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Family and Community Rejection and a Congolese Led Mediation Intervention to Reintegrate Rejected Survivors of Sexual Violence in Eastern Democratic Republic of Congo

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Our purpose in this study is to describe the multiple and interrelated health, economic, and social reasons for rejection and to provide an example of a Congolese-led family mediation program to reintegrate survivors into their families. We conducted this study in Eastern Democratic Republic of Congo (DRC) and included two focus group discussions and twenty-seven interviews. Rejection extends beyond physical dislocation to include economic and social aspects. Family mediation is a process requiring knowledge of traditions and norms. Understanding the context of rejection and supporting promising local reintegration efforts will likely improve

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health, economic, and social outcomes for the survivor, her family, and her community.

BACKGROUND

Rejection by family and community remains an overarching concern amongst survivors of sexual violence. In this study, we examine the multiple and interrelated health, economic, and social impact of rejection and describe the design of a Congolese family mediation program to reintegrate survivors of sexual violence. We conducted two focus groups and 27 in-depth interviews with survivors, their spouses, community members, and service providers. Using our findings, we provide a better understanding of the context, complexity, and importance of rejection and illustrate how supporting promising local efforts may improve the health, economic, and social outcomes of a survivor, her family, and her community.

Rebel and military groups use sexual violence as a weapon of war throughout the world including in Eastern DRC (Mukwege, Mohamed-Ahmed, & Fitchett, 2010; Mukwege & Nangini, 2009; The PLoS Medicine Editors, 2009; Réseau des Femmes pour un Développement Associatif, 2005; Ward & Marsh, 2006). For more than 15 years, military from several African countries and local and regional rebel groups have committed atrocities against the civilian population in Eastern DRC (Human Rights Watch 2002, 2010; United Nations Office of the High Commissioner for Human Rights, 2010; Vinck, Pham, Baldo, & Shigekane, 2008). Sexual violence takes many forms, and may involve physical abuse, public rape, abduction and sexual slavery, repeated rape, and gang rape (Harvard Humanitarian Initiative & Open Society Institute, 2009; Krug Dahlberg, Mercy, Zwi, & Lozano, 2002). Johnson and colleagues (2010) conducted a population-based study in accessible and secure areas of Ituri District and North and South Kivu Provinces; they estimated 39.7% of women were exposed to sexual violence in their lifetime (Johnson et al., 2010). Peterman and colleagues (2011), using data from a 2007 Demographic and Health Survey, estimated a rate of 128 per 1,000 women aged 15–49 years living in South Kivu Province experienced rape (Peterman, Palermo, & Brendenkamp, 2011). Staff of Foundation RamaLevina (FORAL), a Congolese organization working in Walungu Territory (in South Kivu Province), conducted a review of health services provided to more than 600 female survivors of sexual violence between July 2010 and June 2011; they found 45% of women had not received health services after the assault (Kohli et al., 2012). Colleagues working with Harvard Humanitarian Initiative administered a survey with 255 adult women accessing services in a 1-month period in 2007 at Panzi Hospital (located in Bukavu, the capital of South Kivu Province) or one of two rural nongovernmental organizations (NGOs). Seventy-six percent of women in the study reported being raped, with 49% abducted by their perpetrators and 69% reporting gang rape by an

average of three attackers (Harvard Humanitarian Initiative & Open Society Institute, 2009).

The impact of sexual violence includes diminished physical and psychological health, economic insecurity, social exclusion, and discrimination. Health care providers have documented a range of physical health complications including internal tearing, pregnancy, fistula, sexually transmitted infections (STIs), and HIV (Longombe, Claude, & Ruminjo, 2008; Mukwege & Nangini, 2009; Réseau des Femmes pour un Développement Associatif, 2005). Mental health consequences may include depression, symptoms consistent with post-traumatic stress disorder (PTSD), and suicide. The trauma of sexual assault can increase with rejection by the survivors' family and community after the incident. Fearing rejection, survivors may hide the incident and not seek health care and other needed services and support (Bartels et al., 2010; Harvard Humanitarian Initiative & Open Society Institute, 2009; Réseau des Femmes pour un Développement Associatif, 2005; Pratt & Werchick, 2004; Steiner et al., 2009). Researchers conducting a mixed methods study in 2007 with survivors accessing services at Panzi Hospital and two local NGOs in South Kivu Province reported rejection (i.e., a woman can no longer stay in the home of her husband or parents) amongst 29% of the 255 women (Kelly, Betancourt, Mukwege, Lipton, & VanRooyen, 2011b). Staff of Maltesar International reviewed demographic information of rape survivors accessing their medico-social services in South Kivu Province between 2005 and 2007 and found that 6%–12.5% of survivors reported rejection by their family.

Female survivors of sexual violence and community members remain concerned about rejection by family and community after sexual violence. Whereas all survivors are vulnerable to poor health and economic insecurity, those who are rejected may face increased vulnerability including loss to their livelihood, loss of supportive relationships, and loss of status in their community (Harvard Humanitarian Initiative & Oxfam International, 2010). Yet, few researchers have examined what rejection means from the perspective of the survivor. Some researchers have referenced factors that may cause or increase risk of rejection including fear of HIV, having a child after rape, gang rape, and blaming the survivor for being raped (Harvard Humanitarian Initiative and Open Society Institute, 2009; Kelly et al., 2011b; Réseau des Femmes pour un Développement Associatif, 2005). Nevertheless, researchers have not characterized reasons for rejection well, and there remains a gap in effective programming to address rejection. Local, Congolese-led family reintegration programs for survivors of sexual violence exist and include community leaders acting as advisors to families, providing moral support to women, and encouraging the husband and other family members to support the survivor rather than reject her (Réseau des Femmes pour un Développement Associatif, 2005; Steiner et al., 2009). Our purpose in this study includes the following two objectives: a) to describe the multiple and

inter-related health, economic, and social reasons for rejection from family and community from the perspective of survivors of sexual violence and b) to provide an example of a Congolese-led family mediation program using community workers in Eastern DRC to reintegrate survivors into their families.

METHODS

Staff from FORAL and two researchers from Johns Hopkins University Schools of Nursing and Public Health conducted this collaborative, participatory action research study. FORAL is a Congolese NGO that focuses on provision of health, economic, and social support to assist in the reintegration of survivors of sexual violence in their families and communities. We employed qualitative methods to gain an in-depth and varied understanding of the effect of sexual violence, reasons for rejection, and experiences implementing and participating in family mediation.

We conducted this study primarily in Walungu Territory, a rural area negatively impacted by over 15 years of war, between June and July 2010. Survivors of sexual violence, their husbands, community members, and community workers participated in in-depth interviews in two village centers, Ikoma and Mwirama, and the health zone center, Kaniola, in Walungu Territory. Community workers known and trusted in the villages and working for FORAL selected and invited survivors and their husbands to participate in the study. For this study, adult survivors were eligible if they described themselves as being rejected by any family member including their spouse or parents. A broad definition of rejection was used to get a better understanding of what rejection means from the perspective of the survivor. Further, the individuals were selected to represent a range of characteristics including marital status, history of rejection, and participation in and outcome of family mediation.

In Kaniola, health care and service providers participated in interviews to understand programmatic work with survivors and family members in the health zone. In Bukavu, FORAL colleagues identified local service providers for interviews, selecting them based on their knowledge and varied experiences in the field. The research team conducted two focus group discussions (FGDs) in Walungu Territory. We conducted these meetings to understand the community perspective on rejection and reintegration of survivors of sexual violence.

The research team developed interview questions for each participant type. For example, we varied interview questions if the survivor had participated in family mediation or if the community worker had conducted family mediation. We included the following topics: (a) the impact of sexual violence on the individual survivor, her family, and the community;

(b) description of rejection and reasons for rejection; and (c) description of the family mediation program including strategies, expectations, and other services that would improve the success of mediation.

We wrote research instruments initially in English. The research team discussed each question in detail focusing on content, comprehensibility, and utility, and we made revisions prior to translating to French. The team held a detailed discussion on the translated questions to ensure correct translation and wording in Swahili and Mashi—a local language. We conducted all interviews in Kaniola, Mwirama, and Ikoma in Swahili or Mashi, depending on the respondents' preference. We conducted interviews in Bukavu in French. Both the interviewer, who had 5 years of experience working with survivors in Walungu Territory including conducting qualitative interviews, and the translator were heavily involved in reviewing the questions and translation.

Ethical Approval

Members of the Johns Hopkins Medical Institutions (JHMI) Institutional Review Board approved the study. Our primary concerns were for confidentiality and protection of participants.To identify participants, community workers explained the purpose of the study to individuals. If they agreed to meet the research team, the community workers facilitated the introduction. Participation in the study was entirely voluntary and anonymous, meaning no names or identifying information was collected from participants. Respondents were informed that participation, or lack of participation, in the interview or FGD would not impede access to health or social services or impact their employment with FORAL or other organizations. Respondents could refuse to answer any question or stop the interview at any time. A trained interviewer discussed the study objectives in lay language with the participant before taking oral consent.

Field Work

Interviews in Ikoma and Mwirama were conducted at the local health center in conjunction with the FORAL mobile clinic; many villagers access the health center on a daily basis and often wait for care, so interviews were conducted as individuals waited for care. We conducted interviews in a spare room of the clinic or in an open, but secluded, space next to the clinic. The setting was quiet, removed from clinic activities, and far from passersby so that the interviews remained private and could not be overheard. We conducted interviews in Bukavu and Kaniola in the offices of participants, allowing for privacy.

The research team conducted FGDs where the community groups held regular meetings. During the FGD, the facilitator introduced the study and

led the discussion by asking the group questions. Men and women were encouraged to give their opinions. Before moving to the next question, the facilitator ensured that everyone who wanted to say something was able to share. Due to the large size of the groups and active participation, the researcher focused on reasons for rejection, community responses to survivors, and possible strategies and benefits of reintegrating survivors.

Typically, three research team members were present for each interview: the Congolese interviewer, translator, and Hopkins researcher. We used the questions as a guide, with follow-up questions focused on rejection, family mediation, and reintegration. After introductions and informed consent, the interviewer wrote, as close to verbatim, the answers from the respondent. The translator provided real-time translation, allowing the Hopkins researcher to ask for clarification and take detailed notes. At the end of each day, the team discussed the interviews to identify gaps in information to better target respondents for the next fieldwork day. On a weekly basis, interviews were reviewed. Team members reflected on and discussed initial findings leading to a prioritization of areas requiring more depth.

Data Analysis

Although interviews were recorded, the recordings were of poor sound quality and transcription was not possible. The Congolese–U.S. research team members who facilitated and conducted the individual interviews and FGD reviewed and discussed the field notes for accuracy prior to analysis. We performed thematic analysis with all of the field notes. We reviewed field notes multiple times, with each read providing a deeper level of contextualization and analysis. In order to gain a global understanding of the content and context, we reviewed all field notes in their entirety to identify possible themes to explore.

Our additional readings allowed us to identify data that addressed the study aims including the questions on the multiple and inter-related health, economic, and social reasons for rejection from the perspective of the survivors of sexual violence. We also conducted systematic readings across field notes, making comparisons and identifying patterns that occurred within and across individual interviews and FGDs. We combined these pieces of data into "meaningful units according to relatedness into larger units, known as themes" (Leininger, 1985, p. 61). The themes we identified brought "together components or fragments of ideas or experiences, which often are meaningless when viewed alone" (Leininger, 1985, p. 60).

We developed exemplars to illustrate each theme. The following criteria were used when selecting exemplars: (a) logical fit with themes, (b) clarity and strength in message, (c) diversity in speakers, (d) ability to mirror subtle nuances in themes, and (e) singular usage (to avoid using exemplars more

than once) (Hassouneh & Glass, 2008). When selecting the exemplars, we referred back to the field notes from which they were extracted to ground ourselves in their context, thereby ensuring accuracy of intent as best as possible.

Regarding confirmability, we used peer review and debriefing during the analysis process as a qualitative mechanism that serves a similar function to inter-rater reliability in quantitative research (Creswell, 2003). The research team came together and discussed findings and interpretations as necessary during the analysis process to assure consistency and resolve differences and develop consensus in interpretation.

RESULTS AND DISCUSSION

Sample and Setting

The research team conducted 27 in-depth interviews between the four study sites (Table 1). Of these, 13 were with survivors of sexual violence and 3 with spouses of survivors. Husbands of survivors were difficult to identify and thus represent a smaller part of the overall sample. Almost all married survivors had experienced rejection by a spouse; participants also reported rejection by other family members. One of the three husbands that participated had initially rejected his wife but has since reintegrated although certain difficulties remain.

TABLE 1 Profile of Participants in the In-Depth Interviews

	Female survivor	Husband of a survivor	Community member	Mediator	Service provider
Village/city name					
Ikoma	8	2		4	
Mwirama	5	1	1		
Bukavu					2
Kaniola				1	3
Current marital status					
Married	9	3			
Widow	3				
Single	1				
Ever rejected[a]					
By husband	9				
By family members	3				
Participated in mediation	9	1			
Reintegrated with family[b]	7				

[a]Those who have been rejected by their husband may have also been rejected by other family members (e.g., parents, siblings, in-laws). For this table, participants are categorized in only one group with preference given to rejection by husband.

[b]Reintegration has multiple components and here only refers to whether the participant said they were living with their spouse, regardless of the changes in relationship. More detailed information on reintegration is given in the Results and Discussion sections.

A diverse group of community members and service providers participated. Specifically, five community workers who have acted in the role of facilitators of family mediation, two who work with FORAL and three who are affiliated with faith-based organizations in the area, participated. Five service providers participated including three health care providers from Kaniola and two providers working with local NGOs on reintegration programs for survivors in Bukavu. Further, one community member from Mwirama who was familiar with the situation of survivors and works on social causes participated. Of the two FGDs, one was held in Ikoma with a large community group, including the village chief and male and female residents, which focuses on resolving community problems. The second FGD, in Kaniola, was with a community development organization; representatives included 12 men and four women. Below, we present the results of the study according to study aims.

Impact of Sexual Violence

Respondents spoke about the impact of sexual violence on themselves and, in general, on women (Table 2). Almost all participants were concerned about the physical and mental health of survivors including sickness and "fear of sickness." A survivor described not being the "same psychologically and even physically because she has pains that she didn't have (before the sexual violence)" *(Ikoma)*. Participants frequently described feelings of isolation and possible mental health issues: "Every day I think about what happened and that caused me headache. I am ashamed in front of my

TABLE 2 Summary of Findings on Negative Impact of Sexual Violence on Survivors

Level of impact	Examples
Health	• Physical health: injuries, fistula, sterility, HIV, sexually transmitted infections, pain • Mental health: headaches, ashamed, fear, crying • Pregnancy • Insufficient nutrition
Economic	• Loss of property • Loss of land • Inability to work • Loss of employment • Fear of working
Family	• Stigma and discrimination toward children • Poor child health • Deterioration of spousal relationship • Lack of shelter • Rejection by family members • Isolation
Social	• Stigma and discrimination • Deterioration of community relationships

children and all people. I no longer do the work I was doing before. I am alone, abandoned" *(Survivor, Mwirama)*. A facilitator of family mediation described survivors:

> Traumatized, there are some diseases. Psychologically she looks like a madwoman. There is also instability. . . . She has become shame-faced. She isolates herself. She doesn't anymore meet others. She stigmatizes herself, remains hidden. The hands on the jaws *(demonstrates by resting his chin on his hands)*, she wonders if she is still a wife. She no more goes to work. *(Ikoma)*

Service providers and community members described survivors as having headaches, fear, crying, holding the face or jaws in ones hands, and thinking a lot. A husband, who left his wife and later reintegrated with her after family mediation, said sexual violence "brings sicknesses. . . . There is a fear that lingers in her. She jumps for nothing. She has thought very much" *(Ikoma)*. A survivor described sexual violence as "killing the life of the woman" *(Ikoma)*. A community member said she would "prefer that we kill the person who is raped because to rape is worse than killing" *(Mwirama)*.

All participants spoke about the impact of sexual violence on families and communities. Many survivors are mocked and "pointed at" by the community. They described survivors as isolated: "People no longer talk to this woman" *(Survivor, Ikoma)*. Other consequences include poverty, sickness, and misunderstanding between people. One survivor, whose husband was encouraged by his parents to marry another woman and reject his wife, said the following:

> Life changes, face-to-face with the husband. The marital relations are no more the same as before. . . . The children change their behavior because they are ashamed of you. The woman, in the heart of the woman, there is only sadness in her thoughts. The scenes repass all the time. *(Mwirama)*

Another survivor described, "The family relations become difficult especially with the husband who changes his behavior even towards his own children" *(Mwirama)*. One husband said, "It touches the children to see that we don't anymore understand each other" *(Ikoma)*. Another husband described sexual violence as creating "very much misunderstandings between a couple, members of a family, and people of a community" *(Ikoma)*.

In talking about rejection, many women described how they were chased from their homes or abandoned by their partners. Women rejected by their families were described as being alone, isolated, or living by themselves. Their descriptions of rejection extended beyond this too. A facilitator of family mediation said, "A woman not integrated lives badly, without support, without protection—shelter, money—rejected with her children" *(Ikoma)*.

Their description of rejection includes changes in communication, roles in the family, and affection by family members. For instance, a woman whose husband forced her to leave the house and later brought her back home described her life with her husband:

> He brought me back to his house. But he married another wife. We live together. My husband changed his behavior towards me and our children. He has become irritable. Every time he is angry, he leaves me to join the other wife. . . . He doesn't any longer love me. *(Mwirama)*

One man who chased his wife from the home was said to be "angry and coming to insult me (the wife)" *(Survivor, Ikoma)*. One spouse described that while he continues to live with his wife and would like to accept her, he is haunted by images of the incident and the economic loss he endured as a result of the assault. He said, "Before, she could wash my clothes. No more now, because when I think about it, I don't want that she touches my clothes" *(Ikoma)*. Survivors described rejection as including loss of access to employment, possessions, and support for children. Women repeatedly spoke about a need to have their children educated or wanting to return to their husbands so that their kids would have a better life. One community member said that, in general, survivors are "deprived of her fields, the animal breeding" by her family *(Mediator, Ikoma)*. In other words, family members may take their possessions or not allow survivors to continue to cultivate on family land.

Survivors spoke about how, even when some family and friends rejected her, she received support from others. One woman, who was raped twice and had a child due to rape, reported that her husband and siblings rejected her and she now struggles with caring for her child: "Look at my breasts. There is nothing. I miss what to suckle this child with." When asked about her relationship with the community, she said, "I don't have many problems. People help me with the advice, what to eat and to dress myself. . . . They help me to pay the school fees of one child." She later said, "My brothers-in-law help me. They were telling me to stay with my husband. They promised to build a house for me. They continued to support me even in the second rape" *(Mwirama)*. Another survivor who was rejected by her husband and friends said that she did not have problems in the community: "They are not pointing at me. They are moreover the ones who are saying to my family that that (sexual assault) happened to everyone. It wasn't my willingness" *(Mwirama)*.

Several participants said that rape of one member of the community affected all members of the community. One female community member stated that sexual violence "affects the community in an indirect manner because when they kill your neighbor, it is you that is killed. It is all the people who think about what has happened. And it is everyone who has pain

the heart because it is all the families that suffer" *(Mwirama)*. When asked the same question, one husband described the impact on the community using an analogy to cassava crops, the local primary food source: "It's a question of community, because if one is affected, everyone risks contamination. It's like cassava when it's affected by sickness. It's all the field which will be affected" *(Mwirama)*.

Reasons for Family Rejection

Participants described reasons for rejection similarly regardless of who abandoned the survivor (e.g., husbands, in-laws, immediate family members) and who responded to the questions (Table 3). One key concern was about fear of sickness. For example, a husband may not trust a negative HIV test result provided by his wife after rape. One survivor said her husband rejected her because "he was saying that I am sick even if one has not . . . found sickness in me at the hospital" *(Mwirama)*. One facilitator of family mediation explained how men are impacted by rape: "If he was loving his wife, he can no more have sexual intercourse with her. He is afraid of dying because of diseases. The men decided to expel their wives because they can't withstand seeing them" *(Ikoma)*. Participants commonly referenced local customs during interviews as reasons for rejection. One facilitator of mediation explained, "if another man has sexual intercourse with a married woman, the husband of the wife is going to die" *(Ikoma)*. Several people spoke of how a woman's worth in the community and family changes after experiencing sexual violence: "The woman who has known another man has no more value" *(Survivor, Mwirama)*. Participants said the community does not distinguish between whether a woman chose to have sex or experienced forced sex; other men "believe it's they (the women) who wanted what happened" *(Husband, Mwirama)*. One survivor who was raped twice by soldiers reported that her own two sisters are "chasing her (from the

TABLE 3 Examples of Reasons for Rejection and Abandonment of Survivors

- Fear of diseases including STI and HIV (even if tested negative)
- Local customs (e.g., marriage annulled if the wife has sexual relations outside of the marriage, survivor considered married to rebel groups)
- Having a child after rape
- Decrease in worth of woman
- Pressure from family, friends, and community members
- Fear of rebels returning
- Rebels considered friends of the survivor not aggressors
- Pregnancy after rape
- Inability to communicate as before
- Loss of wealth
- Witnessed rape
- Being raped more than once, or by more than one person

family home)... because they tell me I went there, I myself, to look for the military" *(Mwirama)*. She explained that her husband chased her from her home because he "was afraid to be killed by the men" who raped her, fearing that the soldiers would return again for his wife. Another survivor who was initially rejected by her husband said, "Most men chase their wives away because they think that the aggressors are our own friends. They say to us, 'Your friends have carried away our belongings'" *(Ikoma)*. Family and community members often refer to survivors as "wife of Interhamwe" (the Hutu rebel group that led the genocide in Rwanda in 1994). Survivors also spoke about how having a child after rape, having others in the community witness rape, or being raped more than once can lead to rejection. The in-laws of one woman who gave birth after rape feared "that the Hutus (rebel group) will come back to claim their son" *(Mediator, Ikoma)*. Another survivor whose husband and brothers rejected her and has not reintegrated even after mediation related:

> He [her husband] was asking me to kill this child issued from rape if I wanted to come back to his home. But I couldn't. It is a child like the others. I don't know the reason that was pushing my brothers to chase me, but I believe that it is the same reason. They were telling me to abort. I couldn't. I was afraid because God could punish me. They don't look at my child with a good eye. They say that it's a Hutu. *(Mwirama)*

Survivors discussed how pressure on the husband or family or stigma from members of the family, friends, and community influenced rejection. One survivor said that after the violence, "Among members of the family, you realize there are those that hate you" *(Mwirama)*. She later explained that after her husband rejected her and she moved in with her mother, "My brothers were coming to tell my mother to chase me for the people who aggressed me are my friends. When they (the rebels) come back to take me, they will kill my mother." One survivor spoke about how, although her husband and family did not chase her from the family home, her in-laws had a problem with the marriage: "They advised my husband to marry another wife" *(Mwirama)*.

One survivor spoke about relationships after sexual violence: "The friends of my husband are kind to me, but on my back, they backbite me" *(Mwirama)*. One survivor said that friends of her husband "follow the humor of my husband. When we don't understand each other (husband and wife), they take advantage of it to say what they want (about me)" *(Ikoma)*. Even with family and peer pressure, not all family members reject survivors. One man who did not reject his wife said, "The members of the community were telling me to repudiate her" *(Ikoma)*. He felt that "people like separating the couples because the women are responsible for our fields, our riches. When they separate them, they destabilize the man."

Description of Family Mediation Program

Participants described family mediation as a process of resolving family conflict, "when persons such as the priest calls a husband for explaining to him the problems in order to reconcile him with his wife" *(Survivor, Ikoma)*. A priest described it as an "act to reconcile people" *(Mediator, Ikoma)*. Generally, participants described family mediation programs as focused on the needs of survivors and family and included only those directly involved in rejecting the survivor: "We must not involve a lot of people, just . . . the members of the family only if they are directly in the problem to solve" *(Mediator, Ikoma)*. When survivors were seeking help as a result of their spouse rejecting them, mediators initially focused on the couple but could expand to include other family members if appropriate.

When asked who conducted family mediation in their community, participants spoke about priests, FORAL community workers, and village chiefs. Only three facilitators of mediation reported having been trained in mediation or basic counseling. A good facilitator of mediation was defined as someone who is "trustful, knowing how to keep secrets, courageous and praying to God" *(Mediator, Ikoma)* and has "a strong heart, not get angry because they (the family and community) menace you . . . to be known in the community, having done . . . work for the community, not . . . problematic or to have problems in her family, to be able to plead for others" *(Mediator, Ikoma)*.

The main reasons for participating in family mediation included needing family and community support, shelter, or help with the children (e.g., food, education) as well as having a positive relationship before the sexual violence. One survivor who initially said she did not want to reconcile with her husband later said she would prefer to be reintegrated with him because "it's better for the education of our children" *(Ikoma)*. One survivor explained that she wanted "to live with her husband. It will be better for me because before we didn't have any problems" *(Ikoma)*. Another survivor spoke about how she continues to "consider him as my husband. I would like once more to live with him" *(Mwirama)*. A survivor who resides with her brother discussed his difficulty in accepting her son who was the "product" of the rape. She wanted her brother to participate in family mediation, so "we can live in peace. And especially that he can accept my son" *(Ikoma)*.

Facilitators described the structure of the family mediation program. They raised awareness about the program during community meetings and church services allowing people to approach the facilitators directly, "they themselves come towards us to explain what problems they have" *(Mediator, Ikoma)*. As many women hid their history of sexual violence, the mediators efforts to raise awareness of the program helped reach people who are otherwise difficult to identify. Facilitators also go to the survivors if they are concerned about their situation, "I didn't want to get out. I was hiding in

TABLE 4 Components of Mediation Program and Required Support Services[a]

Component	Description
Component 1	Identification of survivor who was rejected and/or abandoned by family member and initial discussion and problem identification
Component 2	Visit/repeat visits with family member who rejected/abandoned the survivor and discussions around problems and reintegration
Component 3	Involve influential family members, friends, or community members in discussions if needed
Component 4	Sensitizing the family and community, stigma and discrimination reduction/elimination
Component 5	Follow-up visits
Support services	Medical care
	Mental health support services
	Economic support (e.g., animal husbandry, microfinance, support for cultivating)
	Education support for children
	Clothes
	Shelter
	Support for children

[a]Although components are numbered, services may be provided in different orders, simultaneous or with different emphasis depending on the specific situation. Facilitators of family mediation determine how to provide the services based on the individual case.

my house. I was jumping at all the time. It is (the mediator) who came to find me" *(Survivor, Ikoma).* The participants described five components to family mediation, although their order was not necessarily linear, and facilitators adapted their methods to suit the needs of individual situations (Table 4). The facilitators first talk with the survivor "individually to describe the problem and to reassure that it (rape) can happen to anybody" *(Mediator, Ikoma).* They "come up to this woman. We speak to her. It's then that you can draw the consequences and the trauma and, after, we know what we are going to do" *(Mediator, Kaniola).* Facilitators visit the family member who has been involved in the rejection of the survivor as part of the second component. The facilitators may not "tell him that we talked with his wife and vice versa" *(Mediator, Ikoma).* One facilitator said that when they visit the husband, "We ask him if it's (rape) really a problem; if yes, we ask him to put himself in the place of the other" *(Ikoma).* Another said, [we] "listen to him. We look for solutions with the husband until the husband can understand that it wasn't the fault of his wife. That can happen and has happened to many people" *(Kaniola).* The facilitators often visit the husband, or family member, multiple times before they are heard and discussions ensue: "Even if they chase you, you can't give up. You must come to speak with the husband. He will finish by telling you why he chased his wife. Sometimes it is he who . . . calls the wife to join us" *(Mediator, Ikoma).*

Influential family members or friends can be useful in mediation. One survivor requested her brother-in-law be involved because "he knows how I was living with my husband and knows my behavior" *(Mwirama)*. Facilitators and survivors want to involve people who can influence decision making by the husband and family including godparents, aunts, in-laws, wise men and the village chief, church members, or the husbands' friends. One woman, in hopes of having her brother accept her son who was born as a result of rape, wanted her aunt to be involved because "my brother is afraid of her and can do what she tells him and also she likes my child" *(Ikoma)*.

The fourth component involves sensitizing the family and community and making stigma including "pointing at women" unacceptable. One facilitator described, "After having reconciled the couple, we now invite the members of the family" *(Ikoma)* and make stigmatizing a survivor in the family intolerable. The fifth component involves follow-up visits. In cases where women reintegrate with their family, follow-up visits "to see if really they are living together" *(Mediator, Ikoma)* are needed. Mediators talk with the couple and family members and eat meals together during follow-up visits. They visit families as frequently as needed, in some cases, as often as once a week. Facilitators stated that follow-up is an important component that needs time. They also accompanied survivors to receive health care and social services to continue to support the reintegration.

Survivors and husbands were asked about the kind of information and counsel they received during mediation. One survivor said, the village chief and two wise men, focused on how people "must leave me alone, in peace, because what happened was not my fault" *(Ikoma)*. Another woman said the facilitator told her husband, "It wasn't my willingness, but it was the will of those who raped me and that happened to very many people. That they didn't consume me entirely" *(Mwirama)*. After mediation, she said, "He understood and I returned to my marital home." Another survivor said the mediators told her husband "to put himself in my place" *(Ikoma)*. A survivor who was abducted by an armed groups said the facilitator asked her husband "how we can separate and leave our children like orphans. . . . They were asking him why he was locking himself in his house, that he was going to die isolated, . . . that it is luck that I am alive" *(Ikoma)*.

Reintegration and Support Services

Survivors who reintegrated with their families emphasized social acceptance, improved relationships, better opportunities for their children, feeling at ease and able to speak about problems, and fewer mental health problems: "They no longer hold their cheeks" *(Survivor, Ikoma)*. After mediation, a survivor described how her relationships changed: "I am living in peace in my house. . . . The people of the community begin to receive me. They have understood that was not depending on me" *(Ikoma)*. Another woman who

attended mediation and reintegrated with her husband said, "Mediation helped me. I can see the changes in his behavior because before we were disputing. Before, when they were saying that I am the wife of Hutu, my husband was angry and coming to insult me. Now he doesn't do it anymore" *(Ikoma)*. She also spoke of other women who reintegrated with their husbands:

> The parents oblige the husband to retake his wife. But his behavior face-to-face with the wife is different. What he was doing before for you, he doesn't do anymore. Because the person with whom you live, you can't forget that there is a change even in his manner of seeing you. The woman is happy to live again in her home because she is near her children. I don't know for the man. *(Ikoma)*

Participants described several factors that appeared to make reintegration even after family mediation more difficult. Specifically, when the survivor had a child as a result of rape, the husband married a second wife or she was already living in a polygamous marriage or the family lost their wealth in the attack. A man's parents may encourage him to remarry after the rape, because they no longer considered the couple married if another man rapes her. In these cases, one health care provider said, "We can't any more chase the other" *(Kaniola)* in reference to the second wife. Another facilitator explained, "We have cases of failure. The reasons, it is often, the man . . . has married another wife" *(Kaniola)*. A survivor, whose husband had since remarried, described the advice that the facilitator gave to her husband: "They are telling him to return because it wasn't my intention and that I am his first wife, his legitimate wife" *(Ikoma)*. One woman described her husband who participated in mediation and refused to accept her back: "He was saying that he wasn't loving me any more and that he was going to marry a second wife. . . . They have now one child" *(Mwirama)*. Another facilitator felt that the most challenging situations were when families left the village because of the violence and pillage of their homes. Conducting mediation in these situations requires resources to find the family members and bring them back to the village. One facilitator felt that opportunities for mediation exist: "We must send the mediators where they are or to join them through telephone" *(Ikoma)*.

Participants also spoke of difficulty after reintegration. One widow who talked about her life improving after the reintegration with her in-laws also said, "They backbite me" *(Ikoma)*. Another survivor, who had a child after rape and whose husband allows her to live in the family compound, said, "Mediation helped me a lot because I was crying every time. . . . I would ask . . . to plead for me so that they could accept me and forgive me really and that they no longer speak about it" *(Mwirama)*. Another survivor reported,

"I live with my husband in appearance. There is no sexual intercourse, no economic support" *(Mwirama)*. One woman, who did not participate in mediation, and whose husband rejected her and, then, accepted her back after remarrying, said, "My husband is only there for sexual intercourse" *(Survivor, Mwirama)*.

Across all interviews, people discussed support services that could improve mediation, reintegration, and quality of life of women who are not reintegrated in their families. These services included tuition fees for children, housing, clothing, and economic activities mostly focused on animal husbandry or undertaking small trade. Others spoke about needing "advice so we can live in peace" *(Survivor, Ikoma)* and that "the mediation is a help for the women but also a little means of finance . . . to help them to resume their activities" *(Survivor, Mwirama)*. Survivors and their husbands reported how, in addition to sexual violence, their wealth was stolen including their animals and their houses destroyed during the attacks by rebels, soldiers, or both. Left with little resources, survivors have difficulty acquiring food and shelter: "I was living better before; now I have much difficulty to have something to eat" *(Survivor, Ikoma)*. One man, who lost his "iron sheets for his home, goats, and cows" when his family was attacked in their home, said that he now lives with his wife, but they "don't make sexual relationship" *(Ikoma)*. He sought advice from priests and friends who encouraged reintegration, but he concluded that to improve the relationship with his wife: "I have already received very many pieces of advice. I need financial means or the breeding of animals." His relationship with his wife appeared volatile: "I listen to them and I understand. I think of reconciling with her, but when I arrive at my house, all change. I don't stop thinking about it." One facilitator captured the need for financial support when he said, "it is the poverty because if this wife has a profitable activity, the husband will not do menace any more" *(Ikoma)*. A health care provider in Kaniola also said the following:

> Socioeconomic support is important. . . . If the victim has a microcredit or breeding of animals, she will find herself again with other women. Let it be in the market where one can buy her things like all that other women. She will be in the field where she can talk with everyone. It's a better way of reintegrating her. *(Kaniola)*

Participants concern for children, including those born from rape and who witnessed violence, focused on reintegration, education, health, and nutrition. One facilitator said children need help because "sometimes they cry because they saw, they attended the scene. These children need psychological help. They are sad children, isolated, who have no interest in playing" *(Ikoma)*.

CONCLUSION

In a review of the health impacts of rape, colleagues with the Sexual Violence Research Initiative discussed how negative social reactions to a rape survivor affect her physical and mental health recovery including treatment-seeking behavior (Sexual Violence Research Institute, 2007). Researchers in this study illustrate how the impact of sexual violence must be understood in terms of its physical and mental health and social and economic effects. We introduce some of the ways husbands, family members, and community members, feel violated, endure trauma, and are economically affected by sexual violence. Other researchers have also described how families, economics, and communities change as a result of sexual violence (Kelly et al., 2011a; Réseau des Femmes pour un Développement Associatif, 2005; Sideris 2003; Steiner et al., 2009). Interventions must be situated in the family and community context in which survivors reside. In order to address the effects of sexual violence, program developers should ensure that interventions have a more holistic, local understanding of violence and its effects and the needs of communities.

Several researchers have have shown that sexual violence in the DRC is associated with other types of violence including looting of possessions and rape in public places (Bartels et al., 2010; Duroch, McRae, & Grais, 2011; Pratt & Werchick, 2004). The authors provide some evidence that the associated violence may be reasons for rejection by family members. In this study, we highlight some reasons for rejection by family including gang rape, loss of wealth, forced witness of rape, having a child after rape, and health problems. In their article, Kelly and colleagues support gang rape and having a child after rape as motivating factors for rejection (Kelly et al., 2011b). Researchers should study potential risk factors for family rejection more closely in order to target interventions to those most in need. Individuals at increased risk for rejection may also be at increased risk for other types of trauma including intimate partner violence and physical and mental health problems and lack of economic support. Kelly and colleagues (2011b) examined reasons for rejection using a definition of not being able to live with the family. Other researchers have indicated that rejection is a predominant concern amongst survivors and their communities, but they have not defined the term (Pratt & Werchick, 2004; Réseau des Femmes pour un Développement Associatif, 2005; Steiner et al., 2009). Participants in this study described the experience of rejection, indicating a need for a broader understanding of rejection. Instead of only situating rejection in a physical place (i.e., not being able to live at home), rejection also has economic and emotional components. This description of family rejection is important as it indicates that women may experience rejection differently and in multiple ways. Some may not live with their families; others may have misunderstandings in communication that did not exist before, be unable to resume household duties and experience

tensions between family members, loss of affection, and loss of economic support. Some women described rejection as their husbands not supporting them or their children financially, but they live in the same household. This indicates that rejection is more complex than previously thought. Rejected women who continue to live with their family members may be overlooked by interventions that rely on physical separation as the definition of rejection. Further, family rejection is not universal within the family unit. While survivors report rejection by one or more people in the family (e.g., in-laws, spouse, parents, children), they also discuss how other members of the family provide support and try to assist in the family mediation process. Researchers should explore a more nuanced definition of rejection in future studies.

Staff with local, community-based organizations often implement innovative and culturally appropriate programs yet have limited access to resources. Other researchers have referenced family mediation as a means of reconciling family relationships (Pratt & Werchick, 2009; Réseau des Femmes pour un Développement Associatif, 2005; Steiner et al., 2009); the authors, in this study, present one of the first in-depth examinations of a local Congolese led NGO's response to the needs of survivors of sexual violence in conflict and postconflict settings. We describe the work of facilitators (trained and untrained) conducting family mediation and suggest how we can use future services and research to address the multiple needs of survivors. Trusted individuals from the community discussed five components of the mediation process. The five components are dynamic and occur at different lengths and intensity depending on the case. Reintegration and prospects for successful mediation vary based on individual circumstances including history of previous rape, pregnancy after rape, and stigma from friends and family. Concern from community leaders and members about deteriorating family and community relationships further emphasizes the importance of understanding family mediation as one activity that may help reduce stigma, increase acceptance of survivors, and, with other services including economic activities and education for children, improve health and well-being across the individual, family, and community.

This study has several limitations. As a qualitative study in two villages and a health zone center of Walungu Territory and one urban area, the authors characterize family mediation and the impact of sexual violence in this area. Survivors in other parts of Eastern DRC may face different problems, with a mediation program not being amongst their priority needs. Other similar community-based responses may exist and be implemented differently. With only three husbands enrolled, the authors provide limited insight into the perspective of spouses on the impact of sexual violence, rejection, and their experience with family mediation. Researchers were not able to describe what successful reintegration means to the survivor and her family or whether those who are reintegrated have a better quality of life or

have resumed relationships with their spouse, family, or both as they were before violence.

REFERENCES

Bartels, S., Scott, J., Leaning, J., Mukwege, D. M., Lipton, R., & VanRooyen, M. (2010). Surviving sexual violence in Eastern Democratic Republic of Congo. *Journal of International Women's Studies*, 11(4), 37–49.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed method approaches*. Los Angeles, CA: Sage.

Duroch, F., McRae, M., & Grais, R. F. (2011). Description and consequences of sexual violence in Ituri province, Democratic Republic of Congo. *BMC International Health and Human Rights*, *11*(5).

Harvard Humanitarian Initiative & Open Society Institute. (2009). *Characterizing sexual violence in the Democratic Republic of the Congo: Profiles of violence, community responses, and implications for the protection of women*. Retrieved from http://hhi.harvard.edu/publications/hhi-programs-publications

Harvard Humanitarian Initiative & Oxfam International (2010). *"Now the world is without me": An investigation of sexual violence in Eastern Democratic Republic of Congo*. Retrieved from http://hhi.harvard.edu/publications#WOMEN%20IN%20WAR

Hassouneh, D., & Glass, N. (2008). The influence of gender-role stereotyping on female same sex intimate partner violence. *Violence Against Women—An International and Interdisciplinary Journal*, *14*, 310–325.

Human Rights Watch. (2002). *The war within the war: Sexual violence against women and girls in Eastern Congo*. New York, NY: Author.

Human Rights Watch. (2010). *Trail of death: LRA atrocities in Northeastern Congo*. New York, NY: Author.

Johnson, K., Scott, J., Rughita, B., Kisielewski, M., Asher, J., Ong, R., & Lawry, L. (2010). Associations of sexual violence and human rights violations with physical and mental health in territories of the Eastern Democratic Republic of Congo. *Journal of the American Medical Association*, *304*, 553–562.

Kelly, J., VanRooyen, M., Kabanga, J., Maclin, B., & Mullin, C. (2011a). *Hope for the future again: Racing the effects of sexual violence and conflict on families and communities in eastern Democratic Republic of Congo*. Cambridge, MA: Harvard Humanitarian Initiative. Retrieved from http://reliefweb.int/report/democratic-republic-congo/hope-future-again-tracing-effects-sexual-violence-and-conflict

Kelly, J. T., Betancourt, T. S., Mukwege, D. M., Lipton, R. I., & VanRooyen, M. J. (2011b). Experiences of female survivors of sexual violence in Eastern Democratic Republic of the Congo: A mixed methods study. *Conflict and Health*, *5*(2). Retrieved from http://www.conflictandhealth.com/content/5/1/25

Kohli, A., Makambo, M. T., Ramazani, P., Zahiga, T., Mbika, B., Safari, O., . . . Glass, N. (2012). A Congolese community-based health program for survivors of sexual violence. *Conflict and Health*, *6*, 6. doi:10.1186/1752-1505-6-6

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (2002). *World report on violence and health. Geneva, Switzerland:* World Health Organization.

Leininger, M. (1985). *Qualitative research methods in nursing*. New York, NY: Harcourt Brace Jovanovich.

Longombe, A. O., Claude, K. M., & Ruminjo, J. (2008). Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: Case studies. *Reproductive Health Matters*, *16*(31), 132–141.

Mukwege, D. M., Mohamed-Ahmed, O., & Fitchett, J. R. (2010). Rape as a strategy of war in the Democratic Republic of the Congo. *International Health*, *2*, 163–164.

Mukwege, D. M., & Nangini C. (2009). Rape with extreme violence: The new pathology in South Kivu, Democratic Republic of Congo. *PLoS Medicine*, *6*(12), e1000204. doi:10.1371/journal.pmed.1000204M

Peterman, A., Palermo, T., & Brendenkamp, C. (2011). Estimates and determinants of sexual violence against women in the Democratic Republic of Congo. *American Journal of Public Health*, *101*, 1060–1067.

The PLoS Medicine Editors. (2009). Rape in war is common, devastating and too often ignored. *PLoS Medicine*, *6*(1), e1000021. doi:10.1371/journal.pmed.1000021

Pratt, M., & Werchick, L. (2004). *Sexual terrorism: Rape as a weapon of war in Eastern Democratic Republic of Congo: An assessment of programmatic responses to sexual violence in North Kivu, South Kivu, Maniema, and Orientale Provinces*. Kinshasa, Democratic Republic of the Congo: USAID/DCHA. Retrieved from http://www.peacewoman.org/resources/DRC/USAIDDCHADRC.pdf

Réseau des Femmes pour un Développement Associatif. (2005). *Women's bodies as a battleground: Sexual violence against women and girls during the war in the Democratic Republic of Congo, South Kivu (1996-2003)*. Réseau des Femmes pour la Défense des Droits et la Paix and International Alert. Retrieved from http://www.grandlacs.net/doc/4053.pdf

Sexual Violence Research Initiative. (2007). *Rape: How women, the community, and the health sector respond*. Geneva, Switzerland: Sexual Violence Research Initiative and the World Health Organization.

Sideris, T. (2003). War, gender and culture: Mozambican women refugees. *Social Science and Medicine*, *56*, 713–724.

Steiner, B., Benner, M. T., Sondorp, E., Schmitz, K. P., Mesmer, U., & Rosenberger, S. (2009). Sexual violence in the protracted conflict of DRC programming for rape survivors in South Kivu. *Conflict and Health*, *3*(3). doi:10.1186/1752-1505-3-3

United Nations Office of the High Commissioner for Human Rights. (2010). *Democratic Republic of the Congo, 1993-2003: Report of the mapping exercise documenting the most serious violations of human rights and international humanitarian law committed within the territory of the Democratic Republic of the Congo between March 1993 and June 2003*. Retrieved from http://www.ohchr.org/Documents/Countries/ZR/DRC_MAPPING_REPORT_FINAL_EN.pdf

Vinck, P., Pham, P., Baldo, S., & Shigekane R. (2008). *Living with fear: A population-based survey on attitudes about peace, justice, and social reconstruction in Eastern Democratic Republic of Congo*. Berkeley, CA: Human Rights Center University of Berkeley, Payson Center for International Development, International Center for Transitional Justice. Retrieved from http://www.law.berkeley.edu/HRCweb/pdfs/LivingWithFear-DRC.pdf

Ward, J., & Marsh, M. (2006). *Sexual violence against women and girls in war and its aftermath: Realities, responses, and required resources*. New York, NY: UNFPA. Retrieved from http://www.unfpa.org/emergencies/symposium06/docs/finalbrusselsbriefingpaper.pdf