A qualitative analysis of stigmatisation of sexual and gender-based violence survivors in eastern Democratic Republic of Congo

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By

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ii. ABBREVIATIONS

ANC	Antenatal Care
BEmOC	Basic Emergency Obstetrical Care
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRSV	Conflict-related Sexual Violence
CSO	Civil Society Organisation
DRC	Democratic Republic of Congo
EC	Emergency contraception
FP	Family Planning
IMAGES	International Men and Gender Equality Survey
INGO	International Non-governmental Organisation
IUD	Intrauterine Device
MOH	Ministry of Health

MONUSCO	United Nations Organization Stabilization Mission in the DR Congo
MSF	Médecins Sans Frontieres
NGO	Non-governmental Organisation
OCP	Oral Contraceptive Pill
PAC	Post Abortion Care
PEP	Post-Exposure Prophylaxis
PHR	Physicians for Human Rights
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UHC	Universal Health Coverage
UNHCR	United Nations Refugee Agency
UN	United Nations
VAW	Violence Against Women
VSLA	Village Savings and Loan Association
WAHA	Women and Health Alliance
WHO	World Health Organisation

iii. GLOSSARY

Conflict-related sexual violence (CRSV): Any form of sexual violence that is perpetrated against women, girls, men, and boys that is directly linked to conflict. This can include forced marriage, rape, sex trafficking, slavery, forced pregnancy or abortion, and more.[1]

Gender-based violence (GBV): The United Nations Refugee Agency[2] defines GBV as:

> 'Harmful acts directed at an individual based on their gender. It is rooted in gender inequality, the abuse of power, and harmful norms.'[2]
>
> 'GBV can include sexual, physical, mental, and economic harm inflicted in public or in private. It also includes threats of violence, coercion, and manipulation.'[2]

According to the United Nations High Commissioner for Human Rights it also involves violence against people of all ages with diverse sexual orientations and gender identities as well as non-binary people.[3] According to the Committee on the Elimination of the Discrimination against Women as cited by Jansen[4] GBV is recognized as a violation of international human rights laws:

> 'Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of Article 1 of the Convention on the Elimination of All Forms of Discrimination Against Women' (p.1).

Intimate partner violence (IPV): 'Consists of a pattern of assaultive and coercive behaviours, including physical, sexual and psychological attacks, as well as economic coercion, by a current or former intimate partner.'[4] IPV can occur between partners of all gender identities and sexualities.

Normalisation: A mathematical procedure in Dedoose that allows variables to be compared in a meaningful way.[5] For example, if there are more of one category of respondents than another, raw data would naturally show more results from that category than a less represented category of respondents. The normalisation feature in Dedoose gives each participant category equal weight.

Sexual violence: Jansen[4] defines sexual violence as:

> 'Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, that are directed against a person's sexuality using coercion by anyone, regardless of their relationship to the victim, in any setting, including at home and at work'(p.4).

Sexual violence can range from verbal harassment to rape and includes but is not limited to marital rape, non-intimate partner rape, sexual advances, or harassment at work or in school, sex slavery, conflict-related sexual violence, sexual abuse of disabled persons, forced marriage, and child sexual abuse.[6]

Sexual and gender-based violence (SGBV): The United Nations Refugee Agency[7] defines SGBV as:

> 'Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It includes physical, emotional or psychological and sexual violence, and denial of resources or access to services. Violence includes threats of violence and coercion. SGBV inflicts harm on women, girls, men and boys and is a severe violation of several human rights'(p.1).

Stigma: Weiss et al.[8] define stigma as:

> 'A social process, experienced or anticipated, characterized by exclusion, rejection, blame, or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group' (p.13).

- **Anticipated stigma:** The expectation of discrimination if the condition that is stigmatised is revealed.[9]

- **Associative stigma:** Discrimination or bias towards someone who is associated with someone with a stigmatised condition.[9]

- **Enacted stigma:** The ways in which people stigmatise or discriminate against others who have a certain condition i.e., stigmatizing behaviour or discriminating attitudes.[9]

- **Felt stigma:** Discrimination that a person experiences due to having a certain stigmatised condition i.e., being rejected by family after SGBV.[9]

- **Internalised or self-stigma:** When a person or group adopts negative beliefs and feelings and devalues themselves because of being stigmatised for a given condition.[9]

- **Perceived stigma:** perceptions about how people with certain conditions are treated in a particular context.[9]

Violence against women (VAW): Jansen[4] defines VAW as:

> 'Any act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life' (p.1).

iv. ACKNOWLEDGEMENTS

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v. ABSTRACT

Background: Sexual and gender-based violence (SGBV) is a prevalent problem in eastern Democratic Republic of Congo (DRC) that is exacerbated and facilitated by ongoing conflict as well as patriarchal cultural, social, and gender norms. Stigmatisation of SGBV survivors results in consequences such as delayed treatment for health issues, mental health conditions, isolation, and prevention from seeking justice and more for survivors. For communities it perpetuates harmful cultural, gender, and social norms and results in associative stigma. Although there is increasing data on SGBV stigma in eastern DRC, there is a lack of perspectives from community members and leaders who could help characterise stigma and offer insight to potential interventions.

Objective: Contextualise the stigmatisation of SGBV survivors in eastern DRC to inform future research and anti-stigma interventions to better address SGBV.

Methods: A literature review and a qualitative data analysis of in-depth interviews from eastern DRC community members and leaders was done using the Health Stigma and Discrimination Framework as guidance.

Results: Social, cultural, and gender norms in the DRC facilitate SGBV and its stigmatisation. These facilitators intersect with drivers of stigma, including fear of infection, blame, and a lack of appreciation for the consequences of SGBV to create stigma. These intersect with facilitators to create stigma. Survivors experience different manifestations of stigma that have negative impacts on their well-being. Different stigma practices are used in the community with rejection of survivors being the most common. While there is a lack of anti-stigma interventions in the DRC, available literature shows that combination community anti-stigma interventions that include men and address cultural, social, and gender norms, and that include an economic empowerment component for women as having been effective in reducing stigma for SGBV or other sexual and reproductive health (SRH) conditions.

Conclusion: The SGBV stigmatisation process in eastern DRC is complex and rooted in the same norms that facilitate SGBV. To effectively address SGBV stigma these underlying norms need to be targeted and communities must be actively engaged.

Recommendations: Continue to research the perspectives of community members and leaders on SGBV survivor stigmatisation. Actively engage community leaders and men in anti-stigma intervention programme development and delivery.

Keywords: Democratic Republic of Congo; sexual and gender-based violence; survivors; stigma; interventions

Wordcount: 13,186

vi. INTRODUCTION

I remember having a strong sense of justice instilled in me at an early age. Observing family interact with the healthcare system as child gave me a personal understanding of the impact that health professionals can have on individuals and families, and I knew that I wanted to be a part of that. During my forensic science degree, these principals were reinforced and my passion for women's rights and health issues grew. I became fascinated by the social complexities of sexual and gender-based violence (SGBV), the portrayal of it in the media, and survivors' experiences with healthcare and justice system. As I started my studies to be an advanced practice nurse specialised in women's health, I knew that SGBV would be my focus area.

As an advanced practice nurse, I worked in an outpatient obstetrics and gynaecology practice at Beth Israel Deaconess Medical Centre (BIDMC) in Boston, MA, USA, as well as in an abortion clinic, and a psychiatric residential treatment facility with adolescent boys who have encountered law enforcement. I also volunteered with Physicians for Human Rights (PHR) doing forensic medical evaluations for asylum seekers to be used in court during their asylum process. My patients were often immigrants with complex social issues who had experienced trauma and human rights violations both within and outside of the US. Their experiences in their home countries and when they came to the US profoundly impacted their health. My professional experiences have only solidified my passion for caring for patients and fighting human rights violations. I felt that I was in a unique position to advocate for my patients and knew that I would want to take my career outside of the US. When I sought to advance my education, KIT felt like the right place to do this.

When I started the MIH programme I knew I would be focusing on sexual and reproductive health and rights (SRHR) and SGBV. This thesis is about stigmatisation of SGBV survivors in eastern Democratic Republic of Congo, a context I had little knowledge of prior to this work. I landed on this topic through discussing my studies with a former colleague at BIDMC who is an expert in this field and has done extensive research in eastern DRC. I hope that the results of this study will contribute to the growing body of literature on SGBV stigmatisation in this region and be used by experts in the area to develop anti-stigma interventions.

CH 1: BACKGROUND

1.1 SEXUAL AND GENDER-BASED VIOLENCE

Gender-based violence (GBV) is a human rights violation that spans the globe. Around the world[10] and within Africa one in three women will experience GBV during their lifetime.[11] GBV is rooted in persistent discriminatory gender norms and inequality, which are especially prevalent in Africa.[11] Women and girls are disproportionately affected by conflict and GBV. In the Democratic Republic of Congo (DRC), GBV occurs both within and outside of the context of armed conflict and often leads to stigmatisation of survivors. Stigma can have profound impacts on survivor healing, the community, and normalisation of GBV.

GBV: While women and girls are disproportionately affected, men, women, and LGBTQI persons also experience GBV.[2,3] GBV is a complex term that has become more inclusive over time:

> 'Harmful acts directed at an individual based on their gender. It is rooted in gender inequality, the abuse of power, and harmful norms…GBV can include sexual, physical, mental, and economic harm inflicted in public or in private. It also includes threats of violence, coercion, and manipulation.'[2]

FIGURE 1: DEFINITION OF GBV[2]

While the term violence against women (VAW) is often used interchangeably with GBV, the latter better underscores the complex relationship between gender inequity, unequal power relations, and societal gender roles.[4,11] GBV (Figure 1) encompasses a broad range of VAW including sexual violence, intimate partner violence (IPV), and psychological abuse.

In the DRC conflict-related sexual violence (CRSV) is frequently cited as a primary form of GBV (Figure 2)[12] but other forms of GBV are also prevalent. The term Sexual and Gender-based Violence (SGBV) encompasses the varied types of violence perpetrated against Congolese women and emphasizes the underlying complexities and causes of SGBV (Figure 3).

CRSV: Any form of sexual violence that is perpetrated against women, girls, men, and boys that is directly linked to conflict. This can include forced marriage, rape, sex trafficking, slavery, forced pregnancy or abortion, and more.[1]

FIGURE 2: DEFINITION OF CRSV[1]

The United Nations Refugee Agency[7] defines SGBV as:

> 'Sexual and gender-based violence (SGBV) refers to any act that is perpetrated against a person's will and is based on gender norms and unequal power relationships. It includes physical, emotional or psychological and sexual violence, and denial of resources or access to services. Violence includes threats of violence and coercion. SGBV inflicts harm on women, girls, men and boys and is a severe violation of several human rights'(p.1).

FIGURE 3: DEFINITION OF SGBV[7]

1.2 STIGMA

Stigma definitions vary, often according to what stigmatised condition is being discussed.[8] When defining stigma, social researchers have conceptualized its different manifestations. Though terms can vary along with conceptual models, there are some commonly recognized stigma manifestations: stigma practices (or enacted stigma) and stigma experiences (perceived stigma, felt stigma, internalised or self-stigma, anticipated stigma, and associative stigma).[9]

The stigma definition from Weiss et al.[8] is used as it closely aligns with the descriptions of stigmatisation of SGBV survivors in the literature:

> 'A social process, experienced or anticipated, characterized by exclusion, rejection, blame, or devaluation that results from experience or reasonable anticipation of an adverse social judgment about a person or group' (p.13).[8]

FIGURE 4: DEFINITION OF STIGMA[8]

1.3 SGBV AND STIGMA

Survivors have described stigma experiences and practices related to SGBV.[13,14] SGBV stigma has negative effects on health including increased rates of depression, anxiety, hyperarousal, intrusive thoughts,[15–17] and consequences of decreased health seeking behaviour.[13,18] Survivors around the world have reported social isolation and note that shame and stigmatisation contribute to their lack of SGBV reporting.[19] Negative views about sex and sexuality can contribute to stereotyping and prejudicial views of SGBV survivors as unclean, promiscuous, or adulterous.[19] Understanding community members' perceptions of SGBV and stigma is important for improving the health of survivors.

While men do experience sexual violence (particularly sexual and gender minorities and those in conflict settings) along with significant stigmatisation, women are more commonly targeted in the DRC,[17,20] and the sociocultural and economic determinants of SGBV and its stigmatisation are not equivalent between men and women.[21] SGBV stigma towards men and women warrant separate examination to account for how gender norms and different perceptions around sexuality and masculinity influence it.[21,22]

1.4 COUNTRY PROFILE: THE DEMOCRATIC REPUBLIC OF CONGO

1.4.1 Demographics

The DRC is a central African country (Figure 5) with a surface area similar to Western Europe[23] and a total population of 92.4 million in 2021.[24] It is the largest country in Sub-Saharan Africa and the largest impoverished population in the world.[23] It is home to over 200 ethnic groups and several migrant populations.[25] The official language is French, and the four recognised national languages are Swahili, Tshiluba, Lingala, and Kongo. In addition to traditional African religions and Islam, European colonisation in the 15th century brought in Christianity which is now the majority religion.[26]

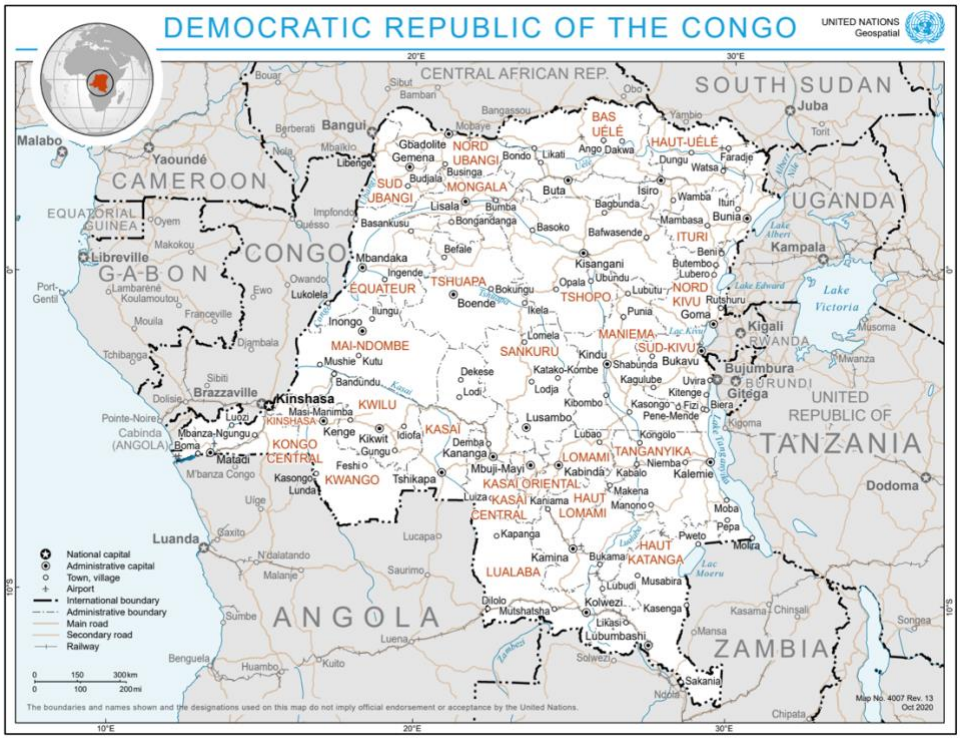

FIGURE 5: 'DEMOCRATIC REPUBLIC OF CONGO'[27]

1.4.2 Historical Context of Conflict

The DRC gained independence from Belgium in 1960.[22] Since the early 1990s it has experienced ongoing armed conflict, and political instability[25,28] involving both internal (DRC) and external (foreign) armed forces.[29] Control of land and exploitation of natural resources, including minerals, are frequently cited as drivers of conflict,[1,30] in addition to ethnic tensions stemming from colonialism and decolonisation, aggression from other countries, and corrupt ruling.[22,25] Congolese rebel armies as well as foreign ones in the east have complicated the government's ability to stabilise the region. The United Nations Organization Stabilization Mission in the DR Congo (MONUSCO) has been present in the east since 1999 to protect civilians and support stabilisation but has had minimal effect.[31] The continuous cycle of conflict contributes to systemic poverty, continued marginalisation of women, and a traumatised population. While the DRC is labelled as 'post conflict' internationally due to the signing of peace agreements, literature and civilians in eastern DRC still recognise the ongoing conflict in the area.[15,22] Instability worsened in the eastern part of the country shortly after the 2018 elections.[1]

1.4.3 Economic Indicators

The DRC is the third poorest country in the world.[32] According to the World Bank, the DRC has a GDP per capita of 580.70 USD as of 2019,[32] with 64.5% of the population living below the poverty line.[33] Of people 15 years or older, 60.8% are employed, and the labour force participation rate is comparable between sexes (60.7% for females and 66.3% for males). Of the total employment in 2019, 64% are employed in agriculture.[32] For women 72% work in agriculture compared to 57% of employed males.[32] Health expenditure in the DRC is 3.3% of the GDP as of 2018 (27). This is over a 1% decrease since 2016 and is not in line with the Sustainable Development Goals (SDG) recommendation that countries increase public spending on healthcare to 5% of the GDP to work towards universal health coverage (UHC).[34]

1.4.4 Healthcare System

The DRC health system has three levels including the implementation level (also referred to as health zones), the intermediate level, and the central level.[35] At the implementation level there are 516 districts, each of which covers 100,000 to 200,000 people.[35] Health financing from households makes up 40% of total health expenditure. At the turn of the 21st century the healthcare system experienced near total collapse due to ongoing conflict and weak governance.[17,35] Funding for healthcare became almost completely dependent on humanitarian aid, a pattern which persists today. This donor dependent system resulted in logistical pitfalls, such as service duplication, lack of transparency, poor resource allocation and disjointed operational planning, resulting in a bare healthcare system with an exasperated and poor workforce.[35] Many of the poor health indicators (Table 1) in the DRC have been exacerbated by ongoing conflict and political instability, which has resulted in economic decline and lack of access to health resources. Conflict has caused humanitarian aid focused on healthcare to funnel

to eastern DRC resulting in South Kivu DRC having the best healthcare system in the country,[35] but access to healthcare including sexual and reproductive health (SRH) services remain low.

TABLE 1: EPIDEMIOLOGICAL PROFILE [32,33,36]

Measurement	Value	Male	Female
Human development index[33]	175 out of 189 countries	N/A	N/A
Life expectancy at birth [32]	61 years	59 years	62 years
Infant mortality rate[32]	66 per 1000 live births	72 per 1000 live births	60 per 1000 live births
Leading causes of disability adjusted life years (DALYS) 2016[36]	Malaria, lower respiratory infections, tuberculosis, diarrhoea, protein energy malnutrition, neonatal preterm birth complications, neonatal encephalopathy, HIV, congenital anomalies, and neonatal sepsis	N/A	N/A

1.4.5 Sexual and Reproductive Health

1.4.5.1 SRH Services

Service delivery for SRH in eastern DRC is provided through the community health program,[37] health centres, and hospitals at varying degrees depending on available supplies, staff, and training. Although overall the healthcare system may be better in eastern DRC,[35] humanitarian funding often focuses on support for SGBV survivors; and other SRH services remain limited.[22,33] A more detailed review of services including antenatal care (ANC), family planning (FP), obstetrical care, abortion and post-abortion care (PAC), and SRH services for adolescents is in Annex 4.

1.4.5.2 SGBV Services

Comprehensive care for SGBV survivors is usually delivered at hospitals, with some health centres having HIV post-exposure prophylaxis (PEP) kits.[38] Multisectoral approaches to SGBV that encompass medical, psychosocial, economic, and judicial support;[39,40] however, rather than appropriate referral to organisations specialised in one of these areas, often in eastern DRC one organisation will attempt to provide comprehensive services even if they do not have the

appropriate training and resources.[40] Referrals may be limited to facilities funded by the same donors and SGBV care may be difficult to access for people living in remote areas.[41] The UN National Guidelines for Sexual Assault survivors states that the minimum standard of care for sexual assault requires PEP, EC, and antibiotics be available.[40] One study shows that among health facilities in eastern DRC, only 8% had one or more trained provider and appropriate supplies for managing rape cases such as PEP, emergency contraception (EC), and antibiotics to treat sexually transmitted infections (STIs).[38] In 2008, 21 public health facilities in eastern DRC were examined and none had PEP or EC.[42]

Organisations at various levels within and outside of the government provide services to SGBV survivors. These include local national and international organisations, nongovernmental organisations NGOs, international NGOs, the ministry of health (MOH), civil society organisations (CSOs), community organisations, and specialised hospitals for treating survivors (Table 2).

1.4.6 Education

Education in the DRC is lagging as with many impoverished and conflict affected countries. The expected lifetime educational attainment is 9.7 years.[33] Women and girls have significantly less access to education than men and boys (Table 3).[23] Education and literacy rates are lower in rural areas compared to urban settings for both genders.[22] Families often must finance education independently resulting in girls being pulled from school and married as a means of economic security.[22] Education for boys is prioritised as they are more likely to get employed, and parents do not believe that they will profit from girls' education once they are married.[43]

1.4.7 Social, Cultural, and Gender Norms and Practices

In precolonial DRC men held the most power with variations along geographical, social, and cultural lines. Women (mostly elite) occasionally gained familial power by influencing male family members, with some gaining autonomous power in the 18th century.[22] Women dominated work in the agricultural sector. With the right to farm and use produce, they achieved elevated status in society and earned some economic independence;[22,43] however, women had little to no decision-making power in the marriage process.[22] Colonisation transitioned DRC's extended clan familial system to the nuclear Christian family structure, solidifying men in the role of head of household, provider, and protector, with women as mother, wife, homemaker, and caretaker, a gender role that persists today.[22,43,44]

Gender roles during colonisation focused girls' education on domestic duties and developed a work system where family earnings were paid to men.[22] With the imposition of Belgian patriarchal social norms, women were seen as less physically productive in agricultural work than men so their access to physical work was limited.[22] Commercialisation of cotton and written law gave men land rights and required women to obtain their husband's permission to work or engage with legal services.[43] Colonisation limited women's education and economic opportunities.

Today the work of women in agriculture consists of local farming to support the family, while men occupy most agricultural export roles,[22] with the latter being more financially lucrative.[43] Women have gained a place in the formal workforce; however, pervasive restrictive gender norms continue to limit this to positions such as nursing and teaching.[22] Limited formal work opportunities contribute to keeping women working in less secure but more accessible informal trades such as agriculture and mining.

Marriage practices in the DRC continue to reinforce colonial gender norms. Married women are seen as their husband's property and their role as wife is rooted in obedience to their husband, who occupies the role of head of house and financial decision maker.[45] Norms are reinforced by religious and cultural beliefs, upheld in the law,[22,43] and dictate that women should be faithful and submit to their husbands sexually.[45] Sex before marriage is associated with promiscuity.[38,45]

Traditional marriage practices like dowries for women and sexual initiation rituals for both men and women reinforce gender power relations in the DRC. Dowries can be economically and physically protective for women, helping to prevent SGBV as their husbands have made an investment and this adds value to the marriage.[45] However, some women feel that dowries reinforce male ownership over women.[45] Sexual initiation rituals may involve survival exercises for men and lessons on hygiene practices and appropriate behaviour for women[45] that reinforce notions of masculine and feminine embedded in demonstrations of physical strength and domestic capabilities respectively. These ideas of femininity and masculinity facilitate SGBV.[11]

Studies show that men view gender equality as a threat to masculinity as they fear women may become disobedient and adulterous if they gain economic independence and interact with other men during work.[43,45,46] Women's dependency on men for economic security can limit their ability to leave abusive relationships. Men may turn to SGBV as a means of exerting control when they feel that gender equality is threatening their masculinity.[45] Women have internalised many of these patriarchal gender norms,[45] which limits their opportunities for independence and creates an enabling environment where SGBV is normalised.[22]

1.4.8 International and National Agreements, Governance, and Laws

Though the DRC has signed and ratified notional and international treaties and agreements (Table 4) to prevent SGBV, poor governance and faulty national laws limit implementation and effectiveness.[20,22] The updated 2006 constitution identifies violence of any kind as a human rights violation, however, marital rape is still not criminalised.[20,47,48] In 2009 the Comprehensive Strategy for Combatting Sexual Violence was developed, and in 2020 the Ministry of Gender, Family, and Children launched a new revision that included IPV in its SGBV definition.[49,50] The Family Code was updated in 2016 to facilitate gender equality by no longer requiring women to obtain men's permission to sign legal paperwork, get a job, or buy property.[48] Corruption, SGBV committed by law enforcement, and lack of female representation in the judicial system contribute to low justice access and support for survivors.[20] Conflict continues to destabilise the government and hinders its ability to apply existing laws consistently. See Table 5 for more barriers to justice for survivors.

CH 2: PROBLEM STATEMENT, JUSTIFICATION, AND OBJECTIVES

2.1 PROBLEM STATEMENT

2.1.1 SGBV in the DRC

International human rights organisations estimate that the incidence of SGBV in the DRC is extremely high; however, lack of resources, ongoing conflict and poor governance, and fear of social stigmatisation cause many incidents of SGBV to go unreported, thus hindering data acquisition and intervention.[1,20] In the DRC women experience various forms of SGBV including CRSV, IPV, rape, sex trafficking, and child marriage. In 2019 data from MONUSCO showed 1,409 cases of CRSV were documented representing a 34% rise in one year.[1] During 2020 there was a 29% increase in sexual violence reports in Masisi and 41% in Walikale, North Kivu. From 2000 to 2019, 37% of women experienced IPV in the previous 12 months.[24] Data from 2014 shows that 51% of women experienced IPV in their lifetime.[51] Women's reports of sexual violence with either a partner or non-partner is more than twice that of what men report having perpetrated (Figure 6).[45] For IPV, 49.1% of women report having experienced it with only 12.4% of men reporting perpetration.[45] This discrepancy could be attributed to different understandings of IPV, such as marital rape not being acknowledged, SGBV being something committed only by armed groups,[45] and/or male hesitancy in admitting to violence for fear of judgement or legal retribution. The UNFPA[24] reports that the prevalence of girls being married by age 18 was 37% in 2019, but data is not reported for boys.[24] Female genital mutilation (FGM) prevalence is reported to be around 5% in the DRC, but actual prevalence is unknown.[24] Thirteen percent of women report engaging in sex work.[45] Of unemployed women, 19% report trading sex for money compared to 9% of employed women, and 17% of women in sex work report engaging in forms of transactional sex like trading sex for food or shelter.[45]

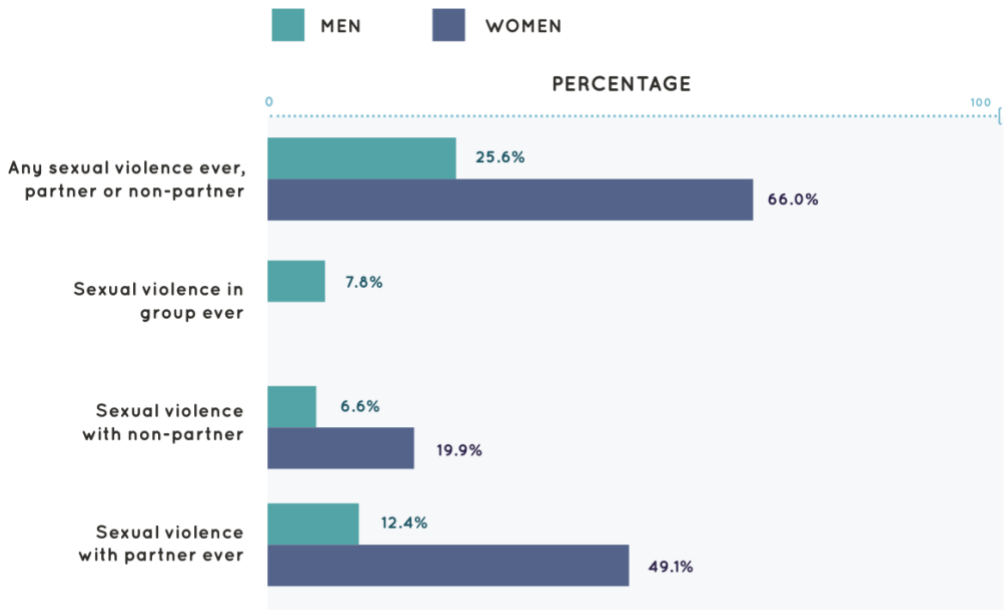

FIGURE 6: SLEGH ET AL.[45] 'SEXUAL VIOLENCE WITH PARTNERS AND NON-PARTNERS: MEN'S PERPETRATION AND WOMEN'S VICTIMIZATION (PERCENT REPORT)'(P.52)

2.1.2 SGBV in Conflict Settings

The risk of SGBV is heightened for women living in conflict situations where gender and power inequities, access to and control over resources, and associated economic, educational, and socio-cultural challenges are present.[51] Conflict in the DRC has been marked with a prevalence of SGBV perpetrated by both armed and unarmed forces as well as state and non-state actors[1,13,52] who often strategically target civilians to gain control through dissolving family, community, and social structures.[22] Intentional transmission of STIs including HIV has been cited as a tactic that perpetrators use to damage communities as well.[53] Combatants and civilians both report raping partners more than non-partners, but this is not a statistically significant difference (Figure 7).[45] Combatants report significantly higher levels of being forced to watch and commit rape compared to civilians.[45] Being forced to commit SGBV and witnessing violence are forms of violence against men and one of the strategies used to dissolve social structures and relationships.

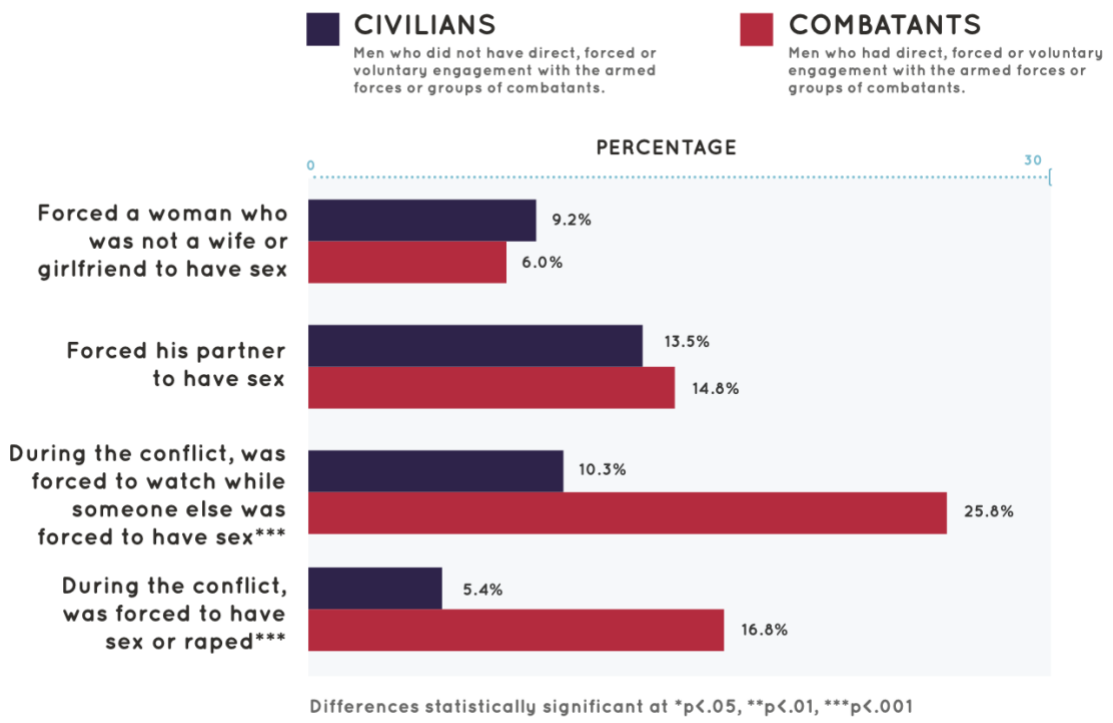

FIGURE 7: SLEGH ET AL.[45] 'PERPETRATION OF SEXUAL VIOLENCE: COMBATANTS VERSUS CIVILIANS (PERCENT REPORT)' (P.54)

Conflict does not just increase SGBV perpetrated by armed forces. When men leave to fight, women take on additional economic and decision-making responsibility in their absence.[22] This independence may cause a perceived or real loss of power for men.[43] This can increase IPV, and men have cited a loss of power as a driver of their violence.[22] Men experience trauma, psychological stress, and economic precarity as result of conflict. They are more likely than women to turn to alcohol and drug use as coping mechanisms which increases the likelihood of SGBV perpetration.[45]

The DRC conflict also contributes to SGBV by affecting economic security, particularly for women and girls.[22] Women often depend on agriculture for income but fighting destroys fields and displacement drives them away from their land.[22] They are also pushed into the informal economy when the formal one breaks down, which is less secure both economically and physically.[22]

Transactional sex can increase in times of crisis as women try to meet economic needs[22] and can become exploitative when Congolese women are forced to engage in sex for access to mines.[54] Women engaging in transactional sex often lack condom negotiating power, time to screen partners, and physical protection.[54] This leaves them vulnerable to SGBV. Conflict has direct and indirect effects on SGBV and can facilitate increases of its various forms.

Natural Resources and SGBV

Natural resources are often discussed as being a driver of violence and SGBV in eastern DRC. The DRC economy is largely based on natural resources, particularly minerals, with poverty and economic insecurity remaining prominent.[22,25] There is a large small-scale mining sector primarily located in the North and South Kivu provinces in the east.[14] Small-scale mining has become increasingly accessible to locals. Small-scale mining uses small tools to extract minerals and may include trading of minerals. About 16% of the DRC population is supported through small-scale mining[14] and about 50% of workers are women who are largely driven to this trade by poverty.[22] Though more accessible, small-scale mining exposes women to security issues in part due to the harmful masculine mining culture.[14,22] Mining myths, such as women cursing mines they enter or that taking a woman's virginity will ensure a man gets rich, facilitate SGBV.[22] Natural resources also fund armed forces in this area.[22] It has been posited that the lawlessness that permeates mining regions where armed forces are in control contributes to high rates of SGBV in the east.[14,30]

Avoiding oversimplification

While SGBV in relation to natural resources is a problem in the DRC, oversimplifying the narrative is dangerous. Oversimplification avoids looking at other SGBV determinants such as the status of women, and social, cultural, and gender norms.[12,22,30] It also neglects looking at civilian perpetrators of SGBV and other types of violence women experience.[14,41] It is for this reason this thesis avoids narrowly focusing on CRSV or sexual violence alone.

FIGURE 8: NATURAL RESOURCES AND SGBV

2.1.3 The Role of Stigma in SGBV

The available literature shows that stigmatisation of SGBV survivors in eastern DRC stems from multiple factors. Cultural, social, and gender norms and the way sexual matters including SGBV are viewed in the DRC (see Background) facilitate stigma.[11,22] In the DRC women bring shame and misfortune to the family if they are raped.[55] Silence surrounding the topic limits open contestation of SGBV and stigma, and prevents communities from addressing the harmful norms that lead to it.[17] SGBV challenges the socially prescribed value of men, women, and the family, and facilitates stigmatisation of the survivor and their family.[46] The act of stigmatising survivors can protect people from associative stigma but also reinforces discriminatory norms, thereby creating a vicious cycle of stigmatisation.

2.1.4 Consequences of SGBV and Stigma

The lack of sanctions against SGBV perpetrators and inadequate healthcare limits survivors' access to justice and healing. SGBV can cause a variety of physical, mental, and psychosocial

consequences for the survivor (Table 6). Stigmatisation can hinder survivors' ability to seek care after violence and lead to an exacerbation of current complications and/or development of new ones, including but not limited to an increased chance of experiencing IPV,[44] depression, delayed HIV treatment, and lack of prenatal care.[56] A retrospective study at the Panzi Hospital in eastern DRC showed that there was an average of 10.4 months delay in care seeking among SGBV survivors, with fear of family finding out and fear of stigma being 2 of the 5 factors contributing to the delay.[56] Current literature shows that 6% to 29% of sexual violence survivors in eastern DRC are cast out from their family or community in a form of enacted stigma.[44] This may be done by husbands, parents, or other relatives who fear social consequences such as associative stigma. Since their marriageability can be impacted by SGBV survivors have been forced to marry their perpetrators.[17] Women who are rejected by their family are more likely to experience adverse mental health outcomes[30] and be displaced, which heightens their vulnerability to SGBV and economic struggles.[44] Survivors in eastern DRC report enacted, felt, internalised, and anticipated stigma. Family members including husbands report associative stigma.[21,44,46,55,56] Survivors report that stigma was at times as traumatic as the SGBV event.[55] Certain SGBV sequalae such as HIV, fistulas, or pregnancy leads to compounded stigmatisation since these conditions are already stigmatised and not easily hidden from their families or society.[44,57] These conditions also make strategically hiding SGBV to prevent stigmatisation challenging for survivors.[56]

2.2 JUSTIFICATION

SGBV negatively impacts not only survivors but also families, communities, and society. SGBV in eastern DRC is perpetrated by armed forces as well as civilians. The available data shows that enacted, felt, internalised, anticipated, and associated stigma are experienced by SGBV survivors and their families in eastern DRC. Stigma is problematic for SGBV survivors internationally and within the DRC context; however, limited data on this topic exists in settings impacted by conflict.[44] While the qualitative literature has begun to characterise the types of stigma that SGBV survivors and their families experience and the factors that lead to it, there is limited focus on the perspectives of community members.

Most funding and humanitarian aid focuses on treatment of survivors, and not prevention through targeting underlying cultural, social, and gender norms that facilitate SGBV and its stigmatisation.[12,15,22] Some SGBV programmes strive to address the underlying facilitators of SGBV and stigma; however, data on their effectiveness is not yet available.[48] Increasing the knowledge on social and cultural determinants in the DRC that contribute to community members' perceptions of women who have experienced SGBV could help inform community-based anti-stigma interventions.[57] The perspectives of respected members of the community who play a role in reinforcing or changing cultural, social, and gender norms can provide deeper insight into potentially successful anti-stigma interventions. Focusing on eastern DRC is important due to the decades of conflict, increasing rates of SGBV in the region, and limited effectiveness of government and humanitarian interventions. The prevalence of SGBV and ongoing conflict in eastern DRC warrant further evaluation of the characteristics of SGBV stigma to inform further research and potential interventions.

This thesis focuses on SGBV stigma affecting women. The justification for this is that as far as we know more women experience SGBV in the DRC; and the determinants of SGBV for men and women, though connected through gender norms, are not the same and warrant separate evaluation.[17,20–22]

2.3 OBJECTIVES

2.3.1 Overall Objective

To contextualise stigmatisation of SGBV survivors in communities in eastern DRC to inform future research and anti-stigma interventions to better address SGBV.

2.3.2 Specific objectives

- Identify factors that contribute to SGBV stigmatisation in eastern DRC.
- Evaluate the types of stigma experienced by SGBV survivors in eastern DRC.
- Identify what stigma practices people engage in to stigmatise SGBV survivors in eastern DRC.
- Identify examples of successful anti-stigma interventions in the DRC and/or other settings.
- Draw conclusions and recommendations for future interventions and research.

CH 3: METHODOLOGY

3.1 STUDY DESIGN

The objectives were investigated through a qualitative design encompassing a literature review and primary analysis of qualitative data obtained as a part of a larger research project in 2017. The literature was reviewed for background information, to find data on factors contributing to SGBV stigmatisation, types of stigmatisation that survivors experience and community members practice in eastern DRC, as well as examples of anti-stigma interventions in or outside of the DRC. See Table 7 for objectives and methods.

The analysis of qualitative data available from BIDMC in Boston, MA USA in collaboration with Women and Health Alliance (WAHA) International and local DRC health centres consisted of 18 in depth interviews (IDIs). The original research project involved IDIs, focus group discussions (FGDs), and participatory learning activities (PLAs) among community members in North and South Kivu provinces DRC to assess perceptions of SGBV survivors and stigma. The original study design, methods, and tools were developed by the Principal Investigator (PI) Dr. Jennifer Scott[58] (Annex 1) and are briefly described here. For this thesis only the IDIs were analysed and combined with a literature review to address the objectives. The literature review, coding framework, and analysis were done by the author.

3.2 LITERATURE REVIEW

3.2.1 Search method

Search engines used included Google Scholar, PubMed, JSTOR, and Vrije Universiteit library. The Sexual Violence Research Initiative (SVRI), Physician's for Human Rights (PHR), and MenEngage networks were consulted along with the following relevant websites: UNFPA, United Nations Refugee Agency (UNHCR), World Health Organisation (WHO), United Nations Development Programme (UNDP), World Bank, and Médecins Sans Frontieres (MSF). A review of literature pertaining to social and cultural factors that contribute to community stigmatisation of SGBV survivors and SGBV stigma and interventions in the DRC and for other SRH conditions was conducted. Snowballing was done to identify additional literature within this inclusion criteria. Keywords are in Table 8.

3.2.2 Inclusion criteria

Peer reviewed and grey literature were included. English articles from 2011 to 2021 were reviewed. Articles with relevant historical or background data on the thesis topic that fall outside this range were included.

3.2.3 Exclusion Criteria

Articles that focus solely on men who have experienced violence or stigmatisation were excluded. Articles in French were excluded due to language limitations of the author.

3.2.4 Limitations for this method

The literature was searched for examples of successful SGBV anti-stigma interventions in the DRC, but limited examples were found so examples from other settings and SRH contexts were used. However, stigma is strongly influenced by culture and local contexts so this may not provide an accurate predictor of how SGBV stigma interventions may work in the DRC. The exclusion of articles written in French limits the amount of literature accessible, particularly from the MOH.

3.3 QUALITATIVE DATA

3.3.1 Respondents

Respondents were purposively and conveniently selected from health centres and communities in and around Bukavu, South Kivu Province, and Goma, North Kivu Province in partnership with WAHA International. The individuals interviewed included females aged 18 and above who were receiving services from WAHA (beneficiaries), and 18 or older males and females including community members, religious leaders, healthcare providers, organisational staff, and community leaders. Respondents were not required to have experienced SGBV and were advised to speak generally about SGBV in the community. Respondents who had conditions that limited their communication were excluded.

3.3.2 Techniques

IDIs are effective at eliciting views and opinions of individuals. With a lack of data relating to community member perspectives on SGBV stigma in eastern DRC, IDIs among this population could provide new insight into the social phenomenon of SGBV stigma. IDIs are done in a private setting which may allow respondents to be more forthcoming than they would in an FGD or PLA. Interviews were about 60 minutes and conducted privately at the organisation. Interviewers were the same sex as respondents and conducted interviews in fluent French or Swahili. See Annex 3 for the semi-structured interview guide. Interviews were audio recorded, transcribed, and translated to English prior to the commencement of this thesis.

3.3.3 Informed Consent

Verbal informed consent was obtained due to low literacy levels among the population and to avoid risks of being associated with the study (Annex 2). Risks and benefits were reviewed. Respondents were informed that what they shared would be kept confidential. Contact information was given to the respondents. No forms were signed and there was no financial incentive.

3.3.4 Data Management

The sources of data from the IDIs in the study included paper, audio, and electronic files and transcripts and translations in Microsoft Word. Microsoft Excel was used to track interview dates, interviewers, interview location, respondent demographics, translators, and translation and transcription status. All data whether paper or electronic was kept locked at the organisation, then scanned to a secure BIDMC server, and later destroyed. All data was de-identified from the start of collection. See Annex 1 for more details.

3.3.5 Data Analysis

The IDI transcripts were uploaded into Dedoose software and were coded and analysed using a deductive and iterative approach. During preliminary review of the IDIs, major themes and codes were written on paper and appeared to align closely with the Health Stigma and Discrimination Framework. This framework along with the objectives, the interview guide, and results from the literature review were used to develop a preliminary coding tree categorised into potential themes first in Microsoft Word, and then in Dedoose. The coding tree was adapted iteratively according to the emergence of major codes and themes throughout analysis. The codes and themes identified deductively were confirmed based on if they appeared in the data. Transcripts were reviewed and coded solely by the author using Dedoose. The co-occurrence of different codes within portions of the transcripts provided more in-depth data on intersecting themes. Respondent genders and community roles were assigned to transcripts in the 'descriptor' section before analysis. Differences in code and theme emergence across genders and community roles were examined using the Dedoose code and descriptor chart. The normalisation feature in Dedoose was used to minimise inflation of data due to variation in number of respondents in each role. Findings from the data were compared to findings from the literature.

3.3.6 Limitations

While IDIs provide in depth personal perspectives from community members on the study topic, they may neglect information gathered in the FGDs and PLA that support or contradict perspectives provided during the interviews. Adolescents experience SGBV and may have differing perspectives on social, cultural, and gender norms in the community compared to adults. Excluding their perspectives could lead to gaps in data. Exclusion of persons with communication issues neglects potential data from disabled persons who are more likely to be targeted for SGBV as well as experience the intersecting stigma of SGBV and disability. The coder was not involved in the original study and does not have first-hand knowledge of the local context. This limits contextual knowledge of eastern DRC and the study, which can affect the author's ability to reflect and work iteratively. The normalisation function in Dedoose could falsely portray the prevalence of themes among certain community member roles, particularly for roles with only one respondent such as a health professional. Data is being analysed 4 years after collection which may not account for local contextual changes since the original study design.

3.3.7 Ethical Considerations

Ethical considerations must be accounted for when conducting research in humanitarian settings and/or on sensitive topics such as SGBV. This study followed the recommended guidelines from the WHO for researching SGBV in humanitarian settings.[59,60] Full ethical considerations are in Annex 1.

CH 4: ANALYTICAL FRAMEWORK

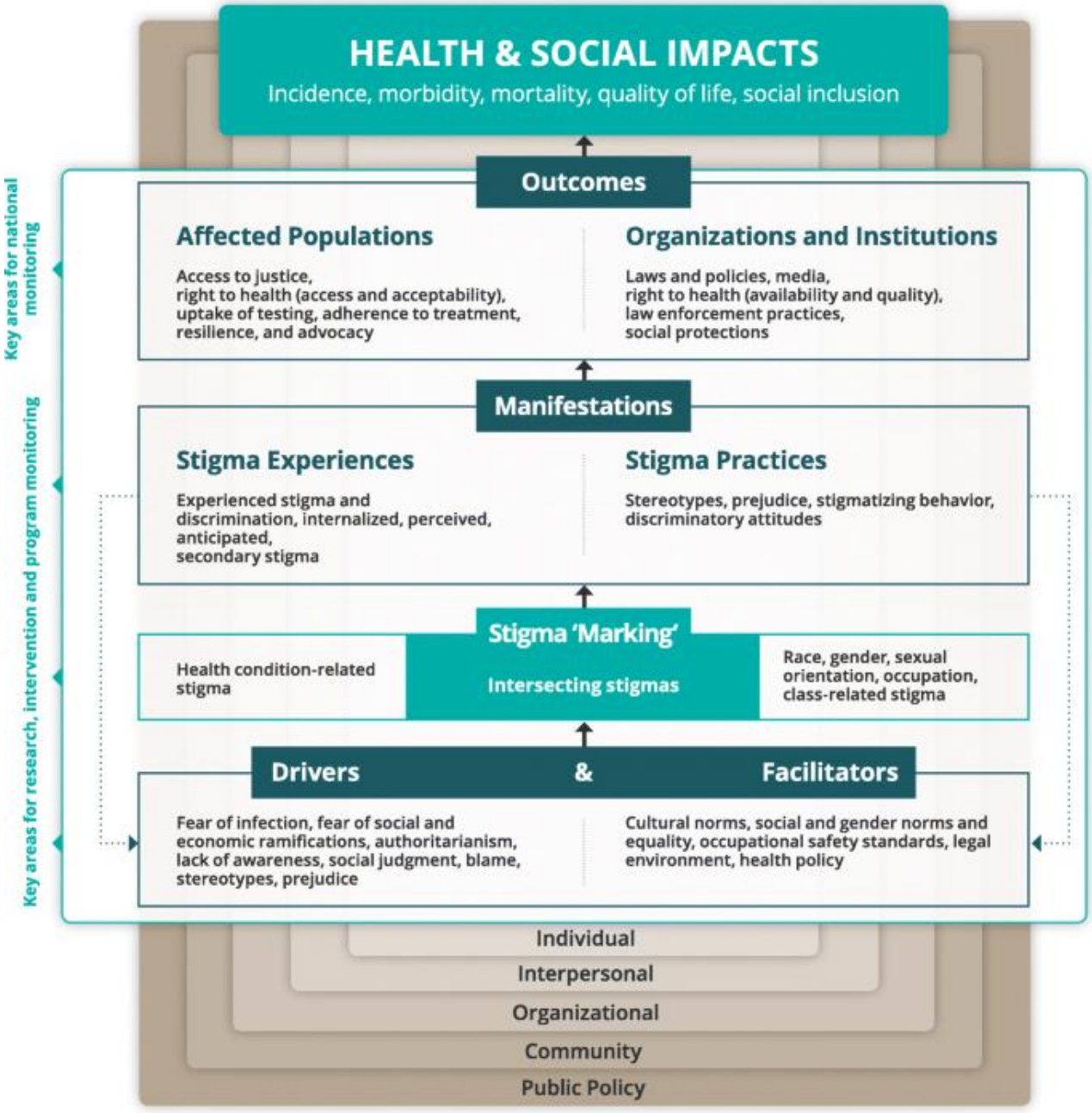

FIGURE 9: STANGL ET AL.[9] 'THE HEALTH STIGMA AND DISCRIMINATION FRAMEWORK' (P.3)

Various SRHR, SGBV, and stigma frameworks were examined with the goal of finding one that would facilitate evaluation of SGBV stigma in eastern DRC. However, available stigma frameworks either specifically focus on other medical conditions, such as HIV, mental health issues, or stigma in general, and are not specific to SGBV or SRHR. Two separate frameworks were used during the literature review with the intention to be used during analysis. The goal was

to integrate the two frameworks into one SGBV stigma framework but this was found to be too ambitious for a master's thesis. Thus, the Health Stigma and Discrimination Framework, which most aligned with major themes emerging from the qualitative data, was used. The ecological model on GBV with the integrated globalised framework[61] (Figure 11) did inform some of the literature review.

The Health Stigma and Discrimination Framework (Figure 9) explores stigma manifestations and the socio-ecological levels that influence.[9] Factors that come together to result in stigmatisation are drivers and facilitators. Drivers are inherently negative (like fear of infection, social judgement), but facilitators can be negative or positive. For example, certain laws or access to services could be protective from stigma, while repressive gender norms can encourage it.[9] Stigma practices (or enacted stigma) and stigma experiences (felt, internalised, anticipated, associative, and perceived) are the manifestations of stigma.[9] The framework also accounts for the outcomes of stigmatisation. This framework was used to conceptualise the stigmatisation process and categorise information emerging from the literature and data. Drivers, facilitators, and manifestations of stigma are presented in the results as they relate to the framework. Results from this study are presented by objective, first with literature review results and second with the qualitative data results where applicable. The interview guide was partially developed using constructs from stigma scale development done by Murray et al.[21] (Annex 5 and Figure 10).

CH 5: RESULTS

The results describe evidence from the literature and qualitative analysis of factors contributing to SGBV and stigma in eastern DRC. The types of stigma experienced by SGBV survivors, the stigma practices (or enacted stigma) used in the community, and examples of, and suggestions for anti-stigma interventions are also included.

5.1 RESPONDENTS

Eighteen respondents (nine female and nine male) were included in the study. Respondent roles consisted of six community leaders (three female and three male); five community members (two female and three male); two organisational staff members (one female and one male); two religious leaders (both male); two beneficiaries (both female); and one health professional (female). Numbers were assigned to each respondent's transcript arbitrarily in Dedoose by the coder/author for ease of reference. Following the first mention of the respondent number when reporting a quote, their role in the community is listed with their gender. For example, *'R1 Male Religious leader:'* is written when respondent number 1 first speaks during a quote. When the interviewer's question is included in a quote, dialogue starts with *'R1 Interviewer.'* Respondent demographics for the 18 IDIs are in Table 9. These respondent demographics were included in the titles of the transcripts obtained from the PI. In the transcripts respondents refer to finger-pointing as *'fingering.'*

5.2 FACTORS CONTRIBUTING TO SGBV AND STIGMA IN EASTERN DRC

The characteristics of, and factors contributing to SGBV stigma in eastern DRC are multifactorial and intersect with one another. The factors that fuel SGBV stigma in the DRC consist of drivers and facilitators.

5.2.1 Literature Review of Facilitators

5.2.1.1 Gender Norms for Men

The effect of gender norms on SGBV survivor stigma is not limited to the role of women. Ideas of masculinity must also be accounted for. The role of a man and husband in the DRC involves protecting his wife and female members of his family.[46,55] Culturally, marriage entitles men to the right to exclusively have sex with their wives.[46] IMAGES shows that more women (62%) than men (48%) believe that men have the right to have sex with women without their consent, and 78% of women report enduring violence to keep their family together.[45] While criminalisation of SGBV may facilitate SGBV prevention as people try to avoid prosecution, lack of marital rape criminalisation facilitates SGBV by reinforcing normalisation of IPV and

creating confusion in the community on what types of SGBV can be reported and prosecuted. More details on laws and policies can be found in the background.

The belief that sex without consent is men's right places the burden of responsibility for SGBV on survivors and not perpetrators. SGBV committed against women signifies men's failing in fulfilling their role as protector and head of household. SGBV is seen as an attack on family identity that may bring shame upon husbands from family and society.[46] Rejecting survivors through divorce, banishing from the home, and/or avoiding sex with their wife and taking another wife is a way in which men can openly distance themselves from the SGBV incident and show the community that they align with norms. Enacted stigma via rejection is a method through which men can regain respect and status in the community.[46]

5.2.1.2 Gender Norms for Women

The value of women is imbedded in their role as clean, virtuous, and faithful wives, and if unmarried, as obedient virgin daughters. In Congolese culture, women lose value after they are raped since the role of women in society is disrupted by SGBV.[21,22,44,46,55] They may no longer be seen as virtuous or faithful to their husbands. Sometimes work opportunities are limited for survivors due to SGBV consequences including injuries, PTSD, fear of recurrent attacks if they were previously attacked on their way to work, such as in the fields or mining, or being barred from or mocked at their work site.[46,62] The cost of medical treatment after SGBV can also be expensive.[46] When this happens there is an economic loss for the family.[62] Women are also valued based on their economic contribution. SGBV threatens traditional ideas of femininity and the economic value of women, which can lead to familial rejection of survivors as family members try to avoid shame and being stigmatised.

5.2.1.3 Culture of Silence

Limited avenues for women's economic independence mean that married women strive to keep their marriage intact, and girls try to maintain their marriageability as it can be economically protective.[17,22] The economic motivation for marriage and the desire to avoid discussing taboo subjects for fear of social judgment contributes to women avoiding SGBV disclosure. This coupled with negative reactions when people disclose SGBV can reinforce silence, which fuels recurrent stigmatisation.

One study shows how rape has become common and normalised in Congolese society due to the decades of violence.[55] Ongoing violence and conflict in the country leads to violence desensitisation,[14,55] which also contributes to silence surrounding SGBV. The 'culture of silence' encompassing SGBV works to normalise violence and harmful beliefs about survivors since it is not openly addressed in society.[17]

5.2.2 Facilitators Emerging from the Qualitative Data

5.2.2.1 Social and Gender Norms

IDI respondents reported that SGBV stigma facilitators include social and gender norms, cultural norms, and the presence of organisational support such as NGOs or humanitarian agencies. Social and gender norms are prominent facilitators of SGBV stigma. Women's role and value being entrenched in motherhood, marriage, working, and behaving according to social norms were described. There was an equal mention of social and gender norms and the value of women between male and female respondents. Female respondents described the value of women as being a wife, mother, and behaving in a socially appropriate way more than male respondents. Male respondents particularly referenced women's value being rooted in work. Results showed that men are seen as the head of the household and have the right to their wives sexually.

When asked about what gives women value:

R17 Female Community leader: A woman's value is huge. Even as a young girl she works more than boys. Married women are more needed by husbands first, and by children and the family at large. In the family a woman does legions of work ranging from the housework to income-generating activities for the good of all the members. Everybody relies on her to some extent.

Society associates rape with promiscuity. How female sexuality is viewed influences how the community views SGBV. This is seen in how survivors are described and labelled in the community:

R3 Male Organisational staff: … People call the victims of sexual violence different words, there are words like… 'Mubakiwa ule' (she is a raped), 'Bibi ya Watu wote,' it means a wife of everyone…

Internalised norms such as male honour and protector of the family and the association of rape with promiscuity, regardless of what happened, justifies abandonment of the survivor which puts her life at risk.

R4 Interviewer: Some survivors of sexual violence told us that they feel that they are useless or that their lives don't make sense. Why?

R4 Male Religious leader: … Someone's respect, especially in our society, a society that is too masculine...Our society's customs and habits disregard women a little bit…What gives women a sense of value is when she keeps her intimacy and is truly a dignified and respectful woman. When people know that she is moral, she is not a woman for everyone.

R4 Interviewer: How does sexual violence change this?

R4 Male Religious leader: Sexual violence brings changes because people consider her as if she has no good morals…sometimes people do not accept that she was ambushed, but they easily conclude that it is her own complicity, her personal will.

5.2.2.2 Cultural Norms

Men discussed cultural norms in depth. Cultural norms such as sex, sexuality, and SGBV are taboo subjects that fuel the culture of silence described in the literature, which creates an environment where SGBV stigma can continue. SGBV brings shame not only to the survivor, but also to people who associate with her, most notably family.

When asked how sexual abuse is regarded publicly:

R16 Male Community leader: Here? As a taboo, some sort of abomination, a shameful event in the eye of our community. This is why people avoid speaking about it; the victims usually retract from the household, and they often take to hiding themselves.

5.2.2.3 Organisational Support

Survivors accessing organisational support (such as NGOs) for assistance were identified by some respondents as increasing the risk of stigma while others thought it to be protective against stigma:

R9 Male Community member: When they receive support, people will say 'Aaaaaah that one, she is a victim; that's the reason why she goes there to get support. There they provide food to raped women.' She'll be fingered more.

R11 Interviewer: Sometimes some NGOs give services and gifts to women who are victims of sexual violence; they provide psycho-social, medical support, and so on. By granting these services, can this exacerbate the stigma to these women?

R11 Male Community leader: I can say no. Because this is what we want. The assistance of these NGOs so that the woman does not feel discriminated.

5.2.3 Literature Review of Drivers of SGBV Stigma

Social fear of disease (specifically HIV) is a well-cited driver of SGBV stigma in eastern DRC.[17,21,44,46,55,62] Enacted stigma often reveals itself through rejection of survivors by their husbands.[46] Fear of social ramifications drives anticipated stigma, such as when people fear being labelled as 'promiscuous' if they discuss sexual matters and talk about or report SGBV,[17] which again contributes to a culture of silence. Social stigma of husbands of survivors, men's own trauma, and the economic burden of medical care for survivors are also reasons for

rejection.[17,55] Different types of SGBV occur and may carry varying levels of stigmatisation. According to one study, rejection was not more likely to occur among survivors who were gang raped;[44] however, another study contradicts this by saying that factors relating to the attack such as gang rape and forced witnessing of rape are reasons for the rape survivor's rejection.[62] Survivors in the DRC are viewed as weak, damaged, valueless and are no longer able to be active members of society.[17] How survivors are viewed in society can be prejudicial or encompass stereotypes that drive their continued stigmatisation. Table 10 shows a high level of victim blaming.[45] Husbands may blame women for not resisting an attack, and wives may blame their husbands for not preventing it, thus showing how SGBV is incompatible with gender roles.[55]

Survivors also cite a lack of faith in the legal and justice system as reasons why they avoid pursuing legal action.[50,63] Results from Babalola et al.[17] show that survivors and community members believe punishments for perpetrators should exist. This demonstrates a lack of awareness of the law and/or lack of faith in the system.

5.2.4 Qualitative Data Results of SGBV Stigma Drivers

Results of the qualitative study showed that drivers of SGBV stigma most commonly include fear of infection, lack of sensitisation to SGBV and stigma consequences, and blame, with less common representations of social judgement, fear of social ramification, and stereotypes.

5.2.4.1 Fear of Infection

Fear of infection was referenced slightly more frequently among females than males. Fear of infection overlapped with enacted stigma, specifically rejection by the husband, which is consistent with the literature findings:

> *R5 Interviewer:… Why do husbands abandon their wives? Why do families abandon survivors of sexual violence?*
>
> *R5 Female Health professional: Especially husbands who are not educated, they think like this: 'As my wife has been raped, she is going to infect me with diseases.' This is the reason why the man walks away: to escape diseases…*

5.2.4.2 Lack of sensitisation

Respondents describe how in the community a lack of appreciation for SGBV and stigma consequences, and consent drives stigma. They believe this treatment of survivors is unfair and that awareness raising efforts could prevent it:

> *R17 Interviewer: A few victims declared that they have been forced to part from their families.e.g.…a father speaking to daughter who has just been raped 'you have been*

abused? Go out of my home right now and never set your feet here again.' What can you say about that?

R17 Female Community leader: According to me, this is not fair treatment. Such a father should be begged to understand the girl didn't agree to what the rapist did. So, the father needs awareness-growing campaign to avoid taking such a hasty bad decision.

5.2.4.3 Blame

Blame encompasses victim blaming as well as survivors blaming themselves for SGBV and drives felt and internalised stigma. Female respondents were almost twice as likely to mention victim blaming compared to male respondents. Victim blaming is closely tied with the value of women and an overarching negative view of SGBV survivors in the DRC:

R3 Male Organisational staff: Behaving like a woman means avoiding being raped; a woman is not supposed to go to unsafe places. This is the fact that shows that she is valuable. In addition, a married woman has to behave as a dignified woman.

R8 Male Community member: …There are certain activities that can be organised, but they themselves do not know how to participate because they blame themselves for something. They think that 'people will talk about us,' they …. exclude themselves …. the community in itself cannot prevent them from not participating in the activities.

When asked about whether they thought different types of SGBV were more or less stigmatised, respondents reported stranger rape as being the most stigmatised form; however, they did not elaborate on why this is.

5.3 TYPES OF STIGMA EXPERIENCED BY SURVIVORS

5.3.1 Literature Review of Stigma Experiences

The literature presents evidence of felt, perceived, internalised, anticipated and associative stigma. Since much of the available literature looks at perspective of survivors, evidence of enacted stigma is often described as felt stigma (such as experiencing rejection), since it is coming from the point of view of the survivor and not the community which may utilise stigma practices. Felt stigma and enacted stigma are related but not the same.[21]

5.3.1.1 Felt Stigma

Survey results in eastern DRC show that survivors experienced felt stigma when they feel like they lost the respect of their children.[44] They also experienced rejection from their family members with 51.3% being told they should leave the house and 43.6% of those subsequently

leaving.[44] One study shows that the odds of a women experiencing rejection (felt stigma) from her family and household is 10 times higher after rape.[44] Survivors also report feeling ashamed of themselves.[17]

5.3.1.2 Associative Stigma

Male family members of SGBV survivors may experience associative stigma,[46] and families may encourage them to leave their wives who are SGBV survivors.[55] Men cite shame, perceived and felt stigmatisation, and a lack of respect from the community as reasons why they leave.[46,55] One study reports that children born to SGBV survivors may be treated poorly or rejected by the husband of the survivor.[17]

5.3.1.3 Anticipated Stigma

Anticipated stigma can lead to self-isolation as a protective measure for survivors. More than two thirds of survivors who anticipated stigmatisation from the community changed their churchgoing patterns to avoid stigma.[44] SGBV survivors may be restricted from farming through enacted or internalised stigmatisation which results in their isolation. The negative economic outcome results in further stigmatisation as women are not fulfilling their duty to care for their family. This demonstrates the intersection of SGBV and poverty stigma.[21]

5.3.2 Qualitative Data Results on Stigma Experiences

From the data, 4 of the 5 types of stigma experiences were found. The most common stigma experience was felt stigma from the survivor. Male respondents described felt stigma more than female respondents. Internalised stigma was also described, as well as associative stigma, which is usually experienced by husbands or children of survivors. Male respondents described internalised stigma and associative stigma more than female respondents.

5.3.2.1 Felt Stigma

Felt stigma primarily overlapped with stigmatising behaviour, such as rejection - isolation from and quarantining by the community - and finger-pointing:

> *R3 Interviewer: Considering what you just say, what are the challenges that women victims of sexual violence face?*
>
> *R3 Male Organisational staff: …They don't have Joy ... they are not respected in their community. They are neglected…they are even likely to be isolated, because they are almost quarantined in the community… She is not comfortable. She doesn't feel that she belongs to the community. She is under depression. She is uncomfortable to share her point of view in the community because she was raped.*

R4 Male Religious leader: Generally, after having undergone sexual violence, women feel marginalised and stigmatised, and then diminished in their being.

5.3.2.2 Internalised Stigma

When asked about isolation and shame, respondents show how the two are linked with each other and internalised stigma:

R8 Male Community member: They isolate themselves because they underestimate themselves…they have not the same value...Even though the community does not isolate them… As they have anxiety, they quarantine themselves. They quarantine to avoid others talking about something that will hurt them.

R1 Male Religious leader: …she will say 'Aaaaaah, I was raped; maybe they will think that I am not faithful. I've known many men.' It is created in her, then she's ashamed…

5.3.2.3 Associative Stigma

Associative stigma overlapped with rejection as husbands who experience associative stigma or anticipate associative stigma will reject their wives who survived SGBV. However, other members of the family as well as friends are noted to experience associative stigma:

R13 Interviewer: Do the husband and the members of the community suffer from stigma if the wife or a family member has been subjected to sexual violence?

R13 Female Organisational staff:… 'That one, her daughter was raped, this family is cursed.' So even the family is stigmatised. Friends, the brothers close to the victim are stigmatised as well.

R13 Interviewer: And the children?

R13 Female Organisational staff: Yes, the children are victims. The mother is raped, the husband is ashamed, he fled. Children ask where is dad? It is the community that informs the children that your father is gone because your mother was raped…

5.3.2.4 Anticipated Stigma

Anticipated stigma occurs when survivors expect a negative reaction from the community. This causes them to avoid disclosing their survivor status for fear of social repercussions:

R13 Female Organisational staff: After sexual violence life changes for the victim…many women fail to disclose for fear of rejection, stigma, fear of abandonment, fear by many things.

5.4 STIGMA PRACTICES EMPLOYED IN THE COMMUNITY

5.4.1 Literature Review Results

In the literature, evidence of SGBV stigma practices like enacted stigma emerge as rejection, violence from family members, verbal abuse or mockery, and victim blaming.[44,46] This was also seen in the qualitative data. Though being permitted to stay in their home may seem positive, it can expose survivors to more family-based stigmatisation manifested through verbal and physical abuse.[17,44] In one study 48.5% of survivors reported worsening violence from family after SGBV.[44]

5.4.2 Qualitative Data Results

Rejection was a commonly identified form of enacted stigma along with labelling and finger-pointing. Equal numbers of male and female respondents referenced rejection. Labels used to stigmatise and describe survivors include various negative terms that mean dirty, prostitute, and victim. There were no examples of women being labelled with positive words such as 'survivor.' Finger-pointing is a common form of enacted stigma. Male respondents discussed finger-pointing more than female respondents. Survivors in the community are frequently subjected to gossip and mockery, yet there are some instances where respondents note that there can be signs of compassion from community members. Though less common, other forms of enacted stigma such as discriminatory attitudes, stereotyping, and prejudice were present in the data. The various forms of stigmatising behaviour often occur together:

> *R14 Female Community member: They will always point her fingers: 'She is a prostitute.' 'She was raped.'*

> *R10 Interviewer: But how do people feel when... in your community when they see passing a woman who was raped, how do they see?...*
>
> *R10 Male Community member: ...People whisper, whisper in their ears while pointing at the person: 'Here's the one that was raped, this one is a victim of sexual violence.' Others laugh; others may show a little regret.*

5.5 ANTI-STIGMA INTERVENTIONS

Although the body of research is growing, a lack of data on the effectiveness of SGBV anti-stigma interventions in the DRC remains. This section describes literature results on SGBV anti-stigma interventions and SGBV programmes in the DRC that address factors contributing to stigma. It also describes SRH anti-stigma interventions from other settings. Many of these programmes combine interventions such as economic empowerment and sensitisation.

5.5.1 Interventions from the Literature

5.5.1.1 Psychosocial

One study from North and South Kivu in the DRC evaluated the effect of cognitive processing therapy (CPT) on female survivors of SGBV.[64] CPT is a type of psychotherapy that is designed for SGBV survivors. It encompasses education and cognitive restructuring.[64] Results showed that the participants who received group CPT experienced a moderate reduction in felt stigma (defined as perceived and internalised stigma by Murray et al.[21]) compared to baseline. While the reduction in stigma persisted after six months, it did lose statistical significance, suggesting booster CPT sessions may be an option for continuation of this type of intervention in the future.[64]

In response to the IMAGES results, the Living Peace IPV prevention programme was developed for men with partners who were survivors of CRSV.[65] This 15-week psychosocial intervention programme aimed to help men reframe their definitions of masculinity, reduce SGBV stigma, and restore community support and cohesion.[65] Respondents were men who had partners who were survivors of CRSV, men who had perpetrated IPV, or men who had experienced conflict-related violence.[65] Respected male community members with healthy coping mechanisms who were not known perpetrators of SGBV were included as well to avoid further marginalisation of families affected by CRSV. Results showed that 75% of families had sustained a complete cessation of violence after three years, and women became more involved in household and economic decision-making. More gender equality was seen with sharing of household tasks and childcare, and men demonstrated more equitable attitudes.[65] Male respondents became agents of change in the community by breaking silence and discussing how female survivors of SGBV could and should be accepted.[65] Sustained positive changes were not noted in families where men suffered from mental disorders and/or alcohol abuse.[65]

5.5.1.2 Economic Empowerment and Sensitising Men

A few studies focused on economic interventions. A group savings program for female survivors of SGBV was shown to reduce felt stigma.[66] Two support programs in eastern DRC that focused on socioeconomic support including loans, education, agriculture training, and providing livestock or seeds significantly improved survivor's economic well-being. While perceptions of social inclusion also improved, this was not different from the control group.[53] Participants from two other studies also suggested that economic interventions might be helpful in at least alleviating financial effects of women's employment being affected by stigma.[55,62]

The Gender Equality and Women's Empowerment Programme (GEWEP) II works with vulnerable women and girls in the DRC and other countries providing economic aid primarily through Village Savings and Loan Associations (VSLAs).[67] In the DRC, GEWEP II achieved improvement in all target areas which were to improve the economic status for women and girls, improve SRHR access, increase male engagement in prevention; and increase household resilience.[67] The programme was successful in sensitising men to gender issues including SGBV and helped develop male role models and engage religious and community leaders as agents of change.[67] However, male participants experienced negative behaviour including rejection from the community, which prompted adding engaged men experiencing social inclusion within their networks as a key part of the programme.[67]

The Stronger Women, Stronger Nations Programme implemented in North and South Kivu focuses on economic and social empowerment for vulnerable women.[68] Men's empowerment programmes (MEPs) run alongside Stronger Women, Stronger Nations. MEPs involve male group discussions focused on equality issues such as IPV, women's health, and economic empowerment. Results showed increased income, savings, decision-making power, participation in social groups, and less anxiety among women.[68] Quantitative data showed no improvement in gender attitudes among women, and IPV prevalence remained approximately the same (30% for participants vs 32% for controls).[68] Women with family members participating in MEPs did not experience statistical improvements; however, women described improvements in men's behaviour and drinking habits.[68]

The Congo Men's Network (COMEN) works in eastern DRC with men to help them develop positive masculinities and create male allies in the fight against SGBV and HIV.[69] They have successfully developed community interventions, provided sex education to men and adolescents, and been involved in awareness raising campaigns and policy and advocacy.[69]

The 2018 DRC GBV Prevention and Response Project from the World Bank International Development Association (IDA) aims to facilitate participation in GBV prevention programs, increase survivor use of multi-sectoral GBV services, and provide emergency services.[48] Components of the program target stigma through male and community leader involvement to lead behaviour change interventions.[48] The program aims to target inequality in homes through mediation focused on communication and positive notions of masculinity, and facilitate women's economic independence through VSLAs.[48] The programme finishes in 2023 and interim results are not available.

5.5.1.3 Community Interventions and Gender Norms

A realist review of anti-stigma interventions to increase HIV testing in low-and middle-income countries found that while awareness raising and improving knowledge surrounding HIV was important and common in all interventions, it was not effective on its own in reducing stigma.[70] Combination interventions that included community engagement, increasing knowledge, and strategies such as home testing were the most effective.[70] Interventions that actively involved the local community were more successful in increasing knowledge and changing attitudes.[70] Barriers to addressing stigma included laws against homosexuality, gender inequality, and traditional beliefs.[70]

A review of HIV and sex education interventions for adolescents (ages 19 and under) found that HIV education is important but not effective on its own in reducing HIV and stigma if gender norms and power dynamics are not also addressed in the intervention.[71] Programs that addressed gender and power dynamics had 80% decreased rates of pregnancy or STIs compared to 17% of the programs that did not address these constructs.[71] Education programs that addressed gender and power were also more likely to sustain effects for over a year.[71]

In Mozambique HIV rates continue to be high with 13.1% of women compared to 9.2% of men being infected.[72] Patriarchal gender norms like those seen in the DRC result in women facing

barriers in negotiating condom usage and discussing the taboo topic of sex with their partners or others.[72] A community dialogue program that operated over 18 months in 267 villages sought to increase HIV education through community engagement activities that focused on overcoming cultural, social, and gender norms.[72] Results showed that gender equity attitudes and behaviours almost doubled from the control group to the intervention groups, communication increased between partners, men had more gender equitable views, and HIV stigma and knowledge improved.[72]

Abortion is another highly stigmatised SRH issue. Values clarification and attitude transformation (VCAT) workshops involve interactively assessing people's morals to help them recognise when personal values conflict with cultural, social, and gender norms.[73] One VCAT intervention improved abortion knowledge, attitudes, and behaviour significantly in Africa among abortion providers, trainers, and stakeholders.[73]

A mixed methods study in Mexico looked at whether story circles reduced the level of individual stigma among 18 women who had abortions.[74] Story circles offered a safe space for women to talk about their experiences and receive education to fight misinformation. The intervention helped women break the silence surrounding abortion, feel less isolated, and reframe abortion into a positive event.[74]

5.6 ENTRY POINTS FOR SGBV ANTI-STIGMA INTERVENTIONS

This section describes entry points for SGBV anti-stigma interventions emerging from the literature and qualitative data.

5.6.1 Literature Results

5.6.1.1 Legal Repercussions

Study participants from the literature describe what components they think would be most helpful in anti-stigma interventions. Community members in two studies spoke about ways in which SGBV survivors are stigmatised, and they believed that legal repercussions for the perpetrator and psychosocial and community support for the survivor could help reduce stigma and that these interventions should be facilitated by families and community members.[17]

5.6.1.2 Engaging Men

Male and female focus group discussions revealed that women felt that men were an ideal target for anti-stigma interventions; i.e., if men were able to accept their wives who survived SGBV, the rest of the community would be more likely to accept them as well.[55]

5.6.1.3 Community Sensitisation

Both male and female participants in this study suggested that education and sensitisation programs to teach the community how to support survivors were important.[55] One article reviewed a Congolese family and community mediation program to reintegrate SGBV survivors.[62] They found that most mediators were religious leaders, community leaders, and NGO leaders. Good leaders were described as trustworthy. They did not, however, measure the effect of the mediation program or address other manifestations of stigma that SGBV survivors experience. Study participants did cite economic interventions as potentially beneficial in reducing stigma.[62]

5.6.1.4 Deserving of Respect

Community level stigmatisation of SGBV survivors is frequently described by individuals; when interviewed on how they believe survivors should be treated, individuals report that survivors deserve better treatment and disagree with the community's stigmatisation of them.[17] This is seen in the qualitative data as well where respondents report that survivors deserve more respect.

5.6.2 Qualitative Data Results

5.6.2.1 Deserving of Respect

Female respondents were more likely to express that survivors should be treated better. All respondents advocated for better treatment of survivors, stating that they deserved respect, and that rape was an accident:

> *R13 Female Organisational staff: …a woman raped remains a woman and deserving of respect, even though she was raped. It's just an accident that happened, but she deserves of respect…Why should a woman who is raped be considered as a curse? Even if the girl is raped she deserves of respect and honour.*

5.6.2.2 Community Support

Respondents believe interventions centred on facilitating community support for survivors, encouraging compassion towards and acceptance of survivors, and helping them reintegrate with the community would be most effective in reducing SGBV stigma. Female respondents mentioned community support more than male respondents. Other important but less frequently referenced types of interventions were those that focused on economic support, family cohesion and support, reframing survivorship, psychosocial or medical interventions, and restoring survivor value and respect. Respondents, particularly female, described in depth how survivors

bear some amount of responsibility for protecting themselves from stigma. This was frequently tied with how the community values women.

When asked how survivors could protect themselves from stigma:

R17 Female Community leader: She must be humble to be accepted in the community. She should avoid boasting. Being too proud. She should be friendly with everybody.

5.6.2.3 Compassion

Self-isolation was a common example of how survivors avoid stigma and was even promoted by some respondents as a legitimate intervention. Self-isolation was described by men more than women. When talking about how communities can support survivors, respondents reported ways in which community members can show compassion as possible interventions. They reported that support is shown through acceptance of survivors:

R18 Female Community leader: Her life is no doubt full of worries. The community should be made aware that what happened to her is misfortune which may strike any woman. As the victim has surely been physically and morally wounded, she needs healing…she needs both the help of investigators and her community to survive the disaster.

5.6.2.4 Reframing

A prominent example of reframing was respondents saying that people should be made aware that 'it (SGBV) can happen to anyone.' It was equally described by men and women. This concept was described using various but similar phrases and sought to elicit compassion from people by removing the taboo of SGBV, fighting victim blaming, and normalising the event:

R6 Interviewer: What can we do to prevent the breakup of marriage?

R6 Female Community leader: … After treatments, we now call Papa of the House (her husband) just to inform him that: 'Your wife does not have HIV/AIDS, so she only had internal wounds and she was healed. Just know that the act of rape can happen to anyone. It can happen even to your sister or anyone else. Look how the children are suffering…' We can still restore that family…

R16 Interviewer: Do women keep their chance after sexual abuse in their society?

R16 Male Community leader: Well, people who have come to understand that what happened to them may happen to any other woman will treat them fairly.

5.6.2.5 Sensitisation

Sensitisation emerged from data on possible interventions. At times respondents explicitly mentioned sensitisation programmes for families and communities to reduce stigma; but it was also implicit in many of the interventions they described. Husbands were seen as pivotal targets as they could facilitate acceptance, respect, and compassion for survivors and ways to gain community support. Sensitising the community to survivor needs such as medical and psychosocial care was seen as essential.

> When asked what we can do to restore survivor's value:
>
> *R5 Female Health professional: Sensitisation. Especially illiterate husbands need to be sensitised. Counselling them and convincing them that their wives didn't consent with the rapists. If only her husband understands this, he will never flee or reject his wife. On the contrary he is the one who can make all the family to respect her. Her mother in-law can start stigmatising her, but the man will tell his mom: 'Why do you treat my wife like that? You are also a woman; it can happen to you.' So, the woman will have her weight (value or respect) and she will not have the idea of abandoning her family. Secondly: supporting them. Especially with medical care and counselling for them to recover. Show them that it happens, and they should not lose hope. I think that is what I can say.*

5.6.2.6 Economic Empowerment

Economic interventions were proposed as being helpful in restoring the value of survivors and were tied to women's value as workers. Work was also identified as way survivors could reintegrate and feel more connected with their community:

> *R11 Male Community leader: Well, they need to do activities, such as revenue-generating activities. Because the husband, when he sees that, 'My wife has a good job…when my wife has a good business, does a business.' Really her husband will consider her more.*

CH 6: DISCUSSION

The value of women in the DRC is rooted in repressive gender norms that predominantly limit their role to that of a socially virtuous wife, mother, or daughter. Organisational staff provided detailed descriptions of the value of women and how they are viewed in society. This may be due to their education level, position in society, and experience working with survivors. While community members may have an inherent understanding of norms and the roles that they are expected to adhere to in society, they may lack the empowerment in breaking the silence to discuss them. Their detailed knowledge of norms, the roles of women and men, and their involvement with the community make them ideal engagement targets for anti-stigma programme development and delivery. Engaging leaders in interventions can prompt re-evaluation of norms and values and facilitate community discussion on these topics to help the community (including leaders) change internalised norms.

Women are also valued for their ability to work and earn income. This was not directly seen in the literature; however, the literature showed that women have increased economic responsibility during times of conflict. The ongoing conflict in the DRC may contribute to women's economic independence and value as workers. Male respondents found the role of women as workers as valuable and mentioned the potential benefit of economic interventions more often than female respondents. Additionally, SGBV and stigma interventions in the DRC have focused on economic components and proven to be successful in increasing women's value and decreasing SGBV stigma. Respondents of both genders also suggested that economic SGBV stigma interventions would restore survivors' value and facilitate reintegration into the community. Men valuing women for their work and economic contribution suggests a shift in how women are valued. This indicates that stigma interventions focusing on strengthening women's economic status could be well received in the community, particularly if men who are sensitised to SGBV and stigma are engaged in economic intervention development and delivery.

Results show that men are an opportune target for SGBV and SGBV anti-stigma interventions since they may be perpetrators of SGBV and are respected in society. In patriarchal societies men occupy most leadership roles and have influence over cultural, social, and gender norms. Engaging men can help them rethink gender roles and facilitate equal distribution of labour, decision-making, and women's autonomy to help elevate women's status in society. Lessons from interventions show that social support is important in preventing engaged men from being stigmatised by their community. In addition, perpetrators of SGBV often have traumatic histories themselves. Faulty coping mechanisms combined with inequitable gender norms facilitate perpetration of SGBV. By developing interventions that work directly with men and focus on healing trauma, the cycle of violence can hopefully be halted, and inequitable norms and attitudes can be changed. Community organisations, local NGOs, and religious organisations are often well established within communities. These organisations and individuals can help identify male community members who would be ideal persons to incorporate into interventions. Additionally, these organisations may be best equipped to develop and deliver community interventions focused on changing gender norms since they have a deep knowledge of the norms that permeate eastern DRC. They may also have their own experiences in seeing what has and has not been successful in the region in the past.

Drivers of stigma, like fear of infection and victim blaming are enabled by repressive norms which reinforce the view that survivors are dirty and have lost value. While fear of infection may be a valid concern between partners given the high burden of HIV in the DRC, community stigmatisation of survivors due to this fear shows a lack of understanding on transmission and management of STIs. Misinformation about SGBV, and a lack of appreciation for its contributing factors and consequences can facilitate stigmatisation. The literature on HIV and abortion stigma interventions recognises that education and fighting misinformation are important components of interventions, but not effective on their own.

Sensitisation and education go hand in hand. Through education on SGBV, its consequences, and consent, community members may start to show compassion towards and acceptance of SGBV survivors. Results from the literature and data support sensitisation in interventions, particularly among men who may be able to facilitate survivor acceptance from the rest of the community. The expectation that survivors be humble, submissive, and friendly to mitigate stigma can be addressed through sensitising community leaders to the community's role and responsibility in the stigmatisation process. This could help prevent survivor self-isolation, rejection from the community, and facilitate reintegration. Sensitisation may also facilitate conversation about SGBV and help break the culture of silence that allows harmful practices to go unchecked.

While results demonstrate that on an individual level people think survivors should be treated better, community level stigmatisation continues. Respondents felt that community interventions might be effective, which aligns with data from the literature. SGBV interventions that addressed underlying cultural, social, and gender norms that facilitate stigma often involved community engagement. Community interventions were found to be effective in reducing stigma for other SRH issues such as HIV and abortion. These interventions prompted respondents to critically analyse their values and attitudes towards the stigmatised condition through storytelling, VCATs, and group discussions about gender norms. Individual beliefs that survivors should be treated better provides hope that community level anti-stigma interventions may be well received, particularly if the silence surround SGBV can be broken and open dialogue on stigma and SGBV can take place. Facilitating a critical analysis of social practices and behaviour among community members could help them break from harmful norms and empower each other to treat survivors better.

The 'it can happen to anyone' narrative that emerged from the data was not seen in the literature. This narrative appears to be a way in which community members try to facilitate acceptance of and compassion towards survivors by encouraging others to recognise that SGBV is not a survivor's choice, and it is prevalent in the DRC. While it appears well intentioned, it raises concerns about facilitating normalisation of SGBV. Normalisation of SGBV has already been shown to be a problem in the DRC and can prevent communities from acknowledging the issue and systematically addressing the underlying factors that contribute to it and its stigmatisation. Careful consideration on how communities facilitate acceptance through compassion and education versus normalising human rights violations is essential.

Many organisations work to prevent and manage SGBV in eastern DRC, but lack of coordination between sectors and organisations have been cited as barriers to effectiveness.[40,50,63] Intersectoral communication and collaboration has improved efficiency of some sectors,[75] and organisations

such as the UN actively work with the government to facilitate oversight and better collaboration.[76] NGOs, religious organisations, the community health component of the health system, and CSOs that are working on the ground may have relationships with the communities. Support from larger INGOs and international organisations like the various UN branches can be crucial to their success, but intersectoral coordination is essential. Appropriate referral and not forcing a 'one size fits all' response to SGBV from one organisation should be prioritised. To promote more holistic access to SRH for all Congolese persons, donor-based referral restrictions should be lifted. Progress has been made with the recent adaptation of including IPV in the Comprehensive Strategy for Combatting Sexual Violence, but clear law criminalising marital rape is still non-existent. To fight all forms of SGBV in the DRC the law needs to reflect the international commitments, which is to eliminate all forms of violence against women. So long as marital rape continues to be omitted from laws, it will reinforce harmful gender norms such as men's ownership over women.

Results from the literature and data largely confirm one another. Community perspectives provide insight into the stigmatisation process in eastern DRC. Given the complexity of factors contributing to SGBV and stigma such as social, cultural, and gender norms, as well as conflict, an integrated approach that involves the entire community, including men, is required for success.

6.1 ANALYTICAL FRAMEWORK RELEVANCE

The Health Stigma and Discrimination Framework is robust and not all components were used as this would have resulted in a lack of depth of the analysis. Factors that contribute to stigma, such as drivers and facilitators, and stigma manifestations were particularly relevant to the thesis. Though not explicitly used to guide analysis or structure results, the influence of socio-ecological levels (public policy, organisational, community, interpersonal, and individual) are seen with interventions, entry points for interventions, and factors such as gender norms that influence SGBV stigma. Additional themes outside of the framework such as the value of women, possible interventions, and how survivors are viewed in society emerged. Development of a framework specific to SGBV stigma would likely incorporate these themes and be better equipped to SGBV stigma research.

6.2 LIMITATIONS

A more in-depth literature review of successful anti-stigma interventions conflict settings outside of the DRC, as well as SRH anti-stigma interventions could have provided more information for this thesis. Due to time constraints and word limits this was not done. Coding was done by only one individual. Double coding from another researcher would have contributed to the validity of the results. Since there were an equal number of male and female respondents, normalisation did not affect the gender data. Initially normalised data was used to compare differences between community members based on their role. However, large differences in results between the normalised and raw data were noted. This raised questions about the validity of these results and so a comparison between respondent roles was omitted from the results. This could limit the depth of the analysis.

CH 7: CONCLUSION AND RECOMMENDATIONS

7.1 CONCLUSION

This study found that drivers and facilitators such as cultural, social, and gender norms as well as fear of infection, fear of social ramifications, and negative views of survivors, victim blaming, and lack of appreciation for SGBV, its consequences, and consent all intersect to create SGBV stigma. Survivors' stigma experiences include felt, internalised, and anticipated stigma as well as associative stigma for people connected to survivors. Stigma practices such as rejection, finger-pointing, gossip, and mockery are common in the community. Stigma interventions and entry points for interventions focused on community engagement and sensitisation, and economic empowerment for survivors. SGBV interventions address cultural, social, and gender norms that propagate gender inequality and facilitate stigmatisation.

Simply addressing the consequences of SGBV or focusing on survivors as the intervention target is inefficient and neglects the underlying cultural, social, and gender norms that continue to fuel inequity and survivor stigma in eastern DRC. Interventions should take a holistic approach and address community behaviour at large alongside the underlying norms that drive SGBV and its stigmatisation. A pitfall of the SGBV response in eastern DRC has been the funnelling healthcare resources, NGOs, and humanitarian organisations into the regions without a coordinated response, effective lines of communication, and referral. Intersectoral and interorganisational collaboration needs improvement.

The decades of trauma and violence that have plagued the DRC cannot be ignored. Results from the Living Peace IPV Prevention programme that involved male leaders, perpetrators, and men who had been traumatised demonstrates that male involvement is a successful tactic for reducing potential stigma. As both perpetrators of and survivors of SGBV, as well as community leaders, men should be prioritised as SGBV stigma intervention targets. Research and interventions should consider the entire population and prioritise the needs of men as well as women. Combination, community level intervention programs that include men and community leaders as targets for programmatic intervention and focus on underlying cultural, social, and gender norms are ideal for SGBV stigma mitigation.

7.2 RECOMMENDATIONS

Due to the author's lack of contextual first-hand knowledge of eastern DRC these suggestions are tentative and should be adjusted and implemented by researchers with expert knowledge of the local context.

7.2.1 Intervention Recommendations

1. Work with local NGOs, community organisations, and religious organisations to engage men in the participation, development, and delivery of community SGBV anti-stigma interventions.
2. Disseminate study results to UN organisations operating in eastern DRC to facilitate government involvement and encourage collaboration across sectors and organisations to develop and deliver anti-stigma interventions.
    a. Partnering with the MOH and Ministry of Gender Family and Children who are already involved in SGBV policy making and prevention can help strengthen intersectoral collaboration.
    b. NGOs on the ground in eastern DRC (such as WAHA, Panzi foundation, HEAL) are established within communities and ideal for intervention delivery. Their efforts would be strengthened through better intersectoral coordination and support.
3. Incorporate lessons from SGBV and anti-stigma interventions in the DRC, and SRH anti-stigma interventions into new interventions. Lessons include:
    a. Ensure engaged men are socially included to prevent backlash
    b. Use combination interventions
    c. Address underlying gender norms and power dynamics that fuel inequity and stigma.
    d. Evaluate the impact of current SGBV programmes (such as the DRC GBV Prevention and Response Project) on underlying facilitators of stigma to inform future interventions.

7.2.2 Policy Recommendations

1. Disseminate results to human rights organisations who work across sectors (like PHR) to discuss the relevance of, and the creation of pathways for criminalising marital rape.

7.2.3 Framework Recommendations

1. Modify the Health Stigma and Discrimination Framework to develop an SGBV stigma framework.

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ANNEX 1: STUDY DESCRIPTION

STUDY DESCRIPTION

TITLE OF PROTOCOL	An assessment of stigma related to gender-based violence
Principal Investigator	Jennifer Scott, MD, MPH

B1. PURPOSE OF PROTOCOL

The study will use qualitative methods, including in-depth interviews, focus group discussions and participatory learning and action (PLA) activities, to assess stigma related to gender-based violence (GBV) in order to inform future instruments and interventions.

B2. SIGNIFICANCE AND BACKGROUND FOR THE STUDY

Gender-based violence is common globally, and is widespread in areas of conflict, including Democratic Republic of Congo (DRC) where up to 40% of women reported GBV.(1, 2) Gender-based violence is described broadly by the United Nations as any act of violence "that results in in, or is likely to result in physical, sexual or physiological harm or suffering to women".(3) It encompasses partner and non-partner sexual, physical, and emotional violence, in addition to sexual exploitation, abuse, and trafficking, and is shaped by gender roles and status in society.(4) Gender-based violence is associated with a number of physical, mental, and sexual and reproductive health conditions.

Stigmatisation, as a result of GBV, has been described in a number of contexts where GBV is prevalent, including in DRC.(1, 5, 6) Stigma is defined as "a social process, experienced or anticipated, characterized by exclusion, rejection, blame or devaluation that results from experience, perception, or anticipation of an adverse social judgment about a person or group".(7) Stigmatisation resulting from GBV likely contributes to a hidden burden of illness by creating a barrier to help-seeking within a variety of domains, including social support, mental health services, and post-exposure prophylaxis after rape to prevent HIV transmission.(8) Stigma related to sexual violence has also been identified as a potential mediator of mental health outcomes and related psychosocial consequences such as social rejection and isolation.(9-11)

While there is a growing body of literature on stigma related to GBV, there is a lack of consensus on defining and measuring stigma among GBV survivors. Consensus on stigma, its domains and its measurement, may help to advance programs and interventions to support individuals, families and communities affected by gender-based violence.

The Principal Investigator (PI) conducted a systematic review in 2015-2016 to describe existing assessments of stigma related to GBV. The results indicate that there are few standardized measures of stigma in the context of violence and that those studies that include an assessment of stigma are limited in how thoroughly stigma was assessed. The review also revealed limited perspectives from men, family, and community leaders, such as religious leaders, which would be helpful for developing future community-based anti-stigma interventions.

The PI has worked in DRC since 2006 on collaborative research projects addressing GBV and psychosocial outcomes, including stigma.(2, 12-19) Most recently, a study of women with sexual violence-related pregnancies in eastern DRC revealed that women reporting social stigmatisation from their partners, families and/or communities were more likely to report symptoms of mental health disorders (11) and to report negative parenting attitudes toward their children.(13)

The PI received funding from The Harvard Global Health Institute Burke Global Health Fellowship to conduct the systematic review and qualitative research. The PI also received a U.S. Fulbright Post-doctoral Award to work in collaboration with social scientists at the École des Hautes Études en Sciences Sociales / Institut des mondes africains to advance the assessment of social stigma related to violence. Dr. Rémy Bazenguissa-Ganga at the École des Hautes Études en Scienes Sociales is the mentor of the Fulbright grant and has extensive research experience in eastern DRC and in other post-conflict settings. Dr. Susan Bartels, formerly at BIDMC and now at Queen's University will contribute to the study and has also conducted in DRC on GBV since 2006. Sarah Murray, PhD, from John's Hopkins School of Public Health is an expert in stigma and GBV with ongoing research in DRC and will provide input on the study. Simone Sasse, a medical student at Harvard Medical School, conducted the systematic review as part of her Scholarly Project and will also contribute to the study.

The research will be conducted in collaboration with a non-governmental organization based in North and South Kivu Provinces, DRC: Women and Health Alliance (WAHA) International. The organization provides women's health services in health centers. The organization provides support to sexual violence survivors.

B3. DESCRIPTION OF RESEARCH PROTOCOL

Study Design – Overview, Methods, Procedures

Overview

This qualitative study will be conducted in eastern Democratic Republic of Congo in the communities served by WAHA International in and outside of Bukavu, South Kivu Province and in an outside of Goma, North Kivu Province.

The study has the following research objectives:

1. Characterize stigma related to GBV, including social and cultural determinants of stigma and impacts of stigma;

2. Explore the relationship between stigma and mental health to further understand the role of stigma in mediating mental health outcomes;

3. Inform the development of an instrument to assess stigma related to GBV for future research and interventions in conflict-affected francophone countries.

Methods

Qualitative data will be collected through in-depth interviews, focus group discussions and PLA activities. Further details on subject selection and recruitment are described in section B3(C).

Qualitative data will be de-identified and analyzed as described below.

Procedures

1. Recruitment and training of interviewers and facilitators:

Interviewers and facilitators will be recruited in collaboration with WAHA and will be fluent in French and Swahili and have experience working in conflict-affected communities and with survivors of violence. Interviewers and facilitators will participate in a training focused on the study objectives, qualitative methods, interviewing techniques, role-playing, protection of human subjects and risk mitigation. The training curriculum will be based on research trainings previously conducted by the PI and co-investigators. When necessary, local specialists with expertise in GBV or mental health will be invited to contribute to training.

2. Informed consent

Verbal informed consent will be obtained from the interviewees and focus group discussion and PLA participants. Verbal informed consent will be obtained due to low levels of literacy among the study population and to avoid a written document that may place the participant at greater risk. The informed consent process is described below in Section B6, and will include details about potential risks and benefits, voluntary participation and the importance of confidentiality. The facilitators will describe the norms for the discussion, such that personal information is not disclosed, personal identifying information is not collected or revealed, and that ideas and opinions expressed in the focus group discussion are not shared outside of the context of the discussion. The

interview, focus group discussion, and PLA content focuses on stigma related to GBV, but the questions do not ask for participants to share or describe their own personal experiences of violence.

3, In-depth interviews

Interviews will last approximately 60 minutes and will be conducted in a private setting within the organization site where there is support staff on site. The interviews will be conducted in French or Swahili by a same-sex interviewer and follow a semi-structured interview guide developed by the PI and co-investigators. The interviews will be audio recorded, transcribed and translated to English.

4. Focus group discussions

The focus group discussions will last approximately 90-120 minutes and will be conducted in a private setting within the organization site where there is support staff on site. The focus groups will be conducted in French or Swahili by a same-sex facilitator. The facilitators will describe the norms for the discussion, such that personal information is not disclosed, personal identifying information is not collected or revealed, and that ideas and opinions expressed are not shared outside of the context of the discussion. One facilitator and one note-taker will be present. Facilitators will use topic guides developed by the PI and co-investigators to facilitate the focus group discussions. The group discussions will be audio recorded, transcribed and translated into English.

4. PLA activities

Participatory learning action activities will last approximately 90-120 minutes and will be conducted in a private setting within the organization site where there is support staff on site. The facilitators will describe the norms for the discussion, such that personal information is not disclosed, personal identifying information is not collected or revealed, and that ideas and opinions expressed are not shared outside of the context of the discussion. The activities were modelled based on previous GBV research. The groups consist of three activities, which are summarized below and are described in further detail in the guide provided with this submission.

ACTIVITY 1: OPEN-ENDED STORY (30 minutes)

This activity involves reading a fictional story to the study participants with the end of the story purposefully excluded. The purpose of the open-ended story is to explore beliefs, opinions, and perceptions. This method is helpful for discussing sensitive topics, as study participants may feel more comfortable discussing the life of a fictional character.

ACTIVITY 2: FREE-LISTING & PREFERENCE RANKING (30 minutes)

Free-listing involves asking participants to list their definitions of a presented topic. It is helpful in understanding cultural perceptions of the topic. In this activity, free-listing will be used to understand the various ways in which social stigma may manifest in the community and explore various strategies to mitigate social stigma. The facilitator writes these on sticky-notes that can be assembled and visualized on a board for the group. Participants are asked to rank the most common aspects of

stigma, which allows for further understanding of the issues that most affect the community.

ACTIVITY 3: COMMUNITY MAPPING (45 minutes)
This activity involves drawing a map of their community and asking participants to indicate where in the community survivors of GBV may encounter stigmatizing attitudes and/or behaviors. Community mapping may be helpful to understand risky areas in the community for women and girls.

5. Data management and security
Following the interviews, focus group discussions and PLA activities, the interviewers and facilitators will review the notes and verify the recording. Any issues arising during the course of the interview or discussion will be discussed immediately with a supervising member of the research team.

A member of the study staff will ensure that the audio records and notes are stored securely at the end of each day. The audio files will be uploaded to a password-protected study laptop and sent via email on a secure server to the PI to be stored on a secure server at BIDMC at the earliest secure internet connection. Once there is verification of an audible file on a password-protected study laptop and on the secure server, the audio file will be deleted from the recorder. The recorders and study documents will be kept in lock box when not in use. The discussion and interview notes will be scanned and the audio files will be transcribed into electronic files on a password-protected study laptop and sent via email and stored on a secure server as described above and destroyed. The notes and transcriptions will be translated to English. The English transcripts will be coded and analysed using a qualitative data program, Dedoose, and further details of the proposed analysis are described below.

6. Study monitoring procedures
The PI, in collaboration with co-investigators, will oversee the project implementation in DRC, both remotely and through on-site supervision, through regular email and phone communication, regular project meetings, and scheduled visits. Throughout the data collection, we will ensure that a member of the study team is based in DRC for key project activities, such as recruitment and training of facilitators and data collection.

Statistical Considerations

a. ***Sample Size Justification:***

The study will aim to enroll up to 140 participants. Each focus group discussion and PLA group discussion will have between 6-10 participants.

-Up to 20 semi-structured interviews

-Up to 60 participants in focus group discussions

-Up to 60 participants in PLA group discussions

There is no formal sample size calculation, as we are not testing hypotheses.

b. ***Data Analysis:***

The de-identified electronic transcripts of the in-depth interviews, focus groups and PLA activities will be uploaded to Dedoose, a qualitative data software program, for coding and analysis by study investigators. Transcripts will be reviewed independently and concepts coded. Concepts will be categorized and major themes and sub-themes will be identified. Descriptive and thematic content analysis will be conducted and general comparisons will be made based on gender and age group.

C. Subject Selection

The sample population will be derived from the health centers and communities in and around Bukavu, South Kivu Province and in and around Goma, North Kivu Province in partnership with WAHA International.

1) Women (≥18 and older) receiving services from the organization and

2) Adult (≥18 and older) male and female community members, including community leaders, health providers, organizational staff, and religious leaders.

This convenience sample will be selected in partnership with WAHA International who is well-connected in the communities.

Exclusion criteria will be any condition that limits the ability to communicate.

B4. POSSIBLE BENEFITS

This study may not directly benefit the participants and community members; however, the data from this study will be used to inform future interventions to support individuals, families and communities affected by violence. The study participants and community members may benefit from the program in the future. Furthermore, the data will be used to build the evidence base on stigma among survivors of violence that could be applicable to other settings and contexts.

B5. POSSIBLE RISKS AND ANALYSIS OF RISK/BENEFIT RATIO

Research conducted on GBV and in humanitarian settings raises many important ethical considerations.(20-25) The study will follow recommended guidelines for conducting research in humanitarian settings and GBV research.(20, 22)

Verbal informed consent will be obtained from participants and interviews, focus group discussions and PLA activities will be conducted in a private setting at the organization. Every effort will be made to ensure and protect participant confidentiality. Specific risks and risk mitigation strategies are outlined below:

1) Possible risks related to study participation: The safety, privacy and confidentiality of study participants will be prioritized. Potential risks may be related to a) speaking about sensitive community and cultural issues, such as violence and norms related to violence; b) breach of confidentiality; and c) privacy.

a) Sensitive study subject matter:
Participants will not be asked about personal experience or past history of violence, but rather will be asked to speak in general about community and cultural norms that may contribute to stigma following GBV and the ways in which stigma may manifest. Participants may experience distress speaking about these specific issues.

Interviewers and facilitators will be trained psychosocial workers at the organization. During the consent process, the facilitators and interviewers will explain the objectives of the study and explain that there may be questions on sensitive community and cultural issues. The participant has the right to decline study participation and to terminate participation at any time. Prior to initiating data collection, the interviewers and facilitators will emphasize that personal experiences of violence should not be shared. During one-on-one interviews, participants may share their own personal experiences of stigmatizing attitudes, but they will not be asked to share experiences of violence and interviewers will be trained to redirect the discussion if participants begin to share personal experiences. During focus group discussions and PLA activities, participants will be encouraged not to share personal experiences of stigma, but rather speak more broadly about norms and

beliefs that lead to stigmatizing attitudes in the community.

The interviewers and facilitators will be trained to ask about sensitive subjects and to recognize signs of distress among participants. For participants who appear distressed, the interviewer or facilitator will contact the research supervisor and appropriate referral will be provided to participants. Participants reporting violence will be provided with information on health, social and legal resources and referred for further services.

The PI and co-investigators have extensive experience conducting studies on violence in these targeted communities and will work to ensure that risks to participants as a result of study participation are minimized to the greatest extent possible. Any public discussion or description of the study will frame the project to be about a general health study and not disclose the sensitive subject matter of the study.

b) Potential breach of confidentiality:
A potential and important risk to participants is if information shared during a focus group discussion is disclosed outside of the study. This could occur if a facilitator disclosed information gathered during the study, or if a fellow participant in a focus group discussion shared the information or opinions expressed during a focus group.

Facilitators will receive training on the importance of maintaining confidentiality and will be trained to reschedule or terminate group discussions if confidentiality of data cannot be assured. During the research training, facilitators will be asked to sign a code of conduct to protect participant confidentiality. Additionally, a code of conduct will be described at the outset of the focus group discussion, including not sharing personal or identifying information, respecting others' opinions, and emphasizing non-disclosure of information shared during the discussion outside of the formal focus group discussion.

In order to further protect participant confidentiality, personal identifying information will not be collected as part of the interviews, focus group discussions or PLA activities. Participants will be assigned a code by the facilitator and basic demographic data will be obtained without a name or other personal identifying information. Data monitoring and security procedures described in Section B8 and in Part P.

c) Privacy:
In order to ensure privacy of study participants, interviews, focus group discussions, and PLA activities will be conducted in private settings and will not be conducted in the presence of any other individual over the age of 2 years except the participants. Facilitators will be trained on the importance of privacy and will be trained to reschedule discussions if a private setting cannot be obtained. They will also be trained to change the subject of discussion, through the use of diversionary questions, if a discussion or interview is interrupted.

2) Referrals: We will work with the local organization to ensure referral for health services and psychosocial counseling for participants who report violence and/or who experience psychological distress as a result of study participation. Facilitators will inform participants about health, legal, and social resources.

Specifically, the study will adhere to WHO ethical recommendations for conducting research on violence against women, including ensuring a referral system as needed for study participants.(20-22)

3) Potential risks to study members:
Conducting research in conflict-affected settings places facilitators and other study team members at potential risk. Facilitators will receive training on security protocols and on recognizing the signs of personal distress and how to seek further support. The PI and co-investigators recognize that facilitators may have their own experiences of GBV and they, too, have been affected by the conflict. This will be addressed during the training and further psychosocial support can be offered and arranged for facilitators confidentially using similar resources as described above in the referral section. The study staff member based in DRC during the data collection will also conduct regular debriefings with interviewers and facilitators on an individual and group basis. Furthermore, the study team will adhere to security protocols as outlined by the organization and will delay or terminate the study if security of participants or study staff cannot be assured due to insecurity unrelated to the study. The travel for the PI and co-investigators will be registered and planned in accordance with Global Support Services at Harvard University and with the U.S. State Department.

4) Risks after data collection:
There are potential risks after data collection to participants, if the subject matter was to be disclosed or if there was a breach of confidentiality or privacy. The verbal consent forms will contain contact information related to the study that will include contact information for the organization and for the PI. The partner organization is well-connected in the communities and provides services to potential participants, thus could provide support to participants following participation in the study.

B6. RECRUITMENT AND CONSENT PROCEDURES

Recruitment

Study participants will be recruited in collaboration with WAHA International in and around Bukavu, South Kivu Province and in an around Goma, North Kivu Province, DRC. A convenience sample will be recruited to participate in the in-depth interviews, focus group discussions and PLA activities. Study participants will be reimbursed $2 USD for transportation related to study participation.

Consent

Verbal informed consent will be obtained from participants due to varied literacy levels and concern that written consent would be the only document linking the participant to the study. Interviewers and facilitators will receive training on the process of informed consent. As part of the consent process, they will explain the study objectives, voluntary participation, and the option of stopping or withdrawing participation at any time. The potential risks of participation and benefits will be explained. It will be emphasized that participants are entitled to the same level of support regardless of their decision to participate. The interviewers and facilitators will indicate that verbal informed consent was obtained and a copy containing contact information will be offered to the participant. Participants will not be required to sign a form. Participants will not receive monetary compensation for participation in the research.

B7. STUDY LOCATION

The study will be conducted in eastern Democratic Republic of Congo in and around Bukavu, the capital of South Kivu Province and in and around Goma, North Kivu Province.

Privacy

In-depth interviews, focus group discussions and PLA activities will be held in private settings within the organization or within the community as determined by the organization. The organization provides support to GBV survivors, in addition to other support services, and meeting in a space designated by the organization that will not compromise the privacy of participants. For group discussions, facilitators will emphasize the importance of respecting the privacy of others. If facilitators or interviewers personally know a participant, they will be reassigned. If a focus group or interview is interrupted by another person, the facilitators and interviewers will be trained in the use of diversionary methods unrelated to the study's focus on GBV. All study-related materials will frame the research as a general health study.

Physical Setting

The study activities will be conducted in a private space in the community as designated by the organization.

B8. DATA SECURITY

The sources of data from this study include: 1) paper notes from the interviews, focus group discussions PLA activities; 2) audio files, and 3) electronic transcripts and translations. Paper resulting from this study will be kept in a lock box in a locked office at the organization during the course of data collection. Upon completion of data collection, the notes will be scanned and uploaded to the secure server at BIDMC by the PI and the paper documentation will be destroyed. Audio recorders will be given to the supervising study team member at the end of each day of data collection. The supervisor will be responsible for transferring the audio files from the audio recorder to a password-protected study laptop within 24 hours of the interview, focus group discussion or PLA activity. The audio recorders will be stored securely in an office and in a lock box when not in use. The study laptop will be stored securely in an office when not in use. A master copy of audio files will be uploaded and stored on the secure server at BIDMC at the first possible secure internet connection and subsequently deleted from the audio recorder once the integrity of the audio file is ensured. All electronic, de-identified data will be kept on a password-protected study laptop and emailed to study investigators using a secure server. The PI will store electronic files on a restricted-access folder on the BIDMC secure server, behind the firewall. Identifying information will not be collected during the data collection.

B9 Multi-Site Studies

Is the BIDMC the coordinating site? ☒ Yes ☐ No

Is the BIDMC PI the lead investigator of the multi-site study? ☒ Yes ☐ No

B10 Dissemination of Research Results

Please explain whether you will be able to thank subjects and provide research results and, if so, how this will be accomplished. If you do not think this is feasible, appropriate or applicable to this research, please specify why.

Individual subjects from the qualitative research will not be thanked individually to protect confidentiality; however, a general acknowledgment of the contributions of study participants will be included in any dissemination. Research results will be disseminated in oral, report and manuscript form. The results will be disseminated in collaboration with local partners in DRC.

ANNEX 2: VERBAL CONSENT FORM

Verbal consent

Hello, my name is _____. I am from _____(name of partner organization), working in collaboration with Beth Israel Deaconess Medical Center in Boston, Massachusetts, United States of America. We are working on a research study about social stigmatisation of sexual violence survivors.

We are conducting interviews, focus group discussions and groups with participatory activities. You have been selected to participate in this study because you are a living in a community where _____(name of partner organization) is providing services.

If asking participant to be in an interview:

We are asking you to participate in a one-on-one interview so we can understand more about the issues facing sexual violence survivors. One interviewer will conduct the interview. You will be asked some brief demographic questions and some open-ended questions. The interview will take approximately 60 minutes.

The interview will be recorded using a voice recorder. Neither your name nor any identifying information will be linked to the recording. After we transcribe the interview, we will destroy the recording.

If asking participant to be in focus group:

We are asking you to participate in a focus group so we can understand more about the issues facing sexual violence survivors. Two facilitators will lead a discussion with up to 10 participants for each focus group. You will be asked some brief demographic questions and some open-ended questions. The focus group will take approximately 60-90 minutes.

The focus group will be recorded using a voice recorder. Neither your name nor any identifying information will be linked to the recording. After we transcribe the discussion, we will destroy the recordings.

If asking participant to be in participatory learning and action group:

We are asking you to participate in a participatory learning and action (PLA) group so we can understand more about the issues facing sexual violence survivors... Two facilitators will lead several group activities to stimulate discussion with up to 10 participants. The session will take approximately 90-120 minutes.

The participatory group will be recorded using a voice recorder. Neither your name nor any identifying information will be linked to the recording. After we transcribe the discussion, we will destroy the recordings.

All:

Participation in this study may pose a risk to you including risks related to 1) speaking about sensitive community issues, including norms and violence; 2) disclosure of information discussed; and 3) privacy. Every effort will be made to protect your information. This means that we will not share any of the information you provide with anyone outside of the project team. The interviews and groups will take place in a private setting and all interviewers and facilitators are trained to protect your privacy. Participation is optional and voluntary and you may choose to stop at any time. If I ask any questions that you don't feel comfortable answering, let me know. We also have resources available and can refer you to health services and counseling if you need. Choosing to participate or refusing to participate will not affect the resources that you or your family receives. You may not benefit directly from participation in the study; however, the information you provide may help us improve support services for sexual violence survivors and their families.

If you have any questions before, during, or after your participation, you may contact a study investigator with the contact information below.

It is important that you understand there are no right or wrong answers for any of the things we talk about. Your ideas are extremely valuable, and we are interested in your comments and opinions. If you prefer not to participate, please let me know. Do you have any questions or concerns? Would you like to participate?

☐ Yes (if yes, specify below)
- ☐ Interview
- ☐ Focus Group
- ☐ Participatory Learning and Action Group

☐ No

☐ Handed participant this form

☐ Participant stated s/he did not want to receive this form

Participant's Name: _____
Verbal Consent Obtained By: _____
Date: _____
Contact Information:
Dr. Jennifer Scott, Beth Israel Deaconess Medical Center, Dept of OBGYN, 330 Brookline Avenue, Boston, MA 02215 USA, +1-617-667-2286
or
Beth Israel Deaconess Medical Center Human Subject Protections Office, 330 Brookline Avenue, Boston, Massachusetts, 02215, phone +1-617-667-4524
or
Bibyshe Ta Takubusoga Mundjo, Actions pour la Réinsertion Sociale de la Femme, Bukavu, South Kivu Province, phone (+243) 9 94 67 56 58
or
Amani Matabaro Tom, Actions Pour le Bien etre de la Femme et de l'Enfant au Kivu (ABFEK), Bukavu, South Kivu Province, phone, (+243) 8 53 52 18 25

ANNEX 3: INTERVIEW GUIDE

Interview Guide

To begin, I am going to ask you general questions about life for women who have experienced sexual violence

Construct(s)	Question(s)
Impact of sexual violence on women	1. In general, what is life like (i.e. social conditions) for women after sexual violence? What challenges do they face? How does this change with time? Does it get better of worse or stay the same?
Impact of sexual violence on family	2. How does family life change (or not) for women after sexual violence? How does this change with time? *Probes: Do women live in the same household? If married / partnered: Do they still live with a spouse / partner? How does this relationship change (or not)? If children: Do they still live with their children? How does this relationship change (or not)?*
Differential access to opportunities	3. After sexual violence, do women have the same opportunities in society as before? If not, why not? *Probe: opportunities to go to school, to work, to get married, to have children?*
Visibility	4. How is sexual violence discussed / acknowledged publicly (or not)? How would someone know who in the community is a sexual violence survivor? *Probes: Where / when / with whom is it acceptable to speak about sexual violence?*

Next, I am going to ask you some questions about what people in your community think about sexual violence survivors.

Construct(s)	Question(s)
Labeling	5. In general, what language (terms) do people in your community use when talking about sexual violence survivors? *Probe: Please describe or give examples. Can you give examples of negative language / terms that are used to describe sexual violence survivors? Can you give examples of any positive language / terms?*
Stereotypes (affective, cognitive, behavioral)	6. What are the stereotypes (i.e. beliefs) about sexual violence survivors in your community? What are the stereotypes (i.e. beliefs) about someone who experienced violence, but not sexual violence? *Probe: Can you give examples of stereotypes about sexual violence survivors?*

Prejudice (feeling)	7. In general, how do people feel when they see someone who they suspect or know has experienced sexual violence? Why is this? *Probe: Can you give me an example?*
Discrimination (behavior)	8. In general, how are sexual violence survivors treated in your community? What behaviors and/o actions are directed toward sexual violence survivors? (i.e. finger-pointing, etc) *Probe: Please describe or give examples*

Next, I am going to ask you questions about what some sexual violence survivors have reported to be their experience after violence. I'm interested in hearing your perspective.

Construct(s): Murray *et al*	Questions
Felt stigma: Feelings of worthlessness	**10a. Some survivors of sexual violence have reported feeling "worthless" or that their lives do not have meaning. Why is this? Is this true? Why or why not?** **10b. What gives women a sense of value in your community? How does sexual violence change this, if at all?** *Probe: further around "value" if terminology not well-understood*
Felt stigma: Feeling detached from others	11a. Some survivors of sexual violence may feel separate from others, or disengaged from others. What do you think? Why would this happen? 11b. Do sexual violence survivors participate in regular community activities following the violence? If not, why not? *Probe: Are there certain activities that women may or may not be able to participate in after sexual violence? Can you give me some examples?*
Felt stigma: Avoidance	12. Some survivors of sexual violence may feel the need to avoid others. Why would this be? What effects may this have on a person? *Probe: Can you give me an example?*
Felt stigma: Shame	13. Some survivors of sexual violence may feel ashamed after violence? Why is this? What are other reasons why a woman may feel ashamed? *Probe: Can you give me an example?*
Felt stigma: Feeling badly treated by family	14. In general, how are sexual violence survivors treated by their families? Are they treated differently after violence? If so, in what ways? *Probe: can you give me an example? Why is this?*
Felt stigma: Feeling stigma	15a. Some survivors of sexual violence have reported being stigmatised after the violence. In your community would this be true? If so, how is stigma toward sexual violence survivors manisfested? In your words, what does it mean to be stigmatised?

	15b. What are other reasons / circumstances (besides sexual violence) why someone would be stigmatised in your community? *Probe: can you give me examples?* 15c. What is it about sexual violence that makes survivors feel stigmatised? *Probe: sexual relations outside of marriage, risk of infection?* 15d. NGOs provide many services to sexual violence survivors. Does seeking services from an NGO / community-based organization make sexual violence survivors more likely to experience stigmatisation by others? If yes, how so? *Probes: Please describe or give examples.*
Felt stigma: Feeling badly treated by community	16. In general, how are sexual violence survivors treated in your community? Are sexual violence survivors at further risk of violence in their communities as a result of stigmatisation? *Probes: Please describe or give examples.*
Felt stigma: Feeling rejected by everyone	17. Some women who have experienced sexual violence have reported feeling rejected by everyone. Is this possible? *Probe: Are there certain people who might feel accepted by others? Probe: Are there certain people in the community who do not reject sexual violence survivors?*
Enacted stigma: Abandoned / thrown out	18. Some women who have experienced sexual violence have been abandoned or thrown out of their relationships / families. What do you think about this? Why would this happen? *Probe: In general, how do spouses and/or families react when someone in the family has experienced sexual violence?(if not asked above)*
Enacted stigma: Rejected by husband Enacted stigma: Rejected by family	19. Some women who have experienced sexual violence have been rejected by their spouses and/or families. What do you think about this? Why would this happen? **In general, how do spouses and/or families react when a woman has experienced sexual violence? Do they treat her differently? If so, in what ways?**
Enacted stigma: Forced to live away from children	20. Some women who have experienced sexual violence have been forced to live away from their children. What do you think about this? Why would this happen?

Next, I am going to ask you to share your ideas about what can be done to support women who have experienced sexual violence? I'm interested in hearing your ideas.

Construct(s) Possible intervention	Questions

Reframing / relabeling	21. Are there ways in which to reframe the way sexual violence survivors are labeled? Are there ways to distinguish positive characteristics of sexual violence survivors? If yes, how could this be done? If no, why not?
Restoration of value (self-value, personal value, social value)	22. What could be done to restore a sense of value? *Probe: For herself?* *Probe: What can the spouse can do? The family? The community? The church?* *Probe: Would this come from within or from outside (i.e. her friends, family, community)* *Probe re: social opportunities--work, go to school, marry, have children, participate in social activities*
Connectedness / Engagement	23. What could be done for women who have experienced sexual violence to feel more connected with others? *Probe: more connected with their spouse/partners? More connected with their families? More connected within their communities/social networks?* *Probe: To participate in social / community activities?*
Respect	24. What could be done to show respect to women who have experienced sexual violence? *Probe: by spouse/partner? By other family members? By the community? By the church? Can you give examples of ways in which respect is demonstrated? (In pre-testing find out if can ask about restoration of honor)*
Acceptance	25a. What could be done for women who have experienced sexual violence to decrease stigma? In your own words, what is the opposite of stigma? What would be examples of accepting / respecting women who have survived sexual violence? 25b. Where in the community would a woman who has experienced sexual violence feel accepted? *Probes: in her home, in church, other places in the community?* 25c. What can the community do to make women feel more accepted after sexual violence? *Probes:* What about spouses/partners? What about family? What about the church?
Support from families	26. What are ways in which families could support / help if a family member has experienced sexual violence? What would be most helpful? What is least helpful? *Probe: can you give me some example of how a family could support a family member who has experienced sexual violence?*

Family cohesion	27. What could be done to prevent the break-up of relationships, marriages, and family relationships for women following sexual violence? Do spouses and/or family members experience stigma if a spouse or family member has experienced sexual violence? If so, how does this manifest? *Probe: couple mediation, family mediation, support from the church*
Support from community	28. What are ways in which communities could support / help if someone in the community has experienced sexual violence? What would be most helpful? What is least helpful? *Probe: can you give me an example of how a community could show support to women who have experienced sexual violence?*
Protection from negative impacts of stigmatizing attitudes	29. Are their strategies that women use to protect themselves from the negative impact of stigmatizing attitudes? Can these be learned or taught? Can you give examples?
Compassion	30. In what ways could people show more compassion toward sexual violence survivors? Can you give me examples? What could be done to change the experiences for women after sexual violence?

ANNEX 4: SRH AND SGBV

SRH services in eastern DRC are lacking despite the improvements in the healthcare system and healthcare funding in this region. Here key details on SRH, SRH service Delivery, and the SGBV response is provided.

I. SRH INDICATORS

One study shows that 14.5% of women's and 20.4% of men's first sexual experience was before the age of 14.[45] The experience was consensual for 84.1% of men and 61.6% of women. In 2017 the maternal mortality ratio per 100,000 live births in the DRC was 473 (23). The unmet need for family planning in 2021 among reproductive aged women in the DRC (ages 15-49) is 21%, and modern contraceptive use is 12%.[24] In one study in eastern DRC only 20% of examined health facilities provided adequate contraceptive services.[38] IMAGES reports that 10% of men and 15% of women used a condom in the last year.[45] More than 60% of both genders hold women responsible for avoiding pregnancy.[45] Abortion rates were 56 per 100,000 in Kinshasa in 2016; however, this is likely falsely low given the illegality of abortion which drives the practice underground.[77] Among women and girls aged 15 to 24, 21.6% have comprehensive knowledge of HIV, and 84% are involved in contraceptive decision making.[24] In 2020 the adolescent birth rate was 138 per 1000 adolescent girls (ages 15 to 19), and 26.7% of women aged 20 to 24 report giving birth before the age of 18.[24] In the DRC the 2021 the fertility rate is 5.6 for each woman.[24]

Progress in sexual and reproductive health and rights (SRHR) in the DRC is lagging. Target 3.1 of the SDGs aims to decrease the global maternal mortality ratio to less than 70 per 100,000 live births.[78] SDG 3.7 aims to have universal access to SRH care by 2030. To achieve SDG 5 (gender equality and empowerment of women and girls), the DRC must work towards eliminating harmful practices such as child marriage, ensuring universal access to family planning and SRH services, and reducing the adolescent birth rate.[79] Specifically, SGD 5.2 aims to eliminate all forms of VAW.[79] The presented SRHR indicators demonstrate poor health outcomes and gender disparities and are not line with the SDGs 2030.

II. SRH SERVICE DELIVERY

a. Antenatal and Obstetrical care

Eastern DRC offers antenatal care (ANC) in line with the national average. In North Kivu 95% of and in South Kivu 90% offer ANC. WHO guidelines recommend five health facilities per 500,000 people be able to provide Basic emergency obstetrical care (BEmOC). BEmOC was available only in the hospital in the 26 health facilities (25 health centres and 1 hospital) reviewed in the Masai health zone in North Kivu.[38] In North and South Kivu a basic service package requires family planning, ante and postnatal care, and obstetric care for normal deliveries.[39] A complimentary package includes emergency obstetrical care and gynaecologic care but delivery depends on resources often obtained through support from INGOs and religious organisations.[39]

b. Abortion and Post Abortion Care

Abortion is illegal unless it is done to preserve health which includes cases with risk to maternal life, mental health, rape, incest or foetal impairment;[80] however, the reality in many parts of eastern DRC is that abortion provided by trained healthcare professionals is only done in cases where the mother's life is in danger.[81] Limitations on abortion provision lead to unsafe abortions. Women in eastern DRC were found to use herbs or medicines outside of the formal healthcare system to terminate pregnancies.[82] Misinformation, lack of awareness of the legal context of abortion, and lack of availability awareness may contribute to this.[82] Adequate provision of PAC was only found in about half of examined health facilities in one study.[38] There are international NGOs that provide training, contraception, PAC supervision, supply provision and community engagement in eastern DRC.

c. Adolescent SRH

Adolescent fertility rate in DRC is among the highest in sub-Saharan Africa, yet SRHR for adolescents is not seen as an urgent need.[39]Adolescents and young people face a perceived and real barrier to FP services as teenage girls are often required to come with mothers and may experience rejection from FP services as sex is not deemed to be something they should be involved in.[81,83] Only 15% of health zones nationally offer youth friendly SRH services[83] and those that do are mostly run by NGOs in eastern DRC.[39] Family planning is more easily accessible for married women who may be required to provide a letter of consent for services if their husband is not present.[81]

d. Family Planning

MOH policy dictates that health centres must provide all short and long-acting contraceptives.[84] FP is provided by governmental and non-governmental institutions that work with each other and NGOs that provide FP services autonomously.[81] FP interventions such as provision of cycle beads, male and female condoms, and spermicides are delivered by trained community health workers (CHW).[37] Less trained CHWs provide community mobilisation and some level of education.[37] Low rate of FP availability and services in the country and unequal distribution in

rural areas in eastern DRC.[81] A mixed methods case study in the Masisi District North Kivu DRC and other humanitarian settings showed that only that a functioning family planning delivery service point was found in only 20% of cases[38]. This is constituted by availability to provide IUDs, OCPs, injectable contraception, and implants by a trained healthcare professional[38].

III. SGBV RESPONSE

Medical care for SGBV survivors exists in health centres and specialised hospitals in eastern DRC. Much of this care focuses on treatment of specific conditions like HIV and fistulas which are SGBV consequences. These services may also provide psychosocial support and assist patients with access to and navigation of the justice system. Women who are not SGBV survivors may suffer from these conditions and require services, but these specialised hospitals may only offer services to survivors.[40] This limits service access to SGBV survivors only and provides an incentive for people who have not experienced SGBV to claim being survivors in order to access SRH services.

The government continues to condemn SGBV and in 2019 signed the Congolese National Police Action Plan on the Fight against Sexual Violence to prevent perpetration of SGBV by the police and enhance their capabilities in responding to SGBV.[1] Physicians for Human Rights (PHR) established the Program on Sexual Violence in Conflict Zones in the DRC that focuses on capacity building for medicolegal documentation, avoiding re-traumatisation of survivors, and evidence collection. It also aims to improve collaboration between sectors. Intersectoral collaboration has proven helpful in prosecuting some cases of SGBV.[75]

ANNEX 5: MURRAY ET AL.[21] STIGMA SCALE

The social experience of SGBV survivors is key in their mental health and psychosocial well-being, and yet most mental health assessments such as those used for post-traumatic stress disorder (PTSD) focus on the factors relating to the traumatic event itself and not the pre and post violence experience.[13] One study adapted a HIV stigma measurement tool to assess stigma after sexual violence; however, an analytical framework or tool focused specifically on SGBV stigma that accounts for socio-cultural contexts is not available.[21,52] Murray et al.[21] developed two locally relevant sexual violence stigma scales in eastern DRC through exploratory and confirmatory factor analyses that measured felt stigma and enacted stigma. They defined felt stigma as a combination of perceived and internalised stigma which may explain some of the overlap of the manifestations of these stigma types seen in the literature and data. After analysis the enacted stigma scale encompassed 4 stigma items (Figure 10) and 8 felt stigma items. They showed that SGBV survivors had 0.58 points higher stigma score compared to those who did not have experiences with SGBV which represented a 50% increase in stigma.[21] They noted that the scales could be used in future research, though there were several limitations.[21] These include enacted stigma measuring only acts of rejection with a lack of other types of discrimination such as gossip, labelling, or refusal of services. Additionally, their research focused on SGBV survivor accounts of stigma and not community perceptions.

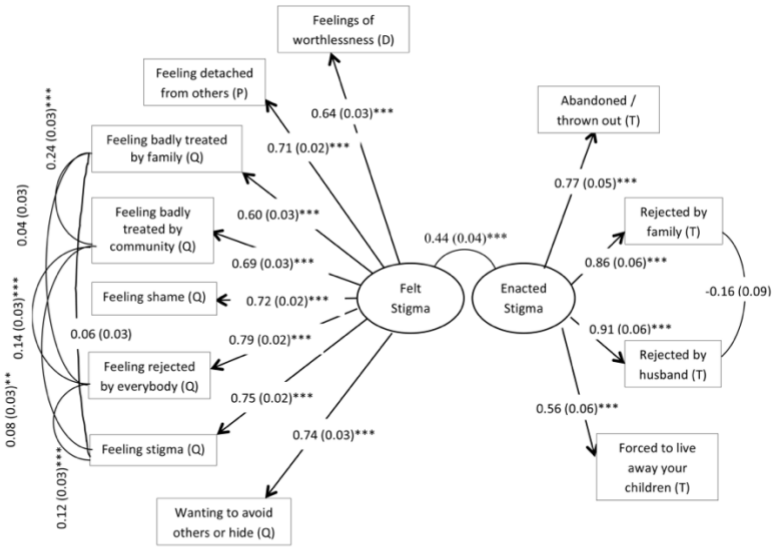

Figure 1. Confirmatory factor analysis of revised stigma scales (n=744)
*p-value <0.05, **p-value<0.01, *** p-value<0.001
D: from HSCL-25 depression subscale
P: from HTQ trauma scale
Q: from qualitative study (not on any other scale)
T: from traumatic exposures questionnaire

FIGURE 10: MURRAY ET AL.[21] 'CONFIRMATORY FACTOR ANALYSIS OF REVISED STIGMA SCALES' (P.502)

ANNEX 5: FIGURES

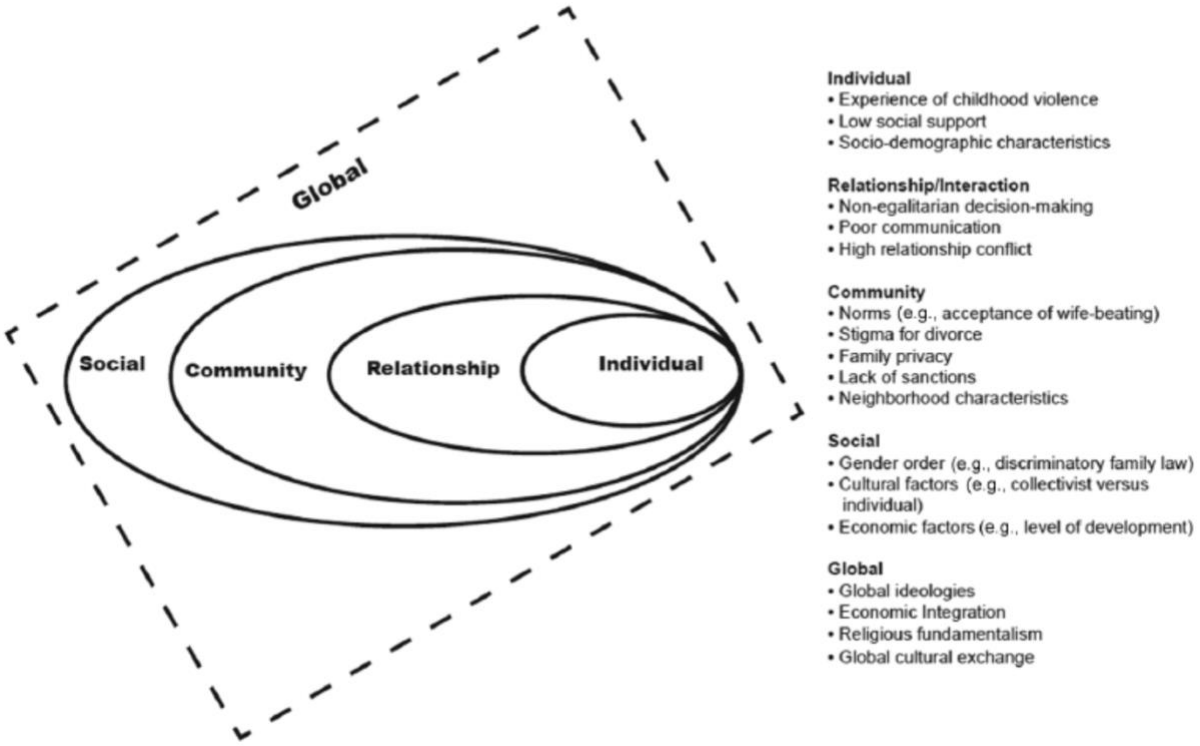

FIGURE 11: FULU ET AL.[61] 'ECOLOGICAL MODEL WITH INTEGRATED GLOBALIZED FRAMEWORK' (P.1445)

ANNEX 6: TABLES

TABLE 2: EXAMPLES OF ORGANISATIONS FIGHTING SGBV IN EASTERN DRC[31,40,50,67,69,75,83,85]

ORGANISATION TYPE	EXAMPLES
Governmental	MOH, Ministry of Gender, Family, and Children, Congolese National Police
International organisations	UN Women, UNFPA, UN Office of the Special Envoy for the Great Lakes, UNICEF, UNHCR, the World Bank, International Conference on the Great Lakes Region, MONUSCO, SIDA
NGOs	Panzi Foundation, HEAL Africa, PHR, Congo Men's Network (COMEN)
INGOs	CARE, Save the Children, Marie Stopes International, WAHA International
Other Humanitarian	International Committee of the Red Cross, MSF

TABLE 3: EDUCATIONAL ATTAINMENT DRC 2016[23]

EDUCATION LEVEL	MALE	FEMALE	TOTAL
Bachelor's degree (age 25 or older)	5.60%	1.50%	3.50%
Post-secondary (age 25 or older)	13.60%	5%	9%
Lower-secondary (age 25 or older)	65.80%	36.70%	50.70%
Primary school (age 25 or older)	78.4%	49.90%	63.60%
Literacy rate (age 15 or older	89%	66%	77%

TABLE 4: EXAMPLES OF INTERNATIONAL AND NATIONAL AGREEMENTS AND LAWS[22,50]

International	National
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)[22]	National Action Plan for the implementation of UN Security Council Resolution 1325 On Women Peace and Security
International Criminal Court (ICC) Rome Statute[50]	2006 Law Relative to Sexual violence
Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (MAPUTO protocol)[22]	2006 updated constitution
Beijing Declaration and Platform for Action	2016 Family Code

TABLE 5: BARRIERS TO JUSTICE FOR SURVIVORS[50]

BARRIER	EXPLANATION
Lack of reparations	Survivors often do not get the reparation that they are due. This may happen because of funding issues, corruption, survivors not attending hearings and other reasons.
Medical exam	Though not legally required, variations in judicial interpretation of the law may mean that courts ask survivors to provide medical exams proving they have been assaulted. This can be problematic as the physical evidence of sexual assault may not exist or may disappear after a certain amount of time and numerous barriers to seeking healthcare exist for SGBV survivors.
Lack of trust	Survivors may avoid prosecution due to lack of trust of police or faith in the justice system. Though efforts have been made to hire women into the Criminal Investigation Department to facilitate trust, there are still few women employed.
Survivor Finances	Survivors are often responsible for legal fees. Costs of getting to courts may also be unaffordable.
Location	There are limited courts available in rural areas.
System funding	Training of law enforcement, judicial workers and lawyers has been done by NGOs, but funding to pay workers can be a barrier.
Language	Court documents and proceedings are in French which can be a barrier to survivors who speak other languages.
Lack of Witness Protection	There is no witness protection system in the DRC which means survivors who come forward may put themselves at additional risk.
Stigma	Survivors may fear stigmatisation from the community if they attend court. Though they are not required to be there, chance of reparations is low if they are not present.
Mental toll	The mental toll of going through the system and dealing with the above barriers as well as risk of re-traumatisation may prevent survivors from seeking justice or cause them to drop out of the process.

TABLE 6: EFFECTS OF SGBV ON SURVIVORS[17,45,86]

PHYSICAL	MENTAL	PSYCHOSOCIAL
- Pain - Bleeding - Death - STIs (including HIV) - Urinary tract infections - Fistulas - Genital injury - Unwanted pregnancy - Pregnancy complications - Other chronic conditions	- PTSD - Depression - Anxiety - Substance abuse - Sleep disturbances - Self-harm - Suicidal ideation - Low self-worth - Shame - Fear - Insomnia	- Rejection from family or community - Economic insecurity - Stigma - Victim blaming - Less satisfaction in future relationships - Higher risk of future violence

TABLE 7: OBJECTIVES AND METHODS

OBJECTIVES	METHODS USED
Identify factors that contribute to SGBV stigmatisation in eastern DRC.	Literature review; primary qualitative data analysis
Evaluate the types of stigma experienced by SGBV survivors in eastern DRC.	Literature review; primary qualitative data analysis
Identify what stigma practices people engage in to stigmatise SGBV survivors in eastern DRC	Literature review; primary qualitative data analysis
Identify examples of successful anti-stigma interventions in the DRC and/or other settings.	Literature review; primary qualitative data analysis
Draw conclusions and recommendations for future interventions and research.	Literature review; primary qualitative data analysis

TABLE 8: KEYWORDS

OBJECTIVES	COMBINATIONS OF KEYWORDS
Identify factors that contribute to SGBV stigmatisation in eastern DRC.	Democratic Republic of Congo, gender norms, culture, gender-based violence, sexual violence, deconstructing, stigma, factors influencing, conflict
Evaluate the types of stigma experienced by SGBV survivors in eastern DRC.	Stigma, manifestations, types of stigma, sexual and gender-based violence, Democratic Republic of Congo
Identify stigma practices used	Enacted stigma, types of stigma, sexual and gender-based violence, Democratic Republic of Congo, community
Identify examples of successful anti-stigma interventions in the DRC and/or other settings.	Stigma, anti-stigma, interventions, effectiveness, health, conflict, HIV, teen pregnancy, child marriage, sexual and reproductive health, success, community, support
Provide recommendations for future interventions and research	Stigma, anti-stigma, interventions, sexual and gender-based violence, effectiveness, health, economic, male involvement, community, mediation, dialogue

TABLE 9: RESPONDENT DEMOGRAPHICS

RESPONDENT	COMMUNITY ROLE	GENDER
1	Religious leader	Male
2	Beneficiary	Female
3	Organisational staff	Male
4	Religious leader	Male
5	Health professional	Female
6	Community leader	Female
7	Community member	Female
8	Community member	Male
9	Community member	Male
10	Community member	Male
11	Community leader	Male
12	Community leader	Male
13	Organisational staff	Female
14	Community member	Female
15	Beneficiary	Female
16	Community leader	Male
17	Community leader	Female
18	Community leader	Female

TABLE 10: SLEGH ET AL.[45] 'ATTITUDES RELATED TO SEXUAL VIOLENCE (PERCENT AGREE OR PARTIALLY AGREE)' (P.53)

	MEN	WOMEN
A woman who is raped has provoked this by her own attitude	35.0	6.4
Sometimes, women want to be raped	29.6	10.3
A man can force a woman to have sex and she may enjoy it	29.9	6.5
When a woman does not show physical resistance when she is forced to have sex, you cannot speak of rape	45.9	26.5
In any rape case one would have to question whether the victim is promiscuous	47.1	29.9
A man should reject his wife when she has been raped	43.4	37.4
A woman who does not dress decently is asking to be raped	74.8	64.8
A man has a right to sex even if the woman refuses	48.0	62.2