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Perceptions of the rape crisis in the Eastern Democratic Republic of Congo: A community-based approach using an opportunistic design

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*Mapendo M. Koya[1] and Emmanuel K. Mpinga[2]**

School of Health Sciences (HESAV), University of Applied Sciences and Arts Western Switzerland, Lausanne, Switzerland[1]; Institute of Global Health, Faculty of Medicine, University of Geneva, Geneva, Switzerland[2]

***For Correspondence:** Email: *Emmanuel.Kabengele@unige.ch*; Phone: + 41 22 379 04 63

Abstract

For almost three decades, the Democratic Republic of Congo (DRC) has experienced cycles of armed conflict, particularly in the east. During these conflicts, systematic rape has been used as a weapon of war to break women and communities. Knowledge produced about this phenomenon to date relates to the epidemiology, aetiology and the consequences of these rapes, particularly on survivors in care institutions, thus ignoring the impact this phenomenon has on the communities. Our survey aims to investigate the extent to which women from the Orientale, North Kivu and South Kivu provinces have experienced rape, as well as their perceptions regarding its frequency, characteristics, and repercussions for/on victims in their communities. From a sample of 1483 women, more than 99% had directly or indirectly experienced rape, on at least five occasions in three-quarters of cases. In their experience, a large proportion of the rapes took place at the victims' homes in the presence of family members and were perpetrated by members of military or paramilitary groups. Frequent health problems (several possibilities) reported include: bleeding (40.8%), pain (23.9%); unwanted pregnancies/abortions (23.4%), urogenital problems including STD (12.0%). Concerning mental health, they reported fear and anxiety (56.3%), depression and suicidal thoughts (16.8 %), insomnia (5.3%); 94.7% reported feelings of humiliation and shame and 6.9% social exclusion and stigmatization. Support for victims comes largely from NGOs (47.6%), families (27.1%) and Churches (14.3%). This is a major cultural, economic, political, human rights, and public health problem, which the authorities and international community must commit to tackling. *(Afr J Reprod Health 2022; 26[4]: 42-56).*

Keywords: Rape, Eastern DRC, health issues, sexual violence, perpetrators, support

Résumé

Pendant près de trois décennies, la République démocratique du Congo a connu des cycles de conflits armés, en particulier à l'Est. Durant ces conflits, le viol a été utilisé de manière systématique. Les connaissances produites sur ce phénomène portent plus sur l'épidémiologie, l'étiologie et les conséquences de ces viols, notamment sur les survivantes en institution, et non dans les communautés. Notre étude vise à déterminer dans quelle mesure les femmes des provinces Orientale, Nord-Kivu et Sud-Kivu ont été victimes de viol, ainsi que leurs perceptions concernant sa fréquence, ses caractéristiques et ses répercussions sur les victimes dans les communautés. Sur 1483 femmes ayant répondu à l'enquête, plus de 99% ont subi directement ou indirectement un viol. La majeure partie des viols a eu lieu au domicile des victimes et a été perpétrée par des membres de groupes militaires ou paramilitaires. Les problèmes de santé fréquents rapportés incluent : saignement (40,8 %), douleur (23,9 %) ; grossesses non désirées/avortements (23,4 %), problèmes urogénitaux dont MST (12,0 %). Concernant la santé mentale, la peur et l'anxiété (56,3%), la dépression et les pensées suicidaires (16,8%), l'insomnie (5,3%) ont été rapportés ; 94,7% ont déclaré des sentiments d'humiliation et de honte et 6,9% d'exclusion sociale et de stigmatisation. Le soutien aux victimes provient en grande partie des ONG (47,6%), des familles (27,1%) et des églises (14,3%). Il s'agit d'un problème culturel, économique, politique, de droits de l'homme et de santé publique majeur. *(Afr J Reprod Health 2022; 26[4]: 42-56).*

Mots-clés: Viol, RDC, problèmes de santé, violence sexuelle, auteurs, soutiens

Introduction

While debate is lively on the aetiology of contemporary conflicts within academic and political circles as well as citizen-led social movements for whom the roots of armed conflict in Africa lie solely in colonialism, forgetting precolonial wars and conflicts related to the emergence and expansion of empires and kingdoms, African conflictology has moved on. It points to new dynamics, actors, issues and implications[1,2]. In terms of dynamics, it examines a change in the

aetiology, ranging from postcolonial ideological conflicts to those that are ethnic and economic in nature. Furthermore, while the main actors (foreign capital, local authorities, and dominant spiritual authorities) have not changed, the role of foreign capital has largely increased and mutated into parallel economies due to the erosion of the role of the state[3]. Similar to issues of identity and freedom in the past, new driving forces have made these conflicts multidimensional, encompassing both the security needs of the parties involved to access and control the natural resources necessary for the survival of communities and major geostrategic issues that go beyond the regions and boundaries of the emergence of these conflicts[4,5]. In addition, the combined use of new technologies and certain barbaric practices means that the consequences of these conflicts affect individuals and communities, particularly vulnerable groups, including women and young girls.

The situation overall in the DRC is a perfect illustration of this. From the post-independence wars (1960-1965), this region has witnessed a succession of wars and armed conflicts since the so-called ''Liberation War'' that brought down the Mobutu regime, led by the Alliance of Democratic Forces for the Liberation of Congo (AFDL) in 1996–1997. This war was followed by the 1998–2002 war between the regime of Laurent-Désiré Kabila and armed forces from Rwanda, Burundi, Uganda, Namibia, Sudan, Chad, Angola, Zimbabwe, and Tanzania[6,7]. This was followed by the conflict between the National Congress for the Defense of the People (CNDP) and the Armed Forces of the Democratic Republic of Congo (FARDC) in 2007 and finally the conflict with the March 23 (M23) Movement in 2012–2013[8]. At present, military operations are being conducted against the Democratic Forces for the Liberation of Rwanda and those from Uganda, the Allied Democratic forces (ADF or ADF-Nalu). In addition, numerous militias in Congolese territory keep the east of the country in a permanent state of war.

In spite of the political changeover following the 2018 elections, the security situation remains fragile and worrying in this part of the country. Summary executions and extrajudicial killings, abductions and ransom demands, the enslavement of women and young girls are common practices. In 2021, The United Nations Office of the High Commissioner for Human Rights documented 534 human rights violations throughout the country, of which 75% were committed in the east. ADF fighters have increased their attacks on civilians in the areas of Beni in North Kivu and Mambasa in Ituri, and the Maï-Maï Apa na Pale and the Front patriotique pour la paix/Armée du peuple (FPP/AP) [Patriotic Peace Front/People's Army] have committed a growing number of attacks, particularly in the areas of Nyunzu in Tanganyika and Lubero in North Kivu[9].

Over the years, the conflict has changed in nature. From purely ethnic and political, it has become more complex and heavily influenced by an economic dimension: access to critical mineral raw materials. Armed groups mine and trade these minerals illegally, and purchase weapons with the money they make. The complexity of the conflict is all the greater given the many actors involved: rebel groups, mafia militias, national army, as well as militias from other states and foreign armies. The toll of this conflict is frightening: millions of dead civilians and the destruction of entire villages, roads, schools and hospitals[10-12]. The strategy of the various actors is "total physical and psychological warfare without any respect for the Geneva Convention on the Protection of Civilians in Time of War"[13]. Indeed, all forces involved in the conflict engage actively in heinous acts of violence[14].

From a historical perspective, the rape of women was a known phenomenon in precolonial African societies. In these societies, the construction of social identities by the forced subjugation of weaker clans or ethnic groups, the struggle to access land or forests, and their vital resources, as well as the building of empires and kingdoms, have sometimes been accompanied by raids on livestock and the kidnap of women[15]. During colonization, rapes were reported as a method of social control and exploitation, used both by the regime of Leopold II and the Kingdom of Belgium after him. Even though systematic wartime rape is now counted as a crime against humanity by the international criminal tribunals for Rwanda and the former Yugoslavia, it has continued and even increased over the years in eastern DRC[16]. Some state that these practices "completely annihilate the victim and their close ones […], ravage

communities […], destroy social cohesion […], have devastating economic repercussions"[17].

Other, seldom mentioned, repercussions relate to the emergence and perpetuation of a culture of violence and war, often by new generations of children born during these conflicts, who have grown up marked by war and today are the parents of other children born during these same wars. Similarly, the situation of children born from rape appears to be another major challenge for communities and the women concerned. For some, children born from rape are not accepted because their birth disrupts the representations that provide the basis for common social and societal beliefs. They are made to bear the burden of an issue that predates their own existence: being born the child of the enemy[18].

As can be seen, this situation raises many questions, some of which remain unanswered or have been answered unsatisfactorily, about rape in general, and more specifically how it relates to the DRC. These questions concern the definition and the general theory about rape, the magnitude, nature of repercussions / consequences for victims, the circumstances of rapes, identification of the perpetrators, and so on. This is in spite of several studies that investigate the individual and social consequences of these acts of violence[19-20].

In general terms, rape is defined from several angles. It was defined for the first time by the International Criminal Tribunal for Rwanda in the Akayesu case. Rape is defined as a "physical invasion of a sexual nature, committed on a person under circumstances which are coercive". According to the Tribunal, coercion is an element of the crime that does not necessarily need to be evidenced by a show of physical force: "Threats, intimidation, extortion and other forms of duress which prey on fear or desperation could be coercion"[21].For psychologists, rape is “an event that occurred without the woman’s consent that involved the use of force or threat of force, and that involved sexual penetration of the victim’s vagina, mouth, or rectum”[22]. Considering rape to be torture, sociologists simplify the definition by stating that it is having sexual intercourse with a woman by force without her consent[23]. They furthermore state that from a feminist perspective, rape is a mechanism of social control in patriarchal societies, on the one hand and on the other, rape is more likely in societies where women are considered the sexual and reproductive possessions of men. In these societies, men maintain their power and privileges and assert their sexual rights through threat and the use of force[24,25]. They also explain that the concept of collective rape introduces the dimension of the use of rape as a strategy of the domination, annihilation and objectification of one group of people by another[26]. The rape culture that consequently arises scars these societies, who evolve, in the long term, in endless cycles of violence.

Rape, the subject of our study, is a set of practices carried out during armed conflicts marked in particular by a systematic increase in cruelty, or even sadism against children, the perpetration of such crimes in public or in front of families, carried out repeatedly in detention centres, forced prostitution, rape followed by murder, forced sexual acts by a father on his daughter or a son on his mother, and any other abuses that are difficult to describe and name[27].

Answers to questions on the extent, consequences and responses to rape can be examined in light of data from literature reviews. The estimated number of rape victims is staggering. For instance, in South Kivu, investigators reported that 20,217 women were raped over a period of 3 years (2005-2007) while in North Kivu, the UNHCR reported a 6-fold increase in rape between 2012 and 2013[28,29]. Furthermore, there has been a drastic increase over time in the number of extremely violent rape cases, including gang rape and rape with mutilation[30]. Listed by Peterman *et al*. in a first literature review, works published between 2000-2010 on violence against women in the Democratic Republic of Congo show that around 3.07 to 3.37 million report having suffered sexual violence and around 1.8 million state that they have been raped[28].

Analysing the cases of women who came to the Panzi Hospital in 2006 seeking treatment following sexual violence, the study by Bartels et al. shows that out of 1021 medical files, the average age was[30] with an age range of 3.5 to 80. Around 90% of survivors of sexual violence were either illiterate or had only attended primary school. There were long delays between the incidents of sexual

violence and their arrival at Panzi Hospital (average = 16 months, median = 11 months). The physical effects reported following sexual violence included pelvic pain (22% of women), back pain (11%), abdominal pain (7%) and pregnancy (6%). Thirty six percent of women stated that they were worried about their health, with sexually transmitted infections (STI) and HIV/AIDS the most frequently mentioned health problems[31].

In a literature review published in 2017, Ba and Bopaul looked at the physical, mental and social consequences for civilians who have experienced conflict-related sexual violence. Their results were based on an analysis of 20 studies from six countries, five in Africa (18 studies), and particularly from the Democratic Republic of Congo (12 studies). The number of subjects varied from 63 to 20,517, with 17 studies including more than 100 subjects. Eight studies included males. Gang rape, rape, and abduction were the most commonly reported types of sexual violence. Sixteen studies provided data on physical outcomes, the most common of which were pregnancy (range 3.4-6.3%), traumatic genital injuries/tears (range 2.1-28.7%), rectal and vaginal fistulae (range 9.0-40.7%), sexual problems/dysfunction (range 20.1-56.7%), and sexually transmitted diseases (range 4.6-83.6%). Mental health outcomes were reported in 14 studies, the most frequent being post-traumatic stress disorder (range 3.1-75.9%), anxiety (range 6.9-75%), and depression (range 8.8-76.5%). Eleven studies provided social outcomes, the most common being rejection by family and/or community (range of 3.5-28.5%) and spousal abandonment (range 6.1-64.7%)[32].

Another systematic review is the work of Mpinga *et al*. These authors seek to better understand the interest of the scientific community in describing the magnitude and characteristics of the problem. The analysis covered 2,087 references, of which only 27 are original studies: 20 are based on population surveys and the other 7 are original data based on case studies and reviews. Ten studies provided the prevalence rates of rape victims, 18 provided specific information on the profile of victims, 10 reported that most perpetrators of rape were military personnel, 14 referred to negligence by the government in protecting victims, and 10 reported a lack of adequate healthcare facilities. The authors conclude that awareness of rape in conflict-ridden DRC is still limited as reported in the scientific literature, as there are few published scientific papers[33].

Overall, the knowledge generated by all of these studies comes from hospital and healthcare settings and is limited to South Kivu province alone. One can thus see the need for other types of studies, especially those that look at the community and are extended to other provinces in the country. The group admitted to healthcare facilities is not representative of all victims. In addition, these risk factors and the social determinants of this phenomenon are community-based and not exclusively clinical.

Furthermore, the effects of rape are not only medical and clinical; they affect the whole community and thus the answers offered, from the perspective of prevention, reparation or rehabilitation, can only be effective if they take into consideration the needs and expectations of communities. Communities are simultaneously places where rape takes place and the social entities that must endure the consequences of rape and have to find the resources to respond to it. Prevention, combating and rehabilitating survivors cannot take place and be effective outside of and without communities.

We conducted a cross-sectional community survey among victims of rape in three eastern provinces of the DRC with the intention of better understanding the characteristics of victims, the associated health problems, the patterns of rape and the support victims receive. Knowledge of the characteristics of rape (frequency, perpetrators, location and length of incidents, victims' ages, etc.) could contribute to the design of prevention policies and strategies that are better targeted and that better define the needs of victims and communities. Better knowledge of the nature and types of responses is also a prerequisite to identifying the needs of survivors. The results of this study could thus provide a better assessment of prevention, care and rehabilitation needs within and with communities.

Methods

Study design

A cross-sectional community survey using an opportunistic design, through a quantitative questionnaire, administered by specially trained local investigators, was carried out among girls and women in the Orientale, North and South Kivu provinces of the DRC between June and November 2014. The map showing the affected provinces and the areas where the study was carried out is presented in appendix 1 to this study. The questionnaire was inspired by the work of the Bass team (2013) and the report of the Congolese Ministry of Gender, Family and Children of that same year[34,35].

Setting and data collection

Participants were recruited in their living or professional settings (work, school, etc.) by well-known contact persons (priests and pastors from churches, community leaders, heads of commercial areas). The field investigators (n: 38) were local professionals from NGOs or students from local universities, trained to administer the questionnaire through workshops, and were familiar with local languages and French. The training of investigators involved understanding the questionnaire through explanation of the key concepts in each question and the link to each question. It also included the translation of items (questions) into local languages. They worked in dyads and had weekly contact with the main investigator via Skype or telephone.

The questionnaire included questions on the sociodemographic characteristics of the respondents, health and social problems faced by respondents: frequency and occurrence of rape, types of health problems encountered, access to health services, psychosocial support and justice. It was tested prior to the survey by the field investigators, and adapted accordingly as well as translated into several local languages. Formal and functional changes were made to the questionnaire largely before it was administered. Clarifications were given to the investigators, particularly on questions concerning the rape encounter and the experiences of these women. Respondents answered the questionnaire alone and only those who had difficulties understanding were helped by the investigators.

Data analysis

The data were entered manually into Excel by one of the study's authors (MMK). They were coded and adjusted according to whether they had a similar or almost similar classification in order to facilitate analysis. The Excel database was reviewed and cleaned up by the other author (EKM) and an experienced statistician exported the data to a Stata database for analysis. The calculations essentially provided descriptive analyses. To test the correlations between the characteristics of the respondents and the fact of being confronted or not to rape, bivariate analyses were done using the Chi square test. The results were considered statistically significant if the p-value was < 0.05.

Results

Of the 1507 questionnaires distributed, 1495 were usable. Among the respondents, 33.0% were from North Kivu (mainly Banyarwanda, Bahunde, Batembo and Banyanga), 39.6% from South Kivu (mainly Bavira, Barega, Bafuliru, Bashi and Bahavu), and 27.4% from the Orientale province (equally distributed between Bantou, Batwa and Nilotic). The majority of women were aged between 26 and 35 years (47.5%) and 36 and 45 years (31.5%). The sociodemographic characteristics of respondents appear in Table 1. Of the respondents, more than 95% said that they had encountered rape; 75.4% had been raped more than 5 times, 18.0% between 2 and 5 times, 1.0% once and 5.6% did not remember precisely. The majority of rapes occurred at the victim’s own home (72.4%), at the home of an acquaintance (21.9%), in the forest (3.2%), on the street (2.0%), and in prison (0.5%). The majority of rapes occurred in the evening or night (51.9%), fewer in the afternoon (25.4%) or the morning (19.9%), with 2.8% being not specified. In 82.3% of cases, the rapes occurred in the presence of relatives or family members (Table 2). Perpetrators were identified as members of foreign armies or security forces (47.0%), foreign militias (14.8%), national army or security forces (14.9%), national militias (9.4%), unidentified military (7.6%) and civilians (6.3%). The main risk factors of rape in this part of

Table 1: The sociodemographic characteristics of respondents (n: 1495)

Variables	N: 1495
Age (years)	
≤ 15	6.3%
>15 ≤ 25	7.0%
>25 ≤ 35	47.7%
> 35 ≤ 45	31.5%
> 45	8.1%
Marital Status	
Single	8.5%
Married	75.7%
Widow	12.9%
Divorced	2.9%
Education	
No schooling	0.4%
Primary school (drop out)	18.1%
Primary school (graduate)	24.6%
Secondary school (drop out)	26.6%
Secondary school (graduate)	23.3%
Tertiary school (drop out)	5.4%
Tertiary school (graduate)	1.6%
Professional status	
State/local authorities employee	2.5%
Independent	68.8%
Without a job	25.9%
In training	2.8%
Residence	
Urban	29.4%
Rural	70.6%
Religious affiliation	
Animist	0.5%
Catholic Church	0.8%
Church of the Awakening	48.0%
Evangelist Church	9.2%
Islam	9.6%
Protestant Church	11.3%
None	20.6%
Size of family	
≤ 5 persons	4.3%
> 5 ≤10 persons	77.3%
> 10 persons	18.4%

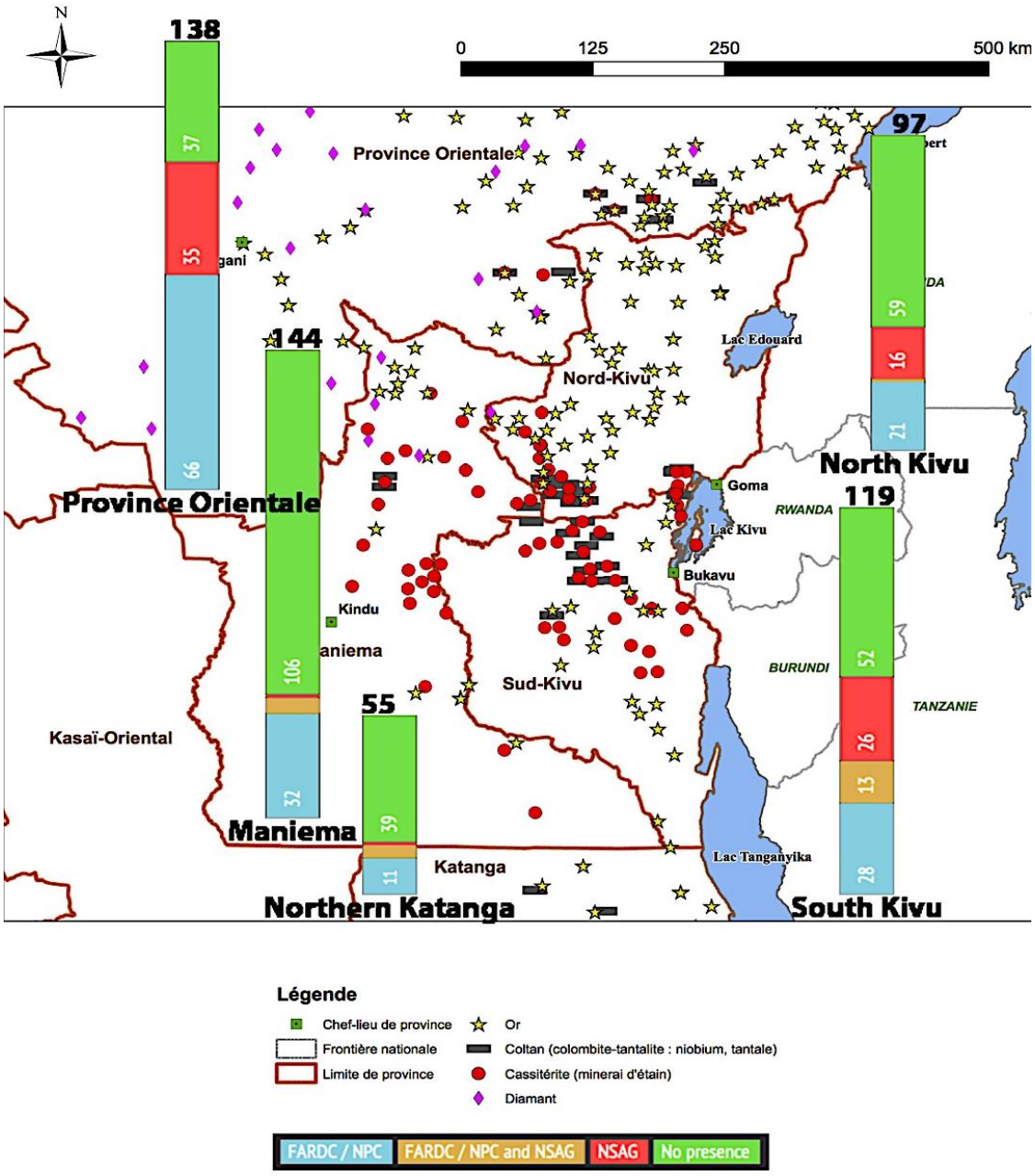
the DRC are being a Bantu woman, being married, living in a rural area, living in a small-sized household and having an independent (self-employed) social, professional and economical status (Table 3).

The most frequently reported health problems (several possibilities) include: bleeding (40.8%), pain (23.9%); unwanted pregnancies/abortions (23.4%), and urogenital problems including STD (12.0%). Furthermore, 56.3% of victims suffered from fear and anxiety, 16.8% from depression or suicidal ideas, 5.3% from insomnia; 94.7% felt humiliated and ashamed and 6.9% reported social exclusion and stigmatization. Satisfactory access to health services was reported by 81.3% and satisfactory access to justice by 2.0% among those who had access to either of these services (above 60% to health services; less than 5% to justice). The respondents particularly identified NGOs as being supportive, and relatives and churches to a lesser extent. (Table 4).

Discussion

Before discussing the main results of our study in detail, the representativeness of the study population will be considered. Our group consists of young people, 8 out of ten of whom are aged under 45, like the total Congolese population, of which only 4% is aged over 60[37]. More specifically, it is also noted that the proportion of respondents under the age of 15 is 6.3% of the total, a proportion not far off from the 4.5% of the population in this age group in the total Congolese population. The respondents' educational level shows that 21% of women aged 15-49 are uneducated compared to 5% of men, which this study corroborates: men are proportionally twice as likely than women to have completed secondary or high school (65% compared to 41%)[36]. Another feature of the representativeness of our group relates to the distribution of the Congolese population between urban and rural areas. The UNDP survey on combating poverty in South Kivu shows that two thirds of the population live in rural areas; this is the same proportion as in our sample[37]. The sociodemographic characteristics of our group are similar to the known indicators of Congolese demographics in general and those specific to the provinces concerned.

Our dataset of 1495 rape victims from the provinces of South and North Kivu and the Orientale province shows that rape affects girls/women of all ages, of all educational and marital statuses and different occupations, from urban and rural areas, and of different ethnicities. Such a broad distribution has been reported by some authors, notably in a study of rape victims attending a hospital for treatment[38]. Such a wide range (age, marital status, education, ethnicity) sets the stage for prevention programmes that should address the needs of victims from different backgrounds and, as some authors put it: "throughout the life cycle"[39].



Snapshot of militarization at mining sites surveyed in 2009/10, OECD, IPSI report, figure15), *OECD* 2015, p. 29.

Figure1: Map of affected provinces and areas where the survey was carried out

One of the major results of our study concerns the proportion of people who state that they have encountered rape (95%). While this result may appear surprising, it should be recalled that in reality this rate does not mean that these persons have been raped themselves. On the other hand, it means that these persons are either witnesses or direct or indirect victims of rape. It should also be recalled that other studies have found similar or even higher prevalence levels than our own. For example, studies by Mankuta *et al*[40]. and Schalinsky *et al*.[41] show 100% prevalence levels. Several factors can

Table 2: Exposure, encounters with rape, frequency of rape, context of occurrence of rape (n. 1495)

	Variables												
	Exposure to rape			**Frequency of rapes**				**Context and place where rapes occur**					
	Yes	No	No answer	Once	2-5 times	More than 5 times	Do not remember	Home	Public place and prison	Work and forest	Witnesses	No witnesses	No answer
Respondents of rape (N)	1477	14	4	11	270	1130	84	1393	28	74	1380	105	10
Percentage of rapes (%)		99.2		0.74	18.07	75.59	5.60	93.18	1.87	4.95	92.31	7.02	0.67

Table 3: Potential risk factors of rape reported

Variables	**Variable's categories**	**Confronted to rape (N rapes)**		**Number of respondents (N)**	**Percentage of confrontation to rape (%)**	**p-value**
		Raped	Not raped			
Socio-professional and economic status	Not self-employed	125	348	473	31.14	<0.001
	Independent (self-employed)	704	318	1022	68.85	
Education level	Basic schooling	633	5	638	43.02	<0,001
	Secondary, tertiary, and other education	836	9	845	56.84	
Usual living environment	Urban area	129	311	440	29.40	<0,001
	Rural area	745	310	1055	70.60	
Household size	Less than 5 persons	940	276	1216	77.28	<0.001
	More than 5 persons	50	229	279	22.72	
Ethnic groups	Bantu	173	930	1103	73.78	0.036
	Not-Bantu	47	345	392	26.55	
Marital status	Married	852	274	1126	75.66	<0.001
	Unmarried	90	279	369	24.05	

Table 4: Problems reported (social problems, health problems), main source of support reported by respondents, support received reported by respondents and respondent satisfaction (as a percentage). (n: 1495)

Main health problems reported by the respondents											**Support received reported by respondents**		**Type of response given to victims and respondents satisfaction**				
Physical health problems					**Mental health problems**						**Categories**	**%**	**Types of response**			**Satisfaction**	
														Yes	**No**	**Yes**	**No**
Unwanted pregnancies	Abortion	Bleeding/ haemorrhage	Pain	Urogenital problems, STI/STD	Depression or suicidal thought	Humiliation and shame	Anxiety and fear	Suspicion	Feeling of insecurity	Insomnia	Stigmatization and social exclusion	Family	5.9%	Access to healthcare services	98.72%	1.28%	81.32%	18.68%
												Relatives	27.1%	Mental health care	97.64%	2.36%	29.74%	70.26%
												Neighbours	1.8%	Material or financial aid	93.66%	6.34%	8.50%	91.50%
												State	1.0%	Access to justice	11.46%	88.54%	2.02%	97.98%
13.11%	10.37%	40.80%	23.95%	11.78%	16.86%							Church	14.3%					
												NGOs	47.6%					
						94.7%	56.3%	9.90%	2.41%	5.35%	6.9%	None	2.3%					

explain the serious scale of this issue. Firstly, there is the presence of many national and foreign armed forces as well as national militias and those from neighbouring countries.

During the decades of conflict, we note that between 1998 and 2003, around eight countries (Zimbabwe, Democratic Republic of Congo, Angola, Namibia, Chad, Rwanda, Uganda and Burundi) were involved. Similarly, instability in the region since the genocide in Rwanda in 1994 has led to the presence of armed Hutu militias, particularly the FDLR, in eastern DRC. Political instability in Burundi in the same period has contributed to the conflict zone being expanded. In addition, in the north, the longstanding presence and activities of Uganda Allied Democratic Forces (ADF or ADF-Nalu) rebels since 1995 constitutes a serious security issue in this region. In addition to this first factor is the proliferation of indigenous Congolese militias of which there were an estimated more than 60 groups in 2015, a number which more than doubled to 130 four years later, according to data from the Kivu Security Tracker in February 2021 and the Congo Study Group[42,43].

Another important contribution from our work is the typical profile of the likely victim of rape in this context. The fact of being an independent woman, living in a rural area, part of a small household (less than 5 people) and married predisposes them to be victims of rape. It is known that they are the population group most at risk of being raped. Contrary to the general victim profile drawn up by Steiner et al., according to which women of all ages were targets of sexual violence[39], our study, like that of Malemo *et al*., reinforces a typical profile of women targeted for rape, more than 3 quarters (75%) are young[44].

As for the ethnic dimension of rape, bear in mind that this has always been raised in previous studies; works by Kovalovska and Haider have, among others, established that rapes committed during the conflict in the Balkans had clear ethnicity-based targets[45,46]. As in the Balkans, the ethnicization of rape in the eastern DRC appears to be closely linked to the retraditionalization and re-patriarchization of societies in the African Great Lakes region. The occupation of the area is combined with gender relations and norms around sexuality to produce ethnicization, which has become a socioeconomic catalyst in these societies. This ethnicization of rape takes root in a political and society environment marked particularly by weak state structures, particularly the judiciary, whose limited action to prevent and rehabilitate victims is hindered by *impunity*. For some, with and due to impunity, which blights the social and legal structure of the DRC, the fight against this problem is more difficult. This is due to a certain number of obstacles, including the lack of resources within the legal system, the (social and cultural) stigmatization of victims, the cost of legal proceedings and the lack of protection for victims[47]. For others, the familiar obstacles that prevent women accessing justice in general include those that concern the judicial system and complex procedures whose intricacies women cannot come to grips with, creating a feeling of frustration and fear that can reduce the access women have to justice. Other factors concern the distance to the courts, the slowness of judicial authorities in making decisions, the cost of justice, the disrepair of judicial institutions and penitentiary establishments, non-enforcement of court decisions or even the scourge that currently blights the Congolese judicial sector: corruption[48].

This analysis is corroborated by the results of our study, which shows that only 1% of respondents acknowledge having received support from the State and 2% were satisfied with access to justice, thus establishing the State's failure. People who have encountered rape have thus provided enlightening details about their vulnerabilities with respect to the institutions or agencies that have given them support. Up to 80% of their support comes from NGOs, their families and close friends. Is this situation specific to rape victims in this country? No. With an estimated budget of USD 5.7 billion in 2018 for a population estimated by the World Bank in the previous year of 81.4 million inhabitants[49,50], the State operates as a subcontractor of these sovereign obligations based on two related phenomena: internalization and NGOization[51]. Consequently, security issues are entrusted to the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo (MONUSCO); financial and economic issues to Bretton Woods World Bank and International Monetary Fund institutions; health to the World Health Organization and to NGOs in this sector,

such as Médecins Sans Frontières; hunger to the World Food Programme and the United Nations Food and Agriculture Organization (FAO) and certain NGOs, like Action Against Hunger. As for the diaspora, it too has taken over from the State by providing resources for healthcare and food, schooling and the burial of relatives. Certain estimates show that the Congolese diaspora transferred around USD 2.3 billion in 2009, which is half of the State budget and exceeds the development aid received[52].

In the experience of the women interviewed in our community survey, most rapes occur at the victims' homes during the evening or night, and in the presence of family members. Similar modi operandi have been reported in the literature in relation to the eastern DRC[19]. Additionally, forcing family members to witness the rapes (82%) heightens the violence and destructiveness of the act and increases the collective suffering of communities by adding to the stigmatization, discrimination and family breakdown. Factoring these two elements into the implementation of projects to protect homes and provide psychological and social support to rape victims and their families should form the basis of the preventive strategies adopted by local and international NGOs as well as by local, national and international authorities[53].

Frequent health problems reported by the women surveyed included both physical complaints like bleeding, pain, unwanted pregnancies, urogenital problems and sexually transmitted infections, as well as psychological issues such as depression, anxiety and suicidal thoughts. In a recent systematic review by Ba et al. of 20 studies on sexual violence in conflict - 12 of which were based on data from the DRC – the authors, like the women surveyed in our study, reported a wide range of psychological problems, including post-traumatic stress disorder, anxiety and depression, as well as physical problems, mainly sexually transmitted infections, traumatic genital injuries, fistulae, and unwanted pregnancies. Like our sample of women, this literature review mentions social problems, such as family and social exclusion and stigmatization[32]. The latter appears to be a key mechanism of social exclusion and breakdown which hinders post-conflict social, political and economic recovery. Drawn from an original survey based on the population in the eastern DRC, the authors of a study on social stigmatization and humanitarian aid note that the victims of rape and their families are subject to higher levels of stigmatization than families that are not affected and that these effects depend on community attitudes and norms[54]. Two collateral effects of rape and stigmatization which have yet to be studied in the context of the DRC are the intergenerational mechanisms that reproduce them, particularly on the children born of these rapes (currently adults) on the one hand, and the types of tailored responses that are likely to break these mechanisms that perpetuate and reproduce exclusion and stigmatization.

Beyond the representativeness of the sample and external validity, our community-focused study has two methodological advantages: its strength is reaching out to over a thousand people and the development of an instrument to assess the type of rapes as well as community needs.

On the other hand, it has the following limitations:

- the sensitivity of questions about intimate areas of life, and the possible impact of local cultures in response to questions about sexuality and reproductive health;
- the fact that it is a matter of remembering painful events, not necessarily recent, perceived as shameful, could affect some responses;
- the fact that perpetrators are not always easily recognizable as belonging to one group or another.

In addition, all of the work carried out in this study allowed us to identify two new fields of research that have thus far not been or have been insufficiently investigated. These are the political economy and the socioeconomics of the phenomenon of rape on the one hand, and the issue of the children, and grandchildren, of women who are victims of rape in the context of violence in the Democratic Republic of Congo. The political economy and socioeconomics of violence (here, of rape) concern the identification, analysis of the forces and structures that (re)produce this violence at the political and economic levels as well as understanding the role of these structures in the emergence of new economies and new modes of political governance as well as the place of violence (rape) in the functioning of the economies and social structures in which it holds sway.

In the context of wars and violence in the DRC, the contribution of studies of this type not only allows other actors in these conflicts (involved in rape) to be identified, but also to involve them in finding suitable solutions to these conflicts. Some preliminary work of this kind has been carried out and highlighted, for example, the oversight of the important relationship between the structures of gender hierarchy and international political economy which can provide information on sexual and gender-based violence in the eastern DRC, which is part of the "global assembly chain" of capitalist accumulation[55]. Other authors have recently looked at the *economies of violence* developed in the eastern DRC, which cover a broader range of activities, beyond the extraction of ore, such as the imposition of taxes, engagement in and control of cross-border trade, forced labour, the sale of rare animal and forest species whose income maintains the perpetrators of rape and the commission of acts of rape against women kept not only in sexual slavery but economy slavery too[56].

Children born from rape must not be confused with children who are raped, even if the former can become both. Recalling that around 20% of raped women reported becoming pregnant in a study of 289 rape survivors at the Panzi Hospital in 2011[57], and bearing in mind that this practice has continued for decades in this region and elsewhere, it can be reasonably considered that there are many such children, who have grown up and become, in turn, young parents. How do these children and their offspring live in communities; what specific problems do they currently encounter and could they face in the future; what type of relationships do they have with their progenitors; how do they assume their roles as parents; these are all key questions that are worth asking and that also need answers.

Conclusion

Using an opportunistic approach through a self-administered questionnaire, the purpose of our study was to identify the characteristics of victims, the related health issues, the patterns of rape and the sources of support rape victims get in the community. The results provided through the analysis of answers from 1483 respondents have established that rape is carried out systematically; it involves various physical and mental health and social problems to which NGOs, churches, family and close friends alone constitute the main sources of support, unlike the State. The emergence and perpetual state of a rape culture in the context of an economy of violence anchored in regional and global capitalism remains, in our view, the main concern for everyone working to restore peace to the African Great Lakes region. It thus remains necessary to analyse and understand the cultural, economic and political mechanisms that (re)produce this violence, initiate and/or reinforce regional and national programmes to prevent and combat rape, fight against the impunity and corruption present in the Congolese judicial system, provide support to survivors as well as the new generations of victims (children and grandchildren) and in particular to (re)build the State and give it the means to perform its sovereign obligations and deal with the need to protect against hunger, illness, violence and injustice. This is also long-term community work which current and future generation must be informed of and trained on in order to be able to engage in it.

Ethical consideration

As the study does not involve biological or genetic manipulation, no special authorization was required from an ethics committee. Nonetheless, the participating women, prior to answering the questionnaire, were briefed on the content and formally asked to give their consent.

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Competing interests

The authors declare that they have no competing interests.

Contribution of authors

MMK and EKM conceived the study. They worked on data collection, data analysis and interpretation

of the results. EKM wrote the manuscript and MMK reviewed it. All the authors have read and approved the final manuscript.

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