determining role in how a woman's family will receive her. 'Your husband is the first person to reject you, and then comes your family. Your family will say that it is not able to deal with your problems and then they reject you.' Nonetheless, many men also emphasised the powerful pressure that their own family could encourage them to abandon their own wives.

Some women said that if a husband truly cares for his wife he will not reject her. Yet the majority of men in the focus groups stated they had no choice in the matter, describing a situation where men need to follow the expectations of local customs and the pressure from their own families to reject their wives. As with the cases in which communities provide support to survivors of sexual violence, the cases in which husbands accept their wives will need to be investigated further.

Local customs: 'You don't have any value in front of your peers'

The role of local customs in creating an environment conducive to the stigmatisation and rejection of rape victims was noted by both men and women in the focus groups. Women perceived that local customs – such as levirate marriage,[2] the concept of women as property, and the idea that women who have been raped bring misfortune upon the family – are central to stigma. Many women argued that customary understandings of women as property contributed to harsh treatment of survivors

after rape. One woman explained that, 'First, it is rooted in our customs. If you have sex out of your marriage, nobody will consider you a woman.' Women from the focus groups emphasised that certain customs that traditionally were directed towards female adulterers were now being applied to victims of rape. For example, one man said that, 'If the husband gets sick, the wife is not allowed to look after him because she has been raped. If she does, something will happen and the husband will die.'

Men sometimes used these customs to justify their rejection of women. One man noted that rejection occurs, 'because it is taboo for a woman to have sex with someone who is not her husband.' When asked why this is the case even if she was forced to have sex, he said, 'Even if it was against her will, the community does not want to understand.' Both men and women emphasised the ways in which rape lowered the worth of women as daughters, wives, or prospective wives, and suggested that this was one of the main reasons for repudiation. 'You don't have any value in front of your peers. Wherever you go, people will always despise you.'

Livelihoods: 'You will be starting your life from nothing'

When asked what the major problems were upon returning home after being raped, women in the focus groups repeatedly spoke of restricted access to their fields; lack of income-generating activities and access to markets; and not enough money to feed or send their children to school. Participants consistently and spontaneously brought up economic issues throughout their discussions. Women emphasised that if they do make it to their fields they often encounter armed men demanding their crops and face the threat of sexual violence. One man agreed with women's call for economic support, arguing that, 'For a victim of rape, receiving medical and psychological support is not enough. If she is not assisted to recover her livelihood, she won't be able to recover completely...'

Men and women alike made the connection between the state of poverty and widespread rape, but with different perspectives. Women saw their increasingly impoverished state as a result of rape, which was often associated with robbery and looting. 'You will be starting your life from nothing, because they burnt houses.' Men, however, saw poverty as a key reason rape is so widespread. Almost all men stressed loss of land and other assets and employment as factors that lead to sexual violence.

Justice, religion, and education: 'She needs support from the whole community'

All groups felt that perpetrators of rape should be punished. Discussions, however, revealed widespread distrust in the justice system and a belief that the rule of law was not adequately enforced. One participant summed up the general consensus, saying, 'The justice is nonexistent. If you have some money they might listen to you, but they will do nothing.' Female participants overwhelmingly felt that they had little recourse after being a victim of sexual violence.

When asked about how communities could come to terms with how to respond to rape, participants stressed education and religion as potentially effective interventions. Men stressed that, 'The only thing that should be done is to educate the community. People should understand that if a woman is raped it is not her fault. So she needs the support from the whole community to help recover from that shock.'

Help from the church, including micro-credit and counselling, were perceived as ways to help couples stay together after rape. However, women noted they were sometimes isolated from communal places, like church, after rape. For this reason, women and men noted a need to educate religious and community leaders about how to appropriately respond to survivors. As one woman noted, 'You can send messages, to churches and to village's board … that people should not be despising those who have been raped.' Men and women pointed to the need for broader social education and noted religion has the potential to change the culture of repudiation. As one woman said:

> [T]here is a need to teach both husband and wife. To tell them that what occurred was an accident that neither of them wanted. A message about how you can gain respect from the other, and to be compassionate.

Limitations

While focus groups are useful for understanding community attitudes, a certain inevitable amount of bias occurs through group dynamics. Participants may be reluctant to voice opposing views, or the most assertive participant may disproportionately affect the results. Key informant interviews may be a further way to gain data on the issue of sexual violence. The presence of a foreign researcher as an observer during the focus groups undoubtedly had some influence on the answers. Focus group participants seemed eager to share their opinions with a wider audience, and the foreign researchers were often seen as representatives of this broader platform. It is possible participants emphasised certain problems with the hope of getting improved services. Researchers attempted to mitigate this by making it clear at the start of the research that participation would in no way affect the services received. Women presenting at Panzi Hospital, where female participants were recruited, may have had different experiences than women not presenting to Panzi. Three of the five men's focus groups were not conducted at Panzi and therefore are a different population than the women's focus groups. This research was conducted in South Kivu, and may not be generalisable beyond this area.

Discussion

Sexual violence is a complex and highly destructive feature of the humanitarian crisis in eastern DRC and can produce profound physical and emotional trauma, as well as disturb the cohesion of communities as a whole. Focus group respondents overwhelming reported that sexual violence was 'brought' by foreigners during the war. This is not to suggest, however, that sexual violence did not exist at all in DRC before hostilities began. All countries have non-conflict related sexual violence, including marital rape, domestic violence and other forms of SGBV.

Women state that the stigma they face as survivors of sexual violence can be as traumatic as the attack itself. The reactions of a survivor's family and community are therefore highly correlated with her ability to recover. Despite the fact that rape is extremely widespread, focus groups respondents noted that survivors still face significant challenges in seeking care and resuming their role in society after the attack. Reasons for this include: perceptions that victims are to blame for being

raped; fear that survivors are infected with STIs or HIV; customary practices that are detrimental to survivors; and peer-pressure on a survivor's husband and family to reject women after rape.

Men and women in the focus groups discussed many of the same issues, but approached them from different perspectives. For instance, women said the most important role a husband could play was to act supportive after rape. Women also noted that men act as important agents influencing women's experiences as they come forward to disclose the rape and begin the process of recovery. Men saw their primary role as being the protector of women to prevent rape; if they failed at this, they often did not see themselves as having further obligations to care for a survivor. Another example of a perceptual difference arose around poverty; female respondents often saw poverty occurring as a result of rape, either because of the pillaging during the attack or as a downstream consequence of being ostracised. Male respondents, on the other hand, saw poverty as a reason why men might rape.

Both men and women recognised the enormous physical, psychological, and social toll that rape carries for women. Men also emphasised that they too were traumatised by sexual violence in their communities, particularly in the cases when they were forced to witness or participate in the attack on family members. Both women and men noted that even if a couple stays together after rape, feelings of anger and shame can significantly change the relationship, highlighting important complexities beyond the simple indicator of whether a woman is simply 'rejected' or 'not rejected.' This finding speaks to the need to provide counselling to women and members of her family both individually and as a group. Counselling and family meditation should not only be offered in cases of clear-cut rejection, but to all families who are struggling to recover from trauma associated with sexual violence.

In addition to the physical and psychological toll, female participants in this study noted that the unpredictability of sexual violence serves to terrorise communities, either in order to make them flee their land or to intimidate populations into allowing militias to use their fields or loot their crops. Women are the driving force behind the subsistence economy of South Kivu, which is based on farming and livestock. These findings suggest that the fear of rape, and the isolation of women from their families and farms as a result of rejection, may have a significant economic impact on individuals, families and communities. Programmes should address this important need by integrating medical and psychosocial services for survivors of violence with referrals to microfinance programmes. It is important to provide socioeconomic interventions that are appropriate to women's lives and fit the economies in which they live.

The increase in civilian rape resulting from a breakdown of social standards was a salient finding from this study. This is supported by recent quantitative findings, which show a precipitous rise in reported cases of civilian rape in South Kivu, DRC (HHI and Oxfam International 2010). A World Health Organization (WHO) study identified the following factors as common characteristics of places with pervasive SGBV: poverty, traditional gender norms that support male superiority and entitlement, social norms that tolerate or justify violence against women, weak community sanctions against perpetrators, and widespread crime and violence in society in general (Jewkes *et al.* 2002, Krug *et al.* 2002). The literature supports this study's findings: Participants noted that poverty, unemployment, impunity and local customs all contributed to an increase in civilian rape.

The sexual violence perpetrated in DRC will have consequences for those growing up in this environment of pervasive insecurity and violence. A number of studies conducted in peacetime environments suggest that experiencing sexual violence, especially as a child, has negative consequences throughout an individual's lifecycle. Boys who witness violence against women as children are more likely to commit violent acts against women as adults; adult women are more at risk of sexual violence if they witness it as girls (Kalmuss 1984, Kishor and Johnson 2004). Many programmes currently focus solely on survivors without recognising that they are often the sole caretakers for children who have also been traumatised. Services aimed at helping children deal with the traumatic experiences they have lived through are vital for helping families and communities recover from conflict-related trauma.

Focus group participants suggested a number of interventions to respond to the problems they spoke about in the discussions. One of the most popular of these suggestions was removing foreign militia groups from eastern DRC, since these groups are often seen as the root cause of sexual violence in the region. Education, training for income generating activities and sensitisation about how to support rape survivors were suggested by both women and men as other important interventions. In addition, a minority of women noted that it was possible for communities to be accepting of survivors, and to facilitate service seeking. Positive examples like this should be investigated to see if this kind of response could be encouraged in other settings.

All participants called for an improved justice system in which perpetrators of rape are punished for their crimes and serve their full prison sentence. Socio-politically, the Congolese government betrays its lack of support for women by not enforcing prosecutions of the perpetrators of sexual violence. The corrupt judiciary system in DRC means that many men and women settle their disputes at the community level.

Conclusion

Results from the focus groups emphasise the need for better counselling services, not only for women, but for men and other family members. While men and women in the focus groups concurred on many issues surrounding sexual violence, it was their perceptual differences that revealed the best opportunities for interventions and programming. Creating programmes to address these perceptual differences could help them decide on appropriate gender roles, not only in responding to rape, but also in preventing it. This is particularly important since female respondents noted that men's reactions to rape were often pivotal in determining whether they would be accepted into their extended families and communities after rape. Male respondents did not speak about this phenomenon in focus groups, which suggests that providing men with information about the significance of their actions, and empowering them to change detrimental behaviours, might help change their behaviour towards survivors of rape. The fact that men were recruited when accompanying survivors to receive services opens an opportunity to engage male family members who make an effort to help survivors after rape and offer concurrent services.

A number of follow-up studies could improve the understanding of the effect of sexual violence and its sequelae on communities. More research is needed to understand what kinds of problems couples experience after sexual violence, and

what kinds of interventions might be beneficial to couples who try to stay together. As Betancourt *et al.* (2010) note, social stigma is a significant factor in mediating the impact of war-related violence on mental health. A study examining what factors make survivors more susceptible to social stigma, as well as those which make individuals and communities more likely to support survivors, rather than ostracise them, would be particularly valuable and could help identify further intervention opportunities. In addition, further research is needed to understand the unique needs of men who experience sexual violence, since stigma around this issue is extremely pronounced in DRC, as in many contexts.

To fully describe how stigma affects a community, it is essential to obtain perspectives from multiple participants who comprise that social space. Comparing men's and women's experiences helps triangulate important common issues; both groups described the trauma experienced by individuals as a result of sexual violence while portraying the destructive effect on communities as a whole. This study marks a step in investigating how suffering is articulated, why certain types of violence have particular significance and in elucidating the interplay of wartime violence with public health, poverty, and social marginalisation. Our results emphasise the importance of holistic, qualitative research in providing new information and perspectives that will aid in the development of improved programming and policies to assist the survivors of sexual violence in eastern DRC.

Notes

1. Interviewees commonly refer to the Rwandan Hutu rebels present on Congolese territory as *Interahamwe* (the Hutu paramilitary organisation which helped carry out the 1994 Rwandan genocide). Since 2000, these rebels have been grouped in a politico-military formation called Forces Démocratiques de la Libération du Rwanda (FDLR), numbering between 15,000 and 20,000 men (International Crisis Group 2003).
2. A practice of 'widow inheritance' where a woman is required to marry her deceased husband's brother.

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