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Review Article

'Sites of Resilience': Women Survivors of Sexual Violation in Eastern Democratic Republic of Congo

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Abstract

This study is part of a larger ethnographic project on the phenomena of war rape in eastern Democratic Republic of Congo. The aim was to explore how women survivors of sexual violence navigated and negotiated surviving in the stigmatized margins of an impoverished existence. The paper departs from a previous study in which women expressed multiple losses and profound dispossession of identity and the subsequent marginalization, often with a child born of rape.

The findings are based on eleven qualitative interviews with women of reproductive age recruited from a variety of organizations supporting women after sexual violation. Thematic analysis and Payne's theoretical framework concerning sites of resilience guided the analysis. Results indicated how the women made pro-active decisions and exhibited resilience in severely compromised environments embedded in a larger oppressive complexity. Their faith in God, limited health interventions (that actually challenged understandings around sexuality and mental health), indigenous healing, and strategic alliances with aid organizations or survival sex, supported these women to manage daily existence in the margins. These survival strategies, identified as sites of resilience, provide vital contextual knowledge for effective interventions.

The findings suggest that strengthening collaboration between existing networks such as the church, health care services and indigenous healing practice would extend the reach of health services, offering sustainable holistic care. This would serve the needs of not only the violated individual but the entire traumatized community, whose function as a supportive collective is essential.

INTRODUCTION

This paper is about women survivors of sexual violence perpetrated in the warscapes of eastern Democratic Republic of Congo (DRC). The women had been raped by soldiers and militia commonly identified as Interhamwe, a Hutu rebel group originally from Rwanda. All the women endured suffering and a variety of consequences; pregnancies, physical and mental ill-health; some were so severely impaired, they were unable to function. Their voices are presented here as they relate their own constructions of resilience.

In a previous analysis of the data [1], women cited enduring multiple and sustained losses after sexual violation, leading to a profound dispossession of identity and life meaning. The embodied violence and subsequent stigmatization was so encompassing that it led to self-abjection and feelings of unworthiness. Some women expressed they did not 'feel human.' Giving birth to a child conceived after rape further magnified their burden. Women explained how the child born of rape represents the perpetrator, serving as a reminder of the traumatic event for the mother, complete with flashbacks, pain and fear. The child is bodily substantiation of the trauma for both the mother and the community and by extension carries the stigma of being 'fathered by the enemy'.

Rape is theorized as a sexual act that underscores power relations rather than a biological-based uncontrollable and lustful desire for sex [2]. Constructions of gendered behavior typically normalize men's aggression and women's passivity and these views have been institutionalized in societal structures [3]. Historically, rape has been considered just an unfortunate side effect of war and the first war rape convictions only took place in the 1990's [4].

Previous work investigating rape perpetrators' motivations in DRC suggest that soldiers themselves rationalize rape as means to satisfy desire and/or as an antidote for rage, humiliation and frustration [5,6]. 'Rape with extreme violence' (REV) was coined to describe the physical destruction of the women's body that has become characteristic of rapes in DRC [7].

How survivors of sexual violence manage in the aftermath has been a neglected area of research yet is increasingly relevant particularly as 'new wars' [8], are on the rise. New wars are

described as low-tech and enduring, featuring inter or intra state ethnic group conflicts marked by the violent trinity of rape, loot, pillage aimed at terrorizing civilians. The multiple conflicts in DRC reflect this reality. Moreover, these conflicts involve multiple trans-national actors and are more often driven by the local individual's survival needs rather than a war ideology. The growing prevalence of 'new wars' that target civilians creates a situation where there is no safe haven outside the battlefront. Entire communities suffer as they witness or are directly affected by violence. In this context, there is an increased need to critically think through humanitarian and public health interventions oblivious of these new dynamics. For example, interventions designed to provide for individual psychological needs must actually address the reality of mass civilian traumatisation.

The DRC may be resource rich and potentially self-sufficient, but the protracted conflict has rendered a country of collapsed infrastructure and weak governance [9,10]. Multiple and complex conflicts referred to as wars within wars are ongoing [11]. Among the most salient drivers of conflict is the global exploitation of natural resources [12]. Locals are exploited and intimidated through violence. The wealth generated from raw materials is rerouted into the coffers of rebels, middle men, the elite or is shipped out of the country to external actors, to provide cheap resources for hyper-consuming western societies [13]. That said, one must resist essentialising the Congo conflict down to singular causality. This conflict is complex and deeply embedded in socio-economic, political and historical dimensions.

In DRC, sexual violence has been used by soldiers, rebels and even civilians, to intimidate local populations; a means available to even the most impoverished war-monger. 'Survival looting' has become de rigueur, using the threat of rape to provide effective leverage in procuring necessary basics for disenfranchised soldiers and even civilians.

Eastern DRC's war has been on-going for two decades. It has claimed more than five million deaths, mostly civilians. Due to the many foreign players implicated overtly and covertly, the war has earned the title of 'Africa's World War' and 'the making of continental catastrophe' [12].

The largest deployment of peacekeepers was sent there in 1999 [14]. Without a war ideology, in a soldier versus civilian dynamic, the chaos of gun-toting banditry [15] is what draws the world's attention, even though, many global actors benefit from and facilitate, the chaos described by Klein as 'disaster capitalism' [16].

To really understand these multiple conflicts, one must look at, not just the 'curse' of natural resources [17] but DRC's history of (post)colonial domination and inter-ethnic conflicts further manipulated by corrupt opportunistic leaders, aided and abetted by external actors to grab and reap their own rewards, leaving little in return to the indigenous population [18].

This paper is about how sexually assaulted women described their experiences of survival in the Congo warscapes. Using Payne's model [19], which captures the complexity of resilience, the aim is to illuminate the ways in which these women survived their marginalized positions. By exploring their 'sites of resilience', opportunities for potential interventions are revealed.

Theoretical framework

The concept of resilience has been used for more than two decades, yet its usefulness and imprecision continues to be debated [20,21]. Resilience in general is understood as recovering, bouncing back after a destabilizing event. Lazurus and Folkman's resilience theory describes coping and adaptation [22] as person's response to a stressor, defined as a stimulus or environmental event that is perceived as threatening. People respond in different ways in order to avoid or minimize the perceived threat. Thus, an individual's coping strategies in the face of stressors are embedded in complex interactions; one's personal attributes, contextual factors and inter-related dynamics therein.

Definitions of resilience have historically focused on the individual's innate traits [23] or highlighted processes of how one's strengths are operationalized in facing adversity [24]. Other research has attempted to critique/evaluate specific factors [25,26]. Ungar in his resilience theoretical work, motivated by these vague and partial definitions [20], argues for a social ecological understanding in order to both operationalize the concept and account for differing cultural contexts. Payne's re-conceptualization of resiliency [19] builds upon this expansion and therefore deemed a relevant model in which to view the violated women's survival strategies.

Sexually violated women have been stigmatized by their communities in much the same way as Payne's original participants, street-oriented black men, have been discriminated, marginalized and barred from participating in economic and educational opportunities. The objective in using this model is not to compare the marginalized lives of these Congolese women to street-oriented black men but because it accounts for the complexity of the historical, spatial and contextual factors that influence how marginalization is framed by societies and global structures; how ethnic, gendered and classed groups strive to survive within a limited sphere.

The sites of resilience model [19] places greater emphasis on the subjective experiences and the individuals' own values instead of 'expert' assessments. A rape survivor engaging in prostitution to feed her children challenges a value-laden 'expert' assessment that she has potentially failed to 'bounce back' whereas survival sex, albeit rife with risk, may be perceived as her only option in these circumstances to fulfill her motherly obligation to provide.

Furthermore, the adapted model exposes an oppressive structural dimension in the relational configuration of ethnicity, gender and class. Within these interwoven factors, 'sites of resilience' are found. Theoretically identified in Payne's model [19] as a Psychological site would be, for example, women's spirituality; a Physical site could be the hospital. Merged sites could be, for example, attending a church service where both physical and psychological 'safety' is perceived. In reality the boundary between physical and psychological sites is blurred. 'Sites of resilience' are relevant in appraising how individuals deal with structural inequalities. The site of resilience model (Figure 1) is dynamic, non-linear and acknowledges layers of complexity. It is not a flow chart but a mapping of complexity. The solid lines around lived experience and history indicate a more fixed

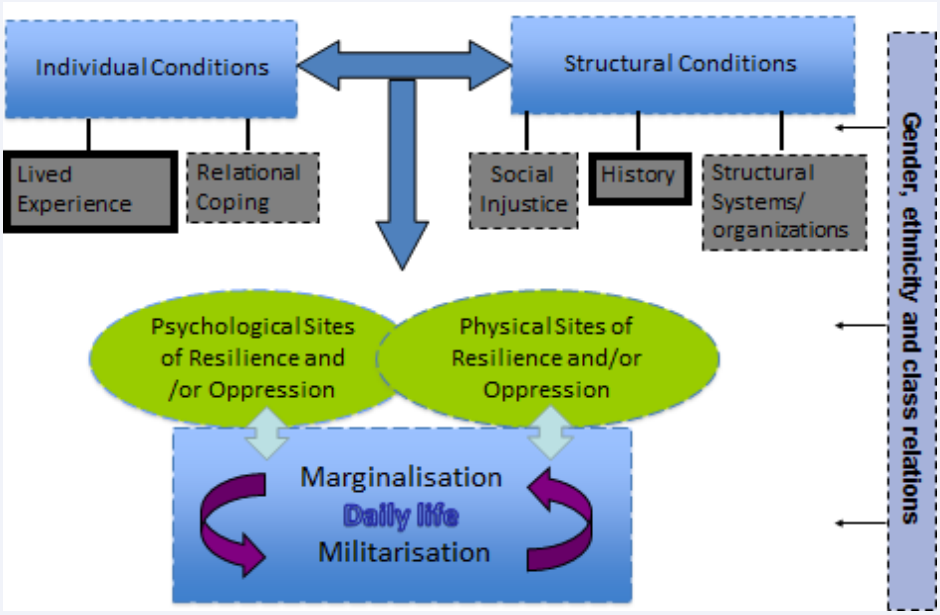

Figure 1 Trenholm et al's adaptation of Payne's sites of resilience model.

notion. Although one cannot change the past, one may re-think past experiences. The dotted lines around the remaining features indicate areas more receptive to change. Gender, ethnicity and class relations are seen as overarching concepts with an overall effect. Sites of resilience are fluid and are determined by the individuals who manage their survival, where they bond, build strength and community. How they navigate and negotiate limited options [27].

Methods

This qualitative interview study, part of a larger ethnography, employed individual semi-structured interviews [28] for their ability to help probe in depth, the very sensitive and intimate experiences of sexual violence and its aftermath. Although the findings are substantiated in this paper by quotes gathered from interviews, ethnographic data provided a background, essential to the analysis. Participant observation enabled an insider/outsider role; a longer field engagement deepened understanding of the context and keeping field notes functioned as a log of observations, decisions, activities, contacts and the practice of reflexivity [29-31]. A local research assistant, engaged in the ethnographic research served as a key informant enabling participant recruitment and serving as a cultural broker. One of the authors (AB), also a national of eastern DRC, provided historical background and cultural interpretations which supported the findings. The main author (JT) was introduced to a many organizations and individuals, further enhancing understanding of the context. Among the many contacts was an indigenous healer who showed how he worked with communities struggling to reconcile through cleansing rituals for affected couples, the sexually violated wife and the traumatized witnessing husband. This was done in combination with visiting local health services.

The study was approved by authorities at the respective institutions and was subject to a review by the regional ethical board, Uppsala University in Sweden. The ethical treatment of human subjects informed the research [32]. Psychological care was available as required.

The interviews took place in Bukavu, South Kivu province at three different institutions providing support to those sexually violated; a referral hospital specializing in obstetrical fistula repair with a program addressing the needs of female victims of violence (H), a residential re- integration unit for female ex-child soldiers and unaccompanied minors (RR) and an occupational training centre (OT).

Eleven women of reproductive age (14-33 years), predominantly rural women from North Kivu, South Kivu province or Rwanda were recruited. Three had been married while the youngest participants had been in school. Those with minimal education subsisted on farming activities or small businesses. Included were any women who sought support services in their recovery from sexual violation. They were in various phases of recovery. For example, those from the hospital were still receiving health care whereas those from the other settings had more temporal distance from their trauma.

Interviewing took place over the space of several weeks, in privacy at the respective institutions, after written and oral informed consent. Semi-structured interviews were conducted by the first author (JT) together with a multilingual social assistant or psychologist already on staff and working with the participants.

The semi-structured interview guide consisted of several broad questions; the impact of the war on their lives; why men rape; what their needs were and any suggestions they had regarding how to address the consequences of sexual violence.

The audio-recorded interviews were translated into English and transcribed with minor editing. Data analysis was continuous [30]. Field notes provided a forum for reflexivity and to record

emerging issues. For example, the importance of spirituality emerged and was incorporated into subsequent interviews. Thematic analysis was employed [33]. This involved transcript reading by several members of the research team in search of patterns and meanings reflecting the study's aim. These meanings and patterns were mapped using a mapping exercise described by Braun and Clarke [34]; it is a practical mode of refining ideas and facilitating consensus, further intuiting salient features into specific themes. The themes were then substantiated by returning to the original text.

Findings

This paper focuses on the main theme: survival strategies. The sites of resilience model provided a wider lens in developing the following four subthemes: Having faith in God; Motherhood, pregnancy and the child born of rape; Resisting stigma and rejection; War economies and the struggle for basics.

The often invisible side of war is how civilians manage daily survival in the midst of uncertainty and violence. Women in this study showed marked resourcefulness, theoretically defined as resilience. This section describes different 'survival strategies' employed by women living within marginalized spaces as dictated by individual factors and structural conditions, captured in the model presented above. Quotes exemplifying the women's voices are included with the support institution's initials and participant number.

Having faith in God

The women's belief in God that guided and provided was frequently spoken of as a source of hope:

Just pray to God, I do not see an alternative, just to put all the worries to God. RR6 The return to family was one such situation hoped and prayed for:

If God allows, even though I have been left alone with him (baby born of the rape), if God allows and I am taken back to my village and family, then I will go with my child and my family will help take care of him. RR1

Many expressed a longing for "home", to return and be reunited with their families although homes were destroyed and family members confirmed deceased. Younger participants yearned to return to school. The default to the belief system of 'God's will' seemed to provide sustenance and comfort.

The belief that God's omnipotence would also touch the perpetrator and instigate a change in his violent ways was verbalized:

If God gets them, they might change and stop doing what they are doing…yes it is only God that can change them and make them stop these deeds. RR3

Motherhood, pregnancy and the child born of rape

The pain of seeing one's child, borne of rape as reflective of the traumatic event was contrasted with the idea that children are a gift from God. The sanctity of motherhood, to give birth and the expectations implied, were expressed by the participants:

I felt in my heart that once I …. see the child, it will console me for what happened…yes, love the child…those who abandon children do not love children…even if you have been raped, you do not just throw away a child, especially once you have given birth and have seen the child. RR2

The participants credited counseling for their decision to accept a child born of rape underscoring the potential benefit this child may provide in the future:

…I was thinking of rejecting my child as well, but thanks to the counseling …. I received, I decided not. I was advised that the child is innocent in all of this, and maybe he will be a help for me some day in the future. H1

Another participant added:

*People advise you not to abort …. May be that child will help you someday. You do not know what God is preparing …*RR3

When this participant fell silent, the social assistant, who had worked intensively with her for months, elaborated how counseling supported her and how God's intervention encouraged her to accept her child:

…with the help of counseling, we did our best to link the child to her mother…. Little by little she started coming closer to the child…. previous to that she used to flog the child whenever he came close to her, she used to say: "out of my sight you Interahamwes' child ". She really did not love that child, but glory to God she started loving him. She now gives shower to her child and gives him food. Social assistant H1

Women impregnated through rape can be under pressure from the community to dispose of the child:

…some people can order you to make an abortion, and if you refuse, they will chase you from here or they can ask you to kill the child when you deliver. RR3

For this participant, there is a gendered component in how one manages mothering the child born of rape:

For some women, if they deliver a boy, they reject him because they fear that he will behave like his father. Sometimes you think, maybe this child will also join the army. But if you deliver a girl, you say okay girls have good hearts, you consider that child as your young sister. RR3

Even though abortion is illegal in DRC, participants suggested it is a strategy for those who become pregnant as a result of rape as expressed in the following quote:

There are those who see the pregnancy as a problem and abort, there are those that persevere with it and keep it, for me I would remove it (…) not to have to see that child. RR3

The fear of the child becoming like the father was also expressed as reason for abortion:

…this child may behave like his father …one can wish to make an abortion in fear that …. the child will have the same heart as his father. OT3

Resisting stigma and rejection

The participants reported how they battled the common discourse, that raped women were responsible for their own

assault. Husbands rejected and blamed women for their rape, often to ease their guilt as a failed protector or, as a safeguard against sexually transmitted diseases. This woman faced blame and rejection and returned to her parents:

I told him (the husband) I didn't do it (the rape) by my own will, but he insisted that I needed to leave. .... he told me that I should not share a bed with him. I slept in the sitting room…he went to a mining quarry to work, he left me. Three months later, he came back with another wife. He chased me…threw my things out of the house… I went back to my parents. H2

Being cleared of HIV or other sexually transmitted diseases was touted as paramount, not just for general health but also for being accepted back to the community.

I think the most important thing is to take care of them and test them to see if they are sick or have been infected. If they are found to be sick or infected, they can then be treated.

RR5

The same wish was expressed here:

I think a lot …whether I got infected. I would like to be tested to ascertain if I am sick…. and then I could go back to my village. RR1

War economies and struggle for survival

When asked what would be most supportive for women recovering from sexual violation; food, shelter, school fees and healthcare dominated. A farming woman, whose husband was killed whilst attempting to protect her, was left widowed with several young children. She strategized around how she could provide for schooling for her child by not eating.

Leaving me with all these charges, I fought to help them grow, helpless with only a small field …it is my hope if I spend …. two days without eating, at least he (the child) can study. N4

Although the participants related being abducted by force, one young woman described a different survival strategy. Some women willingly associated with soldiers for survival:

There were soldiers that took women and treated them…. without beating them and this attracted some women …they went to the soldiers that could provide for them. RR1

Other women rejected by their families took up prostitution:

Certain women earn by night having relations with a lot of men…it is prostitution. Their families have chased them away because they are no longer useful. H1

Health care was also expressed as important to seek. Two sisters who escaped their abductors after a month in captivity sought help from local dispensaries receiving unsatisfactory care. They finally arrived malnourished and exhausted at the hospital in Bukavu almost 200 km from their original home as they describe below:

I also got sick…I went to the dispensary for medical treatment. My older sister's pregnancy grew but the medical services we got there were not satisfactory (…) I got infections and medicine which did not help…. Finally we came here because there is good medical care. H4

A participant with "psychiatric shock" and multiple relapses expressed her gratitude to God and to the nurses at the hospital for not sending her to the psychiatric hospital considered as stigmatizing. Being cared for at the local hospital became a reason for optimism:

I am so grateful to God for the nurses….because they have been taking care of me….and they are still taking care of me to the extent that I don't have to go to X (psychiatric hospital) for treatment of my head….. I am so grateful to them for not sending me to X (psychiatric hospital). H1

The same participant continued to express what others in this study reiterated, that "talk therapy" could be helpful but basic needs must be met simultaneously:

… I received some medicine which helped me….but after a short period, I relapsed… the psychologist started to interact ….and give me some good ideas, I was feeling better when he was interacting with me. The head pains eased when the psychologist was talking to me (…) I could get better someday if I find a place to live. H1

DISCUSSION

Faith in God was evidently a powerful impetus to survive. Christian values in health care settings were described as instrumental in providing a sense of hope, and in promoting mother-child bonding. Participants had a strong desire to seek health care particularly for HIV/STI testing viewed as important in minimizing stigmatization and increasing chance for (re) marriage. Certain experiences of counseling were described as effective when available.

Prostitution, more aptly named as survival sex, was regarded as a last resort. The women disclosed their decision-making processes within their limited repertoire of choices.

Payne's resilience model [19] serves as a foundation to the discussion of survival strategies. The resilience model points to a multifactorial context that limits options. Exposing the multiple elements that shape the context and how these elements enhance or limit possibilities provides a deeper insight.

Faith in God was predominantly expressed as a source of hope, yet women said little about church support. Local leaders cited the church as the only functioning infrastructure in eastern DRC [34]. As a powerful and influential institution, Christian church networks and faith-based organizations form the bedrock of this context. Humans have long been long drawn to religion/spirituality for answers to existential questions. Religion and religiosity refers to religious affiliation, church attendance and involvement, whereas spirituality encompasses a transcendent relationship with a higher power and deeply held values which give meaning and purpose in life, although there is overlap in these terms [35]. Dancing, singing and drama, common in many DRC churches, also represents this overlap. Christian spirituality focuses on the idea of a sovereign God and an eternal life exemplified by notions of accountability, judgment and the need for justice implying profound ethical and moral dimensions [36]. The Christian church's role in facilitating people's spirituality and faith is embedded in this context. It is seen for its guiding principles but also as a purveyor of hope, although the institution has not consistently lived up to this ideal [34,37]. Women have

been raped and rejected, accused of adultery and treated as 'soiled' or impure. By the same token, women have sought refuge within the church and their belief in divine intervention has been inspirational in surviving trauma and stigmatization. Local leaders maintain that church authorities have an overwhelming power to influence their members, contending that if the church denounced sexual violence and its stigmatizing consequences, the current epidemic would end [34]. Maintaining silence around issues of sexual violence is like abdicating responsibility thus contributing to sustained structural violence [38,39]. The church holds a key to an 'untapped potential' to support survivors and to influence community members reactions to the violated woman's plight [39]. The church could also affect the perpetrator's behaviour. In a recent study with male ex-child soldiers, a participant reported he did not rape because his commander was a pastor and forbid the soldiers to rape [6].

These psychological and physical sites of resilience address the structural level presented in the model, in particular, organizations such as the church.

The interconnected nature of spirituality and health is not new [40-42]. Holistic care respects the individual as a multi-dimensional being and recognizes that their religious/spiritual needs are core identity elements [43]. Hope provided through worship communities and belief in divine interventions provides reason for optimism and has been associated with favorable health outcomes [44]. That said, affiliations with church groups risk being unsustainable [45] in the case where the faith community rejects violated victims and the fabric of society is unraveling. The strength of one's personal spirituality may not be enough without faith community support especially in war-torn contexts.

Partnerships between the church and public health organizations are potential psychological and physical sites for resilience. That said, international and humanitarian actors have sometimes marginalized the local church's role [46]. Women clearly expressed that health care and spiritual sustenance were two important survival factors. Therefore collaborative efforts that honor the overlapping mandates of healthcare and spiritual care would be apt. Health care initiatives 'using' religious networks to access the people at the same time disregarding their religious ideologies is a serious conundrum [46]. Recent exploratory studies looking at promoting care, prevention and healing, and the role of local faith communities indicated much potential and the challenge of collaborative efforts, worth overcoming [46,47].

Health effects associated with a strong faith seen as 'positive' religious coping have been encouraging. However 'negative' religious coping, defined for example, as expecting God to solve one's problems, was associated with depression, suicidality and increased stress [48]. Women in this study spoke of their reliance on God's omnipotence but less about their local church's support, perhaps because stigma and displacement have changed their reliance on community. Facing the unrelenting adversity of the warscape, women could easily interpret their suffering as punishment, manifested by their own expressed self-abjection. Health outcomes would thus be deeply affected by these beliefs.

Many issues surrounding sexuality and sexual violence are taboo in the eyes of the church. Women being treated at the hospital did not normally share with each other about their traumatic incidents despite living collectively in after-care programs. Focus group discussions revealed the contrary, with women openly sharing their experiences. Many women who attended individual and secular counseling admitted they were unsure what 'psycho-social care' meant. Adopting an individualistic and secular approach to therapy, common in western societies, ignores the collective and faith-based contexts in which these women live. The Red Cross has taken an innovative approach to 'psycho-social care' by establishing *Maisons d'Ecoutes* (*Listening houses*) [49] in the rural areas staffed by local people trained to listen during 'talk' therapy.

Women reported a sense of relief to talk to someone who listened without any shroud of stigma. However, local persons trained and engaged in listening, must also navigate the same insecure environments of war thus risk their own vicarious or secondary traumatisation [50]. One can also question if confidentiality can be maintained for the service users?

Despite some relief expressed by women who told their stories, others were disappointed because what they really needed was a place to live, food and an income. Organizations such as the Panzi hospital and the City of Joy [51] recognize the chronic economic stress and lack of social support for affected women as barriers to resilience. They thus, offer holistic programs featuring temporary residence, literacy and skills training although, once training is completed, women must return to the insecurity of the warscape.

The overarching goal of service providers is to build capacity and guard against giving aid a permanent role. Community participation and women's empowerment are justifiable and noble goals among humanitarian organizations. Unfortunately these goals have been rendered "buzzwords" [52], and devoid of the meaning that was intended. Aid organizations try to create community amongst survivors and although powerful for healing and necessary for survival, the long-term sustainability of fabricating community is questionable. Existing communities may be guilty of rejecting the rape survivor, while other communities have been destroyed by war.

Creating sustainable communities with empowered women in the midst of war is a daunting challenge that needs addressing.

One such mode of addressing sustainable communities could be through Indigenous knowledge holders or indigenous healers. Indigenous healing is common to this context and is grounded in a spiritual relationship with the land predating health care services [53]. Recall the indigenous healer, who had been successful in mediating between the rejecting community and violated women; he worked in tandem with health authorities. He brought the affected woman to the health clinic for examination, STI testing and basic care, a need similarly expressed as important by women in this study [54]. He supported the matrimonial couple by performing purification ceremonies involving counsel, ritual and administration of herbs. The goal was to make amends between the rejecting and traumatized husband and his sexually violated wife.

Purification ceremonies have been successfully used in promoting acceptance of female ex-child soldiers returning to their original communities in Sierra Leone [55]. Cleansing ceremonies for sexual violence survivors in post-conflict Sierra Leone have also been identified as meaningful in recovery [56]. Both ceremonies symbolize a re-birth of sorts for the individual, anxious to shake off the stigmatizing past and serve as a fresh start in the eyes of the community. The past is released and a life of new possibilities emerges. It can be seen as similar to cognitive behavioral therapy [57] adjusted to its cultural context where the onus is placed on shifting viewpoints and changing thinking.

In light of the extreme shortage of mental health practitioners in low-income countries [58], indigenous healers are culturally competent and a source of trusted support intrinsic to communities. Recognition of their value should not be overlooked in strengthening social systems that cultivate self-help in addressing non-psychotic mental disorders [59]. This is particularly important given the stigmatization surrounding mental ill-health.

Post-traumatic stress reactions are difficult to understand and challenge how illness is viewed. Erratic behaviour often associated with traumatic experiences has been attributed to bad spirits or the work of the devil in DRC [60] and in Sierra Leone [56]. Local understandings of mental illness are powerful and must be acknowledged as they have implications in planning interventions [59]. An indigenous healer has the potential to bridge the divide and could be relevant for addressing stigma related to mental illnesses.

Another facet of the prevalence of sexual violence is the irony of how claiming being raped has been instrumentalised as a way for securing funds. In recent years there has been much criticism of aid creating dependency, thus reifying structural violence [61,62]. Despite all the effort, time and money invested into aid, the desired outcomes are lacking and often result in unintended consequences. Women have, for example, claimed to be sexually violated in order to benefit from rape care programs [54]. Similarly, local organizations have exploited the current donor focus on mandatory gender-sensitive programs, before funding sexual violence initiatives. These falsifications are understood at one level as adaptive to survival, but they can do untold damage to truly violated victims as evidenced by the profound losses suffered by women in this study.

The message conveyed that a woman would be willing to suffer stigma by claiming false sexual violation speaks to a desperate plea.

Moreover, women who make strategic alliances with agencies or soldiers are actually demonstrating resourcefulness in the margins. Participants talked about women who sought to be with soldiers who could provide for them. Coulter's research concerning young women abducted to live with rebels in the Sierra Leone conflict, actually saw marrying their rebel captors as the most viable option versus returning to a stigmatizing community [63].

To be a wife and mother are gendered roles women are valued for. In this study motherhood was one of the most powerful motivators to survive. Bringing forth new life, as a result of rape, when framed as 'God's gift', provided consolation. Conversely, women who rejected their child born of rape demonstrate a type of self-preservation as they seek to avoid the trauma that the child invokes or the economic burden entailed.

Health care facilities with limited resources readily exploit the 'good mother' role coupled with the child as "God's gift" ideology in attempts to bond the mother with the child born of rape. It was clear that the 'mother identity' was an enduring one when all else has been lost; when the child is born, the drive to survive to provide for them, was potent. Conversely, there was also mention from other women that if abortion was available, they would abort. Women, pregnant from rape, still attempt self- or assisted abortions [54]. Some of these unsafe abortion cases have subsequently ended up in hospital. There is little evidence available concerning abortions as they are illegal. However, there is a high likelihood that many women attempting unsafe abortions do not make it to the hospital. Consequences of unsafe abortion have been reported to account for a large proportion of those seeking gynecological services in low-income countries, on average 5-7 women/1000 [64]. This consequence is almost entirely avoidable in settings with accessible, available safe abortion services provided within specified criteria [65]. Sub-Saharan Africa as a region has one of the highest rates of maternal mortality in the world [65] and among them lurk cases of failed abortion [66].

The last discussion point concerns women's use of prostitution as a survival strategy. This represents a site of resilience in much the same way as Payne's street oriented black men use drug dealing or other criminal activities for income generation.

Eastern Congo was the site of the largest UN deployed peacekeeping force mandated to address the high risk groups of women and children targeted for sexual violence. This has not led to the expected changes on the ground [66]. Peacekeepers have been unable to maintain security in this vast and complex warzone. Furthermore, they have also been accused of perpetrating sexual violence against the local population [67]. Their presence constitutes a group who can afford to exploit those involved in survival sex. Prostituting women are judged as deviants by dominant societal norms, whilst these women offer sexual services at the local market for a pittance in order to provide their child basics or school fees. Sometimes women do a direct exchange of sex for food or a bar of soap. Women in this study saw survival sex as an undesirable last resort but a resort nonetheless.

CONCLUSION

This study aimed to raise the voices of women affected by sexual violence in eastern DRC. These marginalized survivors demonstrated resilience, drawing on limited options. Despite profound losses, these women rise again within the margins but for how long and in what condition? What about other affected women who are not visible at support services or those who gave up?

Sites of resilience exemplifies how traumatized women use resourcefulness and creativity to navigate restrictive spaces. Public health and humanitarian aid organizations interested in

creating interventions must recognize a broader context and these sites of resilience.

Given the importance of spiritual coping in this context, healthcare professionals/therapists must incorporate spiritual dimensions into their services. Those in positions of religious authority require training in the care of traumatized victims. Health and religious care workers must seek common collaborative ground, overcoming ideological differences in order to benefit the survivor. Indigenous healing is a trusted source of support, widely available and often more accessible than dispensaries or mental health care and therefore needs to be incorporated into the healing complex. Despite these are important considerations for sustainable approaches in supporting war rape victims, peace is the ultimate goal.

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