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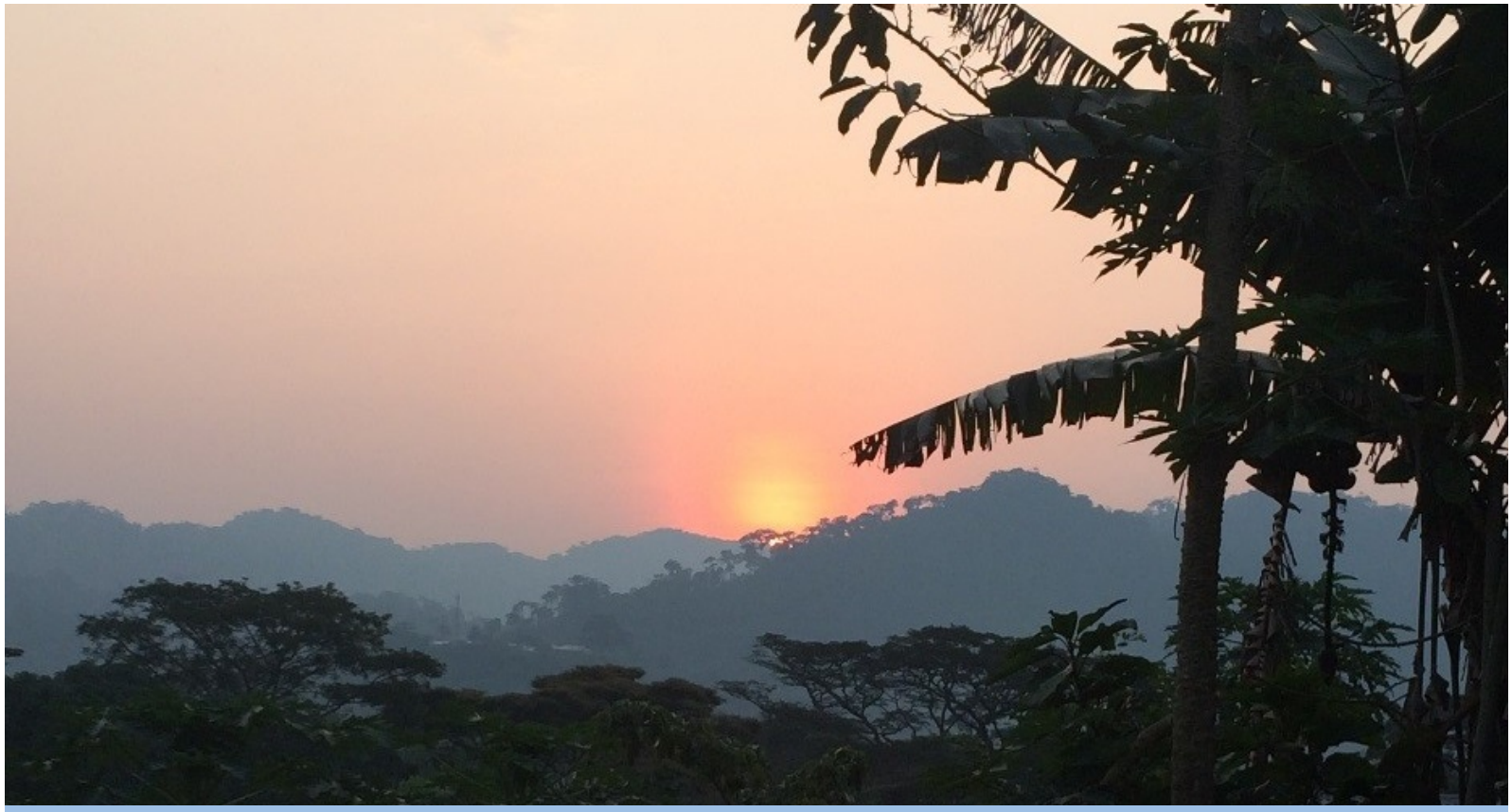

A Population-Based Household Study to Assess Practical Strategies of Prevention and Response to Sexual and Gender Based Violence in Katana, Walikale, and Karisimbi Health Zones, DRC

September 2016

This publication was produced for review by the United States Agency for International Development. It was prepared by IMA World Health.

September 26, 2016

Cooperative Agreement No. # AID-623-A-10-00012-00

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Cover Photo Credit: "Walikale" Lynn Lawry

List of Acronyms

ABA	American Bar Association
BCZS	Bureau Central de Zone de Santé (Central Office)
CDF	Congolese Franc
CPT	Cognitive processing therapy
DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
FDLR	Democratic Force for the Liberation of Rwanda
FY	Fiscal Year
HA	Health Area
HGR	General Reference Hospital
HIV	Human Immunodeficiency Virus
HSCL-25	Hopkins Symptom Checklist (25 Item)
HTQ	Harvard Trauma Questionnaire
HZ	Health Zone
IP	Implementing Partner
IPV	Intimate Partner Violence
Mai Mai	Armed group in Eastern DRC
MNCH	Maternal, Newborn, Child Health
MOH	Ministry of Health
NGO	Non-Governmental Organization
OFDA	Office of U.S. Foreign Disaster Assistance
OSC	Overseas Strategic Consulting, Ltd.
PEP	Post Exposure Prophylaxis
PF	Panzi Foundation
PHC	Primary Health Care
PPSSP	Programme de Promotion des Soins de Santé Primaires
PTSD	Post-Traumatic Stress Disorder
SBCC	Strategic Behavior Change Communication
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infection
SV	Sexual Violence
ULPGL	Université Libre Des Pays Des Grand Lacs
UPC	Patriotic Union of Congolese
USAID	United States Agency for International Development
USD	United States Dollar
USHINDI	We Will Overcome (Swahili)
VSLA	Village Savings and Loans Associations
WHO-EPI	World Health Organization Expanded Programme on Immunization
WHO	World Health Organization

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Executive Summary

Evaluation Objectives

IMA World Health (IMA) contracted Overseas Strategic Consulting, Ltd. (OSC) in May 2016 to conduct a quantitative baseline analysis of three new health zones where IMA and its partners will expand into in August 2016. IMA requested a study to determine the prevalence rates of the forms of sexual gender based violence (SGBV) in the new areas of implementation. The results of this study will be used to further bolster the results of the previous impact evaluation, which determined the impact of Ushindi from the previous five years, lessons learned, and cost effective and impact-focused interventions to pilot in three new health zones in United States Agency for International Development (USAID) priority areas.

The objectives of the study were defined as follows:

- Determine the evidence-based prevalence of all forms of gender based violence in Walikale, Karisimbi and Katana health zones where IMA will implement Ushindi
- Determine the sex differences with regard to SGBV rates
- Determine the evidence-based prevalence of trafficking in these health zones
- Determine the risks for SGBV and trafficking
- Determine the prevalence and nature of mental disorders in these health zones and especially among survivors of SGBV
- Determine the differences in the rates of SGBV and mental disorders between male and female participants
- Determine what types of health, social, educational and employment programming are available for SGBV survivors including special groups such as male survivors, young girls among others
- Determine the health, social, educational, legal and employment programming gaps that exist in the community at present for survivors
- Determine the culturally nuanced potential barriers that exist to the identification and treatment of mental disorders and gender-based violence

Project Background

From July 2010 through July 2015, IMA implemented a USAID Cooperative Agreement, Ushindi: Overcoming Sexual & Gender-Based Violence (SGBV) in Eastern Congo.[1] The Ushindi program implemented a holistic approach integrating psychosocial, medical, legal and economic activities to support survivors of SBGV. The scope of work intended to 1) increase access to timely and quality comprehensive services for individuals affected by SGBV (psychosocial, medical, legal, and socio-economic assistance); 2) improve the quality of services and interventions for individuals and communities affected by SGBV; and 3) reduce the vulnerability of individuals to future acts of abuse and violence. This five-year program was implemented in four provinces among 10 health zones with 1.2 million beneficiaries. In these health zones, the program was included in 106 health areas and 106 health centers (Table 1). The three implementing local partner organizations were:

- **Heal Africa** (based in Goma): works in North Kivu and Maniema provinces
- **Fondation Panzi** (PF; based in Bukavu): works in South Kivu province

[1] Ushindi means to overcome or victory in Swahili.

- **Programme de Promotion des Soins de Santé Primaires** (PPSSP**;** based in Beni): works in North Kivu and Orientale provinces

The Ushindi project covered 10 health zones (HZ), 108 health areas (HA) and 1,118 villages with a total beneficiary population of 1,083,071 people for the first four years (Table 2).[2,3] In 2013, USAID decreased funding levels and the geographic scope of Ushindi which led the program to decrease its geographic scope to seven health with a total beneficiary population of 858,733 people. On January 30th, 2016, IMA received additional funding to complete an amended scope of work, which would be used to continue 'scaled down' assistance to the current seven health zones, consolidate data from five years of intervention for focused analysis and research, measure the impact of the previous five years of treatment and prevention activities on survivors of victims of SGBV as well as on the prevalence of SGVB in the communities served. This additional 4.5 million USD for February 2016 through July 2017 also included focused research, the addition of cognitive processing therapy (CPT) and the expansion of services into three new health zones: Karisimbi, Katana, and Walikale.

Methods

The study was reviewed and approved by the Comité D'Ethique, Université Libre Des Pays Des Grand Lacs (ULPGL) Goma (Annex I).[4] Waiver of documentation of consent was granted by the review board and therefore, verbal informed consent was obtained from all participants. No identifying information was on the survey. The survey utilized numeric codes for each participant that could not be tied back to any participants. Data was kept anonymous at all times.

This study targeted male and female household members (≥18 years of age or emancipated minors) based on the sampling frame who resided in any of the randomly selected health areas and villages/or avenues in Katana, Walikale, or Karisimbi.

The study used a 90X10 randomized population-based cluster sampling strategy to decrease the variance observed in a typical 30X30 sampling strategy (or 900 household surveys). Weighting corrected for potential overestimation and/or underestimation of prevalence data. The quantitative baseline was a cross-sectional study conducted in randomly selected six of twelve health areas where IMA implementing partners would extend the Ushindi program in Katana (South Kivu Province), Walikale, and Karisimbi health zones in North Kivu Province, DRC. Villages were randomly selected from the list of villages supplied by the Chief Medical Officer in each health zone associated with the Bureau Central de Zone de Santé (BCZS). However, a few of the villages were inaccessible due to long distances that could only be covered on foot and/or for security reasons; therefore, only villages accessible could be randomized. For any villages not accessible, the nearest accessible neighbor was used for substitutions.

Instruments were developed in collaboration with IMA and its implementing partners and included a quantitative survey and qualitative survey to capture the nuance and social norms in regard to SGBV. The quantitative survey was written in English and translated to Kiswahili to account for culturally sensitive wording while holding true to the survey intent. The Hopkins Symptom Checklist (HSCL-25) was used to assess depression (15 items) and anxiety (10 items) and the Harvard Trauma Questionnaire (HTQ) to assess PTSD symptoms (16 items). A Semi-structured directed qualitative instrument was

[2] 2 HZs (Lolwa and Komanda) were treated as single project area with one base and one set of staff thus creating nine project areas.
[3] 12 HAs per project area.
[4]The coordinator is Dr. Muteho Kasongo Marina. Email: kambmut@yahoo.com. Tel: +243850200554, and +243998688632.

used to add nuance to very complicated issues such as SGBV and mental health in the areas surveyed. A total of 37 key informant interviews were completed, and included village and avenue chiefs, male and female community members, survivors, a witch doctor, a traditional birth attendant, and Ushindi program staff.

The field teams in each health zone were composed of the data collectors that successfully completed a 3-day training and were supervised by Dr. Lynn Lawry, consultant, and the Ushindi staff. In each health zone, the field teams surveyed 300 households from 30 villages in six health areas. Each team covered one health area and five villages per day with each data collector completing 10 surveys per day; each taking approximately 25 minutes if no sexual violence was reported and approximately 35 minutes if sexual violence was recorded.

Households within villages are sampled according to the World Health Organization Expanded Programme on Immunization (WHO EPI) Method.[5] That is, data collectors began in the geographic center of the village and used a randomization device (Figure 4) to pick a direction to reach the first sampling unit. Each subsequent survey was conducted in the household whose door was nearest (to the right) of the door of the previous household. This continued until all 10 surveys within the cluster were completed, with records kept of refusals, ineligible households, and lack of availability.

Data analysis was performed using the "Survey" module within the statistical software package R, an open-source version of S-plus.[6] Analysis involved the estimation of weighted population and subpopulation means and percentages with confidence intervals, as well as the development of logistic regression models for the calculation of weighted odds ratios.

Limitations

Although data collectors were careful to explain that there will be no material or other gain by participation in the assessment, respondents might have exaggerated or underestimated responses if they believed it would be in their interest to do so.

In some instances (e.g., when interviewing intended beneficiaries), responses might have been constrained due to fear of reporting or stigma such as with questions around SGBV, however, based on our qualitative study, it was noted that SGBV was normalized and responses were less likely to be constrained. Although it is possible that differences within the interviewer due to ethnicity, sex, or overall comfort level during the interview could bias the results, this was largely mitigated through the use of local data collectors, properly trained in interviewing techniques who did not interview in areas they were familiar with.

The quantitative household survey represents adult men and women as well as children in the accessible health areas within Katana, Walikale, and Karisimbi health zones of North and South Kivu, DRC. It will not be possible to extrapolate the data to represent other health areas not within the sampling frame or other provinces. Furthermore, individual and group semi-structured qualitative interviews represent individual experiences of those most willing to speak, and cannot be generalized beyond those interviewed.

[5] World Health Organization. Facilitator Guide For The EPI Coverage Survey: Training For Midlevel Managers. WHO Expanded Program on Immunization (EPI). 1991;WHO/EPI/MLM/91.11.
[6] Lumley T. Survey Analysis in R. 2008. http://faculty.washington.edu/tlumley/survey. Accessed June 15, 2008.

Finally, as identified by Bass et al.[7] the use of mental health measures of unknown validity for identifying clinical cases of post-traumatic stress disorder (PTSD) and combined depression and anxiety, could be non-pathologic reactions to extreme circumstances, and it is therefore unclear what proportions of participants actually met clinical criteria. And although the clinical meaning of standard cutoff scores is therefore uncertain, the score itself can still be meaningfully interpreted; 1.75 indicates that respondents are reporting that symptoms occur, on average, nearly a "moderate" amount of the time (a score of 2.0). Furthermore, this study used these screening tools to estimate the proportion and/or burden (not diagnosis) of possible mental symptoms within the specific population and not individuals. The nature of this study (a multistage clustered random sample survey) allows for the determination of association of population characteristics, but not causality.

Findings

This randomized population-based baseline survey was designed to determine the prevalence of all forms of SGBV for the health zones where Ushindi will be implemented. Based on the methodology used, the findings are generalizable to all health areas of Karisimbi, 12/14 health areas in Katana and 8/14 health areas in Walikale or 727,754 persons in the three health zones. In total, 900 households participated in the survey with an overall response rates of 96.8%.

The prevalence of all forms of SGBV including intimate partner violence (IPV) and trafficking were prevalent not just among women but also among men and children. Symptoms of depression/anxiety and PTSD were more prevalent among women and were elevated in association SGBV, sexual violence, and IPV. Substance abuse, especially alcohol, is a problem among women and men and is closely tied to violence as a precipitant and a consequence of the violence, especially IPV. Harmful traditional practices and negative cultural norms have become normalized and justified by the community. Although usually it is thought that these negative norms are perpetrated by men, it is clear from this study that women also hold some responsibility in propagating negative social norms in the areas surveyed and some of these negative social norms affect men and boys in addition to women and girls. The key findings of the study with population estimates of those affected are summarized in the following:

Finding	Weighted Prevalence Rate[8]	Weighted Prevalence Rate of mental health associated with SGBV[9]	Estimated Population Affected
SGBV			
Women	31.6%		54,384 Women
Men	32.9%	NA	38,514 Men
Children	61.0%		299,438 Children
Sexual Violence			
Women	11.8%		30,313 Women
Men	3.1%	NA	12,789 Men
Children	11% overall		59,103 Children

[7] Bass J, Annan J, Murray SM, Kaysen D, Griffiths S, Cetinoglu T, Wachter K, Murray LK, Bolton PA. Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. N Engl J Med 2013; 368:2182-2191. DOI: 10.1056/NEJMoa1211853

[8] Lifetime rates for SGBV, SV and IPV, suicidal ideation and suicide attempts. Trafficking and Substance abuse represent rates in the last year. PTSD and depression/anxiety rates represent rates in the month prior to the survey.

[9] Presented for statistically significant differences between those who report an abuse compared with those who do not report the abuse.

	7.7% Karisimbi 10.5% Katana 20.5% Walikale		
IPV **Women** **Men**	 22.6% 25.0%	 NA	 43,544 Women 29,779 Men
Trafficking **Women** **Men** **Children**	 12.9% 7.2% 5.0%	 NA	 18,286 Women 12, 432 Men 24,224 Children
Substance Abuse **Women** **Men**	 21.1% 38.9%	 NA	 64,081 Women 64,081 Men
Depression/Anxiety **Women** **Men**	 31.0% 19.7%	42.6% SGBV 62.3% SV 43.8% IPV	 50,237 Women 17,544 Men
PTSD **Women** **Men**	 26.6% 15.9%	62.3% SV	 45,285 Women 14,865 Men
Suicidal Ideation **Women** **Men**	 29.3% 24.1%	49.6% SGBV 66.3% SV 49.9% IPV	 48,235 Women 34,761 Men
Suicide Attempts **Women** **Men**	 19.6% 7.9%	39.4% SGBV 45.8% SV 38.6% IPV 31.7% Trafficking	 33,593 Women 15,966 Men

Major differences among health zones included symptoms of depression/anxiety and PTSD which were four times higher in Walikale than all other health zones and substance abuse which was highest in Karisimbi (50% higher than Katana and twice as high as Walikale).

Based on population estimates and the sexual violence rates reported in the three health zones we surveyed, an estimated 12,000 men and 30,000 women may be at risk for sexual violence. Despite recognition that men suffer sexual violence and a previous study documenting the rates of male SGBV in Eastern DRC, programming could do more to meet the unique needs of male survivors. Inclusion of men in sexual violence definitions, policies and protections in addition to targeted programs to address their needs is a necessity.

This survey shows that not only is intimate partner violence in Karisimbi, Walikale, and Katana is widespread, but is normalized and justified, not only by men but also women within these societies. Given that 43,544 women and 29,779 men are at risk in the areas surveyed based on population estimates, the following serve as recommendations to address this issue in the three health zones surveyed.

This study is the first to document the prevalence of trafficking and its forms in Walikale, Katana, and Karisimbi among men, women and children in the survey areas. Among respondents the most common forms included debt bondage, labor trafficking and sex trafficking in equivalent proportions. By far, the most common form of labor trafficking was forcing women and girls to work in bars and bistros where they were at risk for sexual violence. The fact that there was a statistically significant risk for suicide attempts associated with trafficking suggests the trauma associated with this act is devastating. With an

estimated 18,286 women, 12,432 men and 24,224 children affected in the last year and in the areas surveyed, the programmatic implications and services needed to address this in these three health zones is not insignificant.

SGBV, and IPV all had significant associations to mental health disorders in this study including depression/anxiety, PTSD, suicidal ideation and suicide attempts. This study cannot show causality, and assesses the prevalence of mental health symptom criteria (not diagnosis). However, the strong and persistent associations implore health care providers to deliver a health care strategy that addresses those who have experienced sexual violence in addition to mental health services as necessary components of recovery and rehabilitation for survivors.

Respondents clearly stated that the mental health programs offered in their area were insufficient to meet the needs of the community. They had few barriers to accessing mental health care with the majority stating that "nothing would stop them." The perception of stigma as a barrier to care was quantitatively insignificant and therefore is not an issue in reality for those who need care.

Social norms and values influence how women and children are protected or harmed. Social norms do not function in isolation but are defined in local culture and tradition as a type of cultural identity. Changes to these norms, requires engagement and consensus over time to make positive changes in social norms with regard to women, early marriage, protection of women and children, and SGBV[10]And although usually it is thought that these negative norms are perpetrated by men, it is clear from this study that women also hold some responsibility in propagating negative social norms in the areas surveyed and some negative social norms affect men and boys in addition to women and girls.

Conclusions and Recommendations

SGBV in DRC is prevalent and has unique cultural factors that put men, women, girls and boys at risk for all forms of SGBV. The physical, sexual, reproductive, and mental health consequences are many. Normalized and justified, negative cultural norms have created an environment for SGBV to flourish and continue from generation to generation. This study shows that SGBV is not a small problem in the areas surveyed and requires urgent and contextualized action. Ushindi which has been effective in addressing the overwhelming needs of survivors, should expand to include the inclusion of men and boys as survivors and address other facets of risk such as harmful traditional practices, substance abuse and myths concerning rape. In doing so, it is likely that the interventions designed to strengthen community mobilization and interpersonal communication will have a positive effect on barriers to effective behavior change and ultimately decrease the prevalence and scope of SGBV.

SGBV Recommendations

- Better identification of SGBV survivors within families with recognition of both conflict and the largely community-based SGBV identified in this study
- Improved SBCC to address the community-based violence, harmful traditional practices, rape myths and gender roles in order to adjust negative norms into positive behavior change using the tenants of SBCC
- Increasing the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change

[10] World Health Organization. Changing cultural and social norms that support violence. Available at: http://www.who.int/violence_injury_prevention/violence/norms.pdf

- Work with the Ministry of Health (MOH) and traditional leaders to discourage early marriage, all forms of SGBV and to understand the health and protection consequences of SGBV based on these data
- Integrate SGBV services in maternal, newborn, child health (MNCH) programs to increase referral and identification of those at risk and/or survivors[11]
- Adapt SGBV medical guidelines to include men which is a unique opportunity to be the "first" to develop such guidelines
- Adapt already developed SGBV services to include men and boys
- Improve identification of children at risk for SGBV especially in Walikale
- Further develop child friendly services and guidelines that meet the developmental needs of child survivors
- Consider school-based programs to reach children with SBCC especially in Walikale where child violence rates are exceedingly higher than the other health zones
- Given the elevated numbers of children who have suffered SGBV and sexual violence, the justice sector will need to implement child protections for children in the justice system

IPV Recommendations

- Identification and follow up with pregnant women to evaluate SGBV/IPV risk in the community and at MNCH services to provide early intervention services to at-risk families
- Work with the MOH traditional leaders to address the widespread IPV in these health zones and the accepted normalization and justification of this type of violence
- Through community based programs, such as the *Noyaux Communitaire*, and in concert with local partners, develop an SBCC approach to address normalization of IPV within the community among women and men
- Develop programs to identify and treat community members with substance abuse as means to decrease risks for substance related violence
- Continue to promote social and economic empowerment of women and girls through education, village saving and loans programs (VSLA) especially for those who have suffered violence
- Increasing the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change
- Consider school based programs to decrease violent behavior in children associated with IPV later in life[12]

Trafficking Recommendations

- Increasing the capacity of local partners to adapt their traditional communications programs to SBCC that focuses on behavior change for trafficking
- Promote community engagement through the *Noyaux Communitaire* to increase awareness of trafficking rights, laws and government responsibilities through a contextualized SBCC campaign using local partners

[11] In this study 17% of women reported a pregnancy related to SGBV.

[12] Evidence suggests that programs aimed at parents, including home visits and education, can reduce or prevent child abuse and maltreatment which has the potential to reduce child conduct problems and violent behavior later in life, which may be associated with IPV perpetrated by men. See: Maas C, Herrenkohl TI, Sousa C. Review of research on child maltreatment and violence in youth. Trauma, Violence & Abuse, 2008, 9(1):56–67.

- Target mining operations to extend the reach of Ushindi and identify and treat women, men and children who are at risk for trafficking or have been trafficked
- Support community-level savings and loans and microfinance programs to protect against exploitative lending practices that put communities at risk for trafficking as a means for survival and push parents to "give" their children into situations that are exploitative
- Consider income generation projects through the *Noyaux Communitaire*, especially agriculture production to lessen the need for food which was an important reason reported for staying or being recruited into forced labor and sex trafficking
- Work with traditional leaders to identify, report, refer and address potential cases of human trafficking
- Identified trafficking cases will need referral to the justice system through ABA

Mental Health Recommendations

- Continued integration of lay counselors and mental health services for survivors with Cognitive Processing Therapy (CPT) in Walikale given the significantly elevated rates of mental health disorders
- Substance abuse programming in all health zones to address the risk of substance use and subsequent violence and the potential likelihood of substance abuse among survivors but especially in Karisimbi given the exceptionally high rates of substance abuse in this health zone
- Community outreach programming to identify at risk individuals
- Substance abuse training for health care providers, local Ushindi partners, lay counselors and members of the *Noyaux Communitaire*

Social Norm Recommendations

- The roots of sexual violence are multifaceted, pervasive, and interrelated. Social norm interventions focused on boosting self-efficacy through persuasion, social modeling, and experience mastery need to be combined with the higher level communications interventions to form a comprehensive set of strategic engagements that will affect significant behavior change to decrease the rates and consequences of SGBV
- Enhanced SBCC to address the community-based violence, harmful traditional practices, rape myths and gender roles in order to adjust negative norms into positive behavior change using the tenants of SBCC
- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change especially around victim blaming and harmful traditional practices
- SBCC programming focused on social norms will need to be emphasized in Walikale given the significant difference in agreement with rape myths compared with the other health zones

Background

History of the Ushindi Project

IMA was awarded a USAID Cooperative Agreement, Ushindi: Overcoming Sexual & Gender-Based Violence (SGBV) in Eastern Congo, for the period July 2010 through July 2015, .[13] The Ushindi program implemented a holistic approach integrating psychosocial, medical, legal and economic activities to support survivors of SBGV. The scope of work intended to 1) increase access to timely and quality comprehensive services for individuals affected by SGBV (psychosocial, medical, legal, and socio-economic assistance); 2) improve the quality of services and interventions for individuals and communities affected by SGBV; and 3) reduce the vulnerability of individuals to future acts of abuse and violence. This five-year program was implemented in four provinces among 10 health zones with 1.2 million beneficiaries. In these health zones, the program was included in 106 health areas and 106 health centers (Table 1). The three local partner organizations were:

- **Heal Africa** (based in Goma): works in North Kivu and Maniema provinces
- **Fondation Panzi** (PF; based in Bukavu): works in South Kivu province
- **Programme de Promotion des Soins de Santé Primaires** (PPSSP**;** based in Beni): works in North Kivu and Orientale provinces

Table 1: Geographic scope of Ushindi implementing partners 2010-2013

Project Assisted Health Zones			
Province	**HZ**	**Population**	**Implementing Partner**
Orientale	Lolwa	42,138	PPSSP
	Komanda	78,501	
Nord Kivu	Mutwanga	183,973	
	Lubero	213,548	HEAL
	Alimbongo	184,739	
Maniema	Obokote	73,874	
	Ferekeni	60,444	
Sud Kivu	Shabunda	90,020	Panzi Foundation
	Kitutu	75,233	
	Mwenga	80,601	
TOTAL		**1,083,071**	

In addition to IMA's cadre of local partner organizations, a number of technical partners provided focused support including: CARE (socio-economic interventions), Save the Children (prevention and services to child victims of SGBV), Children's Voices strategic behavior change communication (SBCC) and the American Bar Association (ABA) which provided legal representation and advocacy.

[13] Ushindi means to overcome or victory in Swahili.

During implementation, other supplemental funding was awarded which included an Office of U.S. Foreign Disaster Assistance (OFDA) grant of approximately 1.2 million dollars (USD) to rehabilitate and augment the capacity of health facilities and in 2013, a supplementary Women's Leadership Grant of 1.25 million USD to promote family planning and women's leadership.

The Ushindi project covered 10 health zones (HZ), 108 health areas (HA) and 1,118 villages with a total beneficiary population of 1,083,071 people for the first four years (Table 2).[14] In 2013, USAID decreased funding levels and the geographic scope of Ushindi which led the program to decrease its geographic scope to seven health zones with the population and health area descriptions described in Figure 1. At this time, all technical assistance contracts were discontinued with the exception of the ABA. For year five, due to a decrease in funding, Ushindi scaled back to cover seven health zones within 72 health areas with a total beneficiary population of 858,733 people.

[14] 2 HZs (Lolwa and Komanda) were treated as single project area with one base and one set of staff thus creating nine project areas; 12 HAs per project area.

Figure 1: Map of Ushindi Implementation Health Zones 2013-2015

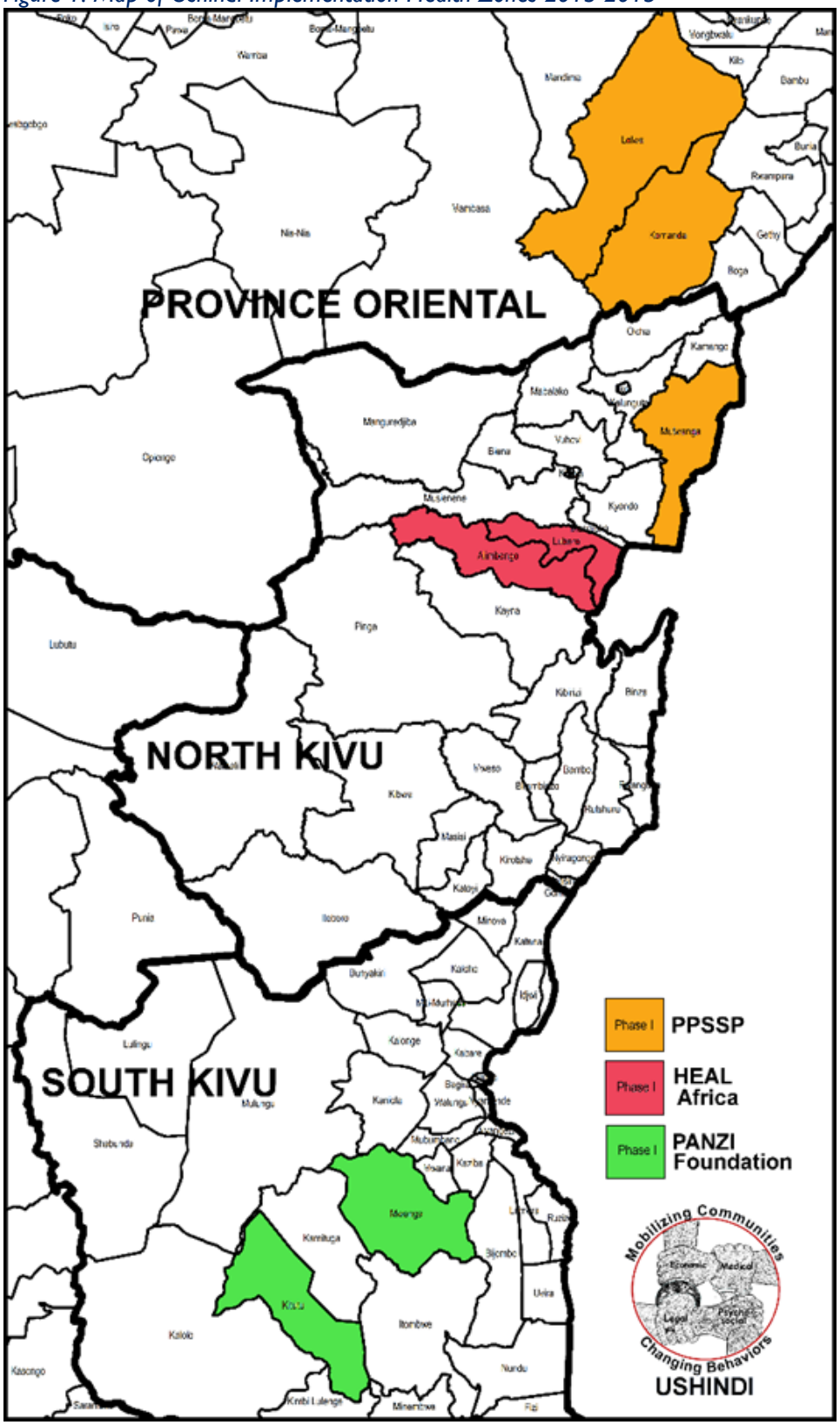

Table 2: Geographic scope and population figures of Ushindi implementing partners 2013-2015

Health Zone	Health Areas in Zone	Total Zone Population	Health Areas Assisted	Total Population Assisted
Lolwa	5	42,138	5	42,138
Komanda	14	170,063	7	78,501
Mutwanga	20	254,582	12	183,973
Lubero	16	242,912	12	213,548
Alimbongo	17	201,209	12	184,739
Kitutu	22	132,155	12	75,233
Mwenga	17	121,524	12	80,601
Total	111	1,164,583	72	858,733

Despite the funding decrease, the large majority of indicators were met or surpassed and the project was completed as planned at the end of FY2015. IMA was asked to continue services for several months. On January 30, 2016 IMA received additional funding to complete an amended scope of work, which would be used to continue 'scaled down' assistance to the current seven health zones, consolidate data from five years of intervention for focused analysis and research, measure the impact of the previous five years of treatment and prevention activities on survivors of victims of SGBV as well as on the prevalence of SGVB in the communities served. This additional 4.5 million USD for February 2016 through July 2017 also included focused research, the addition of cognitive processing therapy (CPT) and the expansion of services into three new health zones: Karisimbi, Katana, and Walikale.

History of sexual violence in the Democratic Republic of Congo (DRC)

DRC has experienced continued violence and civil conflict for more than two decades and is routinely listed as the site of one of the world's worst humanitarian crises which includes millions of women and men subjected to human rights abuses and SGBV.[15] Academics, human rights organizations, non-governmental organizations (NGOs), the United Nations, journalists, and politicians have spoken out about this violence consistently. Of the studies that evaluate sexual violence in the DRC, the majority do not include all forms of sexual violence, are largely qualitative, or evaluate patients presenting to medical care, which comprise a biased, nonrandomized sample.[16] Of the few population-based studies assessing

[15] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562; Lawry L, Rosa JC, Kisielewski M, Johnson K, Scott J, Wieczorek J. The Use of Population-Based Surveys for Prosecutions at the International Criminal Court: A Case Study of Democratic Republic of Congo. International Criminal Justice Review. 2014; 24:1 doi:10.1177/1057567714523982; and Lawry L, Johnson K, Asher J. Evidence-Based Documentation of Gender-Based Violence. In: Stephan Parmentier, Jeremy Sarkin and Elmar Weitekamp (Eds), New Series on Transitional Justice, Prosecuting Sexual Violence as an International Crime: Interdisciplinary Approaches. Antwerp, Belgium: Intersentia Publishers 2013.

[16] Vinck P, Pham P, Baldo S, Shigekane R. Living With Fear: A Population-Based Survey on Attitudes about Peace, Justice, and Social Reconstruction in Eastern Democratic Republic of the Congo. http://hrc.berkeley.edu/pdfs/LivingWithFear-Exec-Summ.pdf. August 2008 and Peterman A, Palermor T, and Brendenkamp C. Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo. Am J Public Health. 2011 June; 101(6): 1060–1067. doi: 10.2105/AJPH.2010.300070.; Murray L, Bass J,

violence in Eastern DRC, estimates of reported sexual violence were between 16% and 35%.[17] Both studies limited inquiries about sexual violence to very narrow definitions and/or age groups and did not ask about perpetrators, circumstances, or the mental and physical health consequences of the violence. Nor did these studies establish if the violence was community based, conflict-related, or violence against men.[18] To date, there is only one evidence based study that is able to estimate the prevalence of sexual violence in the eastern territories of DRC. The 2010 DRC Study was conducted in the territories of North and South Kivu provinces and Ituri district in March 2010.[19] This study included 67 villages (10-15 households per village) and 998 households, representing 5.2 million adults living in 19 territories in North and South Kivu provinces and Ituri district.[20] Data revealed that among the household-based population in the survey area, 39.7% of women and 23.6% of men were reported to have been exposed to sexual violence during their lifetime. Thirty-one percent of women were reported to have been exposed to intimate partner violence compared with 16.6% of men. Of those who were exposed to sexual violence, 74.3% of women and 64.5% of men were exposed to conflict-associated sexual violence. Among the cases of conflict-associated sexual violence, 41% of female survivors and 10% of male survivors revealed their perpetrator was a woman. The most common type of sexual violence reported by both women and men was rape. Using population data from that time, this study estimated 1.31 million women and 0.76 million men were survivors of sexual violence and might need health services specific to sexual violence–related care.[21]

Eighty-eight percent of respondents reported perpetrators to be combatants with the most common perpetrators belonging to the Mai Mai, Democratic Force for the Liberation of Rwanda (FDLR), Patriotic Union of Congolese (UPC) and Interhamwe. These data, including conflict and non-conflict SGBV and interpersonal violence (IPV) are summarized in Table 3.[22]

Bolton P. Qualitative Study to Identify Indicators of Psychological Problems and Functional Impairment Among Residents of Sange District, South Kivu, Eastern DRC. A Report to the Victims of Torture Fund.

[17] Vinck P, Pham P, Baldo S, Shigekane R. Living With Fear: A Population-Based Survey on Attitudes about Peace, Justice, and Social Reconstruction in Eastern Democratic Republic of the Congo. http://hrc.berkeley.edu/pdfs/LivingWithFear-Exec-Summ.pdf. August 2008 and Peterman A, Palermor T, and Brendenkamp C. Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo. Am J Public Health. 2011 June; 101(6): 1060–1067 and Peterman A, Palermor T, and Brendenkamp C. Estimates and Determinants of Sexual Violence Against Women in the Democratic Republic of Congo. Am J Public Health. 2011 June; 101(6): 1060–1067. doi: 10.2105/AJPH.2010.300070.

[18] Reis C and Lawry L. Challenges for Justice in Democratic Republic of Congo for Human Rights Violations. JURIST - Hotline, Mar. 7, 2013, http://jurist.org/hotline/2013/03/reis-lawry-icc-sexual-violence.php and Lawry L, Reis C, Kisielewski M, Asher J. Problems in Reporting Sexual Violence Prevalence. Am J Public Health. 22 September 2011, 10.2105/AJPH.2011.300347. Available at <http://ajph.aphapublications.org/cgi/reprint/AJPH.2011.300347v1>.

[19] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562.; 26 provinces are subdivided into 192 territories. See eMethods at http://www.jama.com.; At the time of the study, Ituri had recently been changed from a province to a district.

[20] Details of the sampling frame, including the selection of clusters/villages, selection of households, and selection of participants within households, are described in the online supplemental eMethods at http://www.jama.com.

[21] Scott J, Polak S, Kisielewski M, McGraw Gross M, Johnson K, Hendrickson M, and Lawry L. A Mixed-Methods Assessment of Sexual and Gender-based Violence in Eastern Democratic Republic of Congo to Inform National and International Strategy Implementation. International J of Health Planning and Management. 2012; DOI: 10.1002/hpm.2144.

[22] IPV is synonymous with "domestic violence" or spousal physical and sexual violence.

Table 3: SGBV data from the 2010 DRC Study

Sex	Lifetime SGBV	Conflict related SGBV	Lifetime IPV	IPV sexual violence
Female	39.7	41.1[23]	30.5	8.5
Male	23.6	10.0	16.6	7.7

The most recent Demographic Health Survey 2013-2014 (DHS)[24] which only reports data on women ages 15-49, collected limited data on SGBV. It is important to keep in mind that the DHS only studies reproductive age women and does not collect data on SGBV among men or assess all perpetrators (e.g. conflict-related) or all forms of sexual violence. Table 4 shows prevalence data from the DHS relevant to the provinces covered by Ushindi.

Table 4: SGBV data from the DHS 2013-2014

Province	Lifetime SGBV	SGBV -12 mos	Lifetime IPV	IPV-12 mos	IPV during pregnancy	SGBV married women Emotional/physical/sexual
Orientale	24	13	48.3	26	9.5	29.4/39.7/19.2
South Kivu	27.6	14.6	25.6	11.4	8.8	33.6/20.3/25.8
North Kivu	34.5	18.3	47.5	31.1	10.9	47.3/41.7/26.1

The original baseline assessment for Ushindi was designed to better understand knowledge, attitudes, and behaviors of implementing areas and did not include a household prevalence study in health zones where Ushindi was not being implemented therefore true prevalence data and the impact of Ushindi on the prevalence of SGBV was not possible to estimate for the 10 health zones where Ushindi was tasked to work from 2010 - 2013. With this in mind, the study was undertaken to determine the prevalence of all forms of SGBV for the new health zones where Ushindi will continue to be implemented. Care was taken to estimate the prevalence among men, women, and children and to determine, for the first time in DRC, the prevalence of trafficking occurring within these areas. Other data such as harmful traditional practices and other important context to understand SGBV in these communities was collected through qualitative interviews. These data will be vital, and add to the impact evaluation in designing a cost-effective and comprehensive approach to SGBV in Katana, Walikale, and Karisimbi.

[23] 41.1/39.7% of the sexual violence reported "ever" was described as perpetrators related to rebel groups.
[24] Demographic Health Survey. DRC 2013. http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf.

Objectives of the study

The objectives of the study were guided by discussions with IMA and their implementing partners and were defined as follows:

- Determine the evidence-based prevalence of all forms of gender based violence in Walikale, Karisimbi and Katana health zones where IMA will implement Ushindi
- Determine the sex differences with regard to SGBV rates
- Determine the evidence-based prevalence of trafficking in these health zones
- Determine the risks for SGBV and trafficking
- Determine the prevalence and nature of mental disorders in these health zones and especially among survivors of SGBV
- Determine the differences in the rates of SGBV and mental disorders between male and female participants
- Determine what types of health, social, educational and employment programming are available for SGBV survivors including special groups such as male survivors, young girls among others
- Determine the health, social, educational, legal and employment programming gaps that exist in the community at present for survivors
- Determine the culturally nuanced potential barriers that exist to the identification and treatment of mental disorders and gender-based violence

Methodology

Definitions

A household was defined as the group of people eating from the same pot and sleeping under the same roof. Substance abuse was noted if the participant reported using drugs or alcohol on a regular basis; more than 2 times per week or in excess each time.[25] Inadequate general healthcare was defined as a lack of hospital or clinic within a 4-hour walking distance. SGBV was determined as any physical or psychological violence carried out through sexual means or by targeting sexuality and included rape and attempted rape, molestation, sexual slavery, being forced to undress or being stripped of clothing, forced marriage, and insertion of foreign objects into the genital opening or anus, forcing individuals to perform sexual acts on one another or harm one another in a sexual manner, or mutilating a person's genitals. Sexual violence (SV) was any sexual act (excluding physical non-sexual violence) that was not consensual including sexual intimate partner violence. Intimate partner violence was defined as sexual or physical violence perpetrated by a spouse or partner.[26] Gang rape was defined as rape by 2 or more individuals. Survival sex was defined as trading sex for food, goods, or other necessities. A combatant was defined as any person who reported being part of any kind of regular or irregular armed force in any capacity. Trafficking was defined (specific to Eastern DRC) as being forced to work in a bar/restaurant/bistro, forced to pimp, forced to be a domestic servant or work in a mine or agricultural field, forced marriage, forced to carry goods (especially within the mining industry), forced indebtedness, forced prostitution and or to be forced to serve as a sexual servant.[27] A perpetrator was defined as any person who directly inflicted violence or a reported abuse.[28]

Human Subjects Protection

The study was reviewed and approved by the Comité D'Ethique, Université Libre Des Pays Des Grand Lacs (ULPGL) Goma (Annex I).[29] Waiver of documentation of consent was granted by the review board and therefore, verbal informed consent was obtained from all participants. The research was conducted in accord with the Declaration of Helsinki, as revised in 2000.[30] Guidelines for interviewing potential SGBV survivors were also followed.[31] Every effort was made to ensure protection and confidentiality and to reduce any potential adverse consequence to the participants. No identifying information was on the survey. The survey utilized numeric codes for each participant that could not be tied back to any participants. Data was kept anonymous at all times.

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[25] American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed.

[26] United Nations. Contemporary Forms of Slavery: Systematic Rape, Sexual Slavery and Slavery like Practices During Armed Conflict. New York, NY: United Nations; 1998:7-8. Final Report submitted by Gay J. McDougall, Special Rapporteur. E/CN.4/Sub.2/1998/13.

[27] Article 3, paragraph (a) of the Protocol to Prevent, Suppress and Punish Trafficking in Persons; https://www.unodc.org/unodc/en/treaties/CTOC/index.html.

[28] United Nations. Contemporary Forms of Slavery: Systematic Rape, Sexual Slavery and Slavery like Practices During Armed Conflict. New York, NY: United Nations; 1998:7-8. Final Report submitted by Gay J. McDougall, Special Rapporteur. E/CN.4/Sub.2/1998/13.

[29] The coordinator is Dr. Muteho Kasongo Marina. Email: kambmut@yahoo.com. Tel: +243850200554, and +243998688632.

[30] United States Department of Health and Human Services. Title 45 CFR Part 46 Protection Of Human Subjects. Available at: http://ohsr.od.nih.gov/mpa/45cfr46.php3. Accessed April 4, 2003.

[31] World Health Organization. Ethical and Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies. http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf.

Geographic Scope

The baseline used a multi-stage clustered sampling method to represent the population in the 12 implementation health areas of Katana, Walikale, and Karisimbi health zones in North and South Kivu DRC. In addition, qualitative interviews were gathered to triangulate the quantitative data and add nuance to the issues found in the household survey.

Sample Size Estimation

In the implementation areas of Katana and Walikale and the entire health zone of Karisimbi, we increased the numbers of clusters and decreased the number of households (90X10) which is widely accepted to decrease the variance found in the typical 30x30 design.[32] To determine an appropriate sample size for this study, we assumed a prevalence of major depression of 0.50, similar to that of other post-conflict communities and a previous study in these same areas.[33] The sample size required to estimate that prevalence via a simple random sample, to within 0.05 with 95% confidence, was 385 households.[34] However, assuming a design effect of two to account for the sample design a sample size of 770 was needed. Therefore, to account for refusals and the design effect/levels of clustering while ensuring power for subgroup analysis, we targeted our total sample size to be ~900 households.

Target Population

This study targeted male and female household members (≥18 years of age or emancipated minors) based on the sampling frame who resided in any of the randomly selected health areas and villages/or avenues in Katana, Walikale, or Karisimbi.

[32] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562; Cochran W. Sampling Techniques. New York: John Wiley and Sons. 1973; Kish L Survey Sampling. New York: John Wiley and Sons. 1965 and Sample Variance Considerations for Cluster Surveys. http://cds.cern.ch/record/541460/files/0203169.pdf.

[33] Johnson K, Asher-Resnick J, Rosborough S, Raja A, Panjabi R, Beadling C, Lawry L. Association of Combatant Status and Sexual Violence with Health and Mental Health Outcomes in Post-Conflict Liberia. JAMA. 2008 Aug 13;300(6):676-90, Amowitz LL, Reis C, Hare-Lyons K, Vann B, Mansaray B, Akinsulure-Smith A, Taylor L, Iacopino V. A Letter from Sierra Leone: Prevalence of War-Related Sexual Violence and Other Human Rights Abuses Among Internally Displaced Persons in Sierra Leone. JAMA 287 (4): 513-521, 2002 and Kim G, Torbay R, Lawry L. Basic, mental, and women's health among internally displaced persons in Nyala province, South Darfur, Sudan. American J of Pub Health. 2007;97(2):353-61.

[34] National Statistical Service. Sample Size Calculator. http://www.nss.gov.au/nss/home.NSF/pages/Sample+size+calculator?OpenDocument.

Sampling Frame

Figure 2: Milka Kaveran (PPSSP) explaining the sampling frame to the data collectors in Karisimbi

Photo Credit: Lynn Lawry

The quantitative baseline was a cross-sectional study conducted in randomly selected six of twelve health areas where IMA implementing partners would extend the Ushindi program in Katana (South Kivu Province), Walikale, and Karisimbi health zones in North Kivu Province, DRC. Villages were randomly selected from the list of villages supplied by the Chief Medical Officer in each health zone associated with the Bureau Central de Zone de Santé (BCZS). However, a few of the villages were inaccessible due to long distances that could only be covered on foot and/or for security reasons; therefore, only villages accessible could be randomized (Tables 5-7). For any villages not accessible, the nearest accessible neighbor was used for substitutions.

To allow an approximate probability- proportional-to-size sampling strategy, existing information on the community sizes, as provided by the health zones, were used to create relative weights and control for the evenly distributed clusters per health zone (Annex II). Weighting corrected for potential overestimation and/or underestimation of prevalence data.

Katana is composed of 18 health areas and has a total population of 209,746 among 188 villages. Six health areas were randomly selected from the 12 implementation health areas chosen by Panzi Foundation and a subsequent five villages were randomly selected per each of the six health areas (Table 5). Cishwagoko (Birava HA) was inaccessible due to difficult terrain and the need to access the area on foot. The substituted village of Lwangoma could not be surveyed due to time and safety considerations. Mabingu health area had only five villages therefore all five were surveyed, however Mantu, a 5km walk was substituted with a nearest accessible neighbor of Kashongolere in the Ihimbi health area. Finally, Cirehe in Kabushwa was also inaccessible. Therefore, due to the size of Chahoboka, 20 surveys were done in this village as a substitution and control for the population size. The total population represented in Katana in the implementation areas by the survey, taking into account inaccessible areas and substitutions, was 152, 057 persons.

Table 5: Randomly selected villages for Katana

Katana Health Zone				
Health Area	**Total Population**	**Village**	**Village ID Code/Disposition**	**Village Population**
Birava (18km)	23,048	Chishoke I	K4-1	3,682
		Chishoke II	K4-2	3,930
		Murama	K4-3	3,233
		Bidabanga	K4-5	2,864
		Lwangoma[1]	Not done - time	2,312
Mushweshwe (10km)	12,898	Rubona	Not done - time	681
		Nyampama	K5-2	588
		Nyabulongwe	K5-3	2,180
		Bibukali	K5-4	637
		Buhehe	K5-5	6,870
Mabingu[2] (18km)	8,483	Bogurane	K1-1	1,256
		Kangoko	K1-2	1,729
		Magese	K1-3	2,166
		Kashongolere[3]	K7-1	1,195
		Ntagalulwa	K1-5	2,137
Kadjuca (21km)	9,845	Chofi	K6-1	1,856
		Bumera	K6-2	1,668
		Cibonaboshi	K6-3	1,298
		Munanira	K6-4	1,125
		Irangira	K6-5	1,202
Kabushwa (8km)	18,086	Chahoboka I &II[4]	K2-1	5,669
		Ciduha I,II & III	K2-2	1,560
		Cirehe	Not done -access	645
		Canyena	K2-4	393
		Muhonga/Mbulamishi	K2-5	831
Ciranga (2km)	12,940	Lulonge	K3-1	839
		Kalimbi	K3-2	415
		Maroc + Murhala	K3-3	365
		Kakondo	K3-4	759
		Camps Forulac	K3-5	451

[1]Lwangoma substituted for Cishwagoko (not accessible/terrain) but could not be surveyed due to time constraints and the need to leave the village before dark
[2]Only 5 villages, one substitution for Mantu due to distance on foot
[3]Nearest neighbor – Ihimbi Health Area
[4]20 surveys done due to size of the village and no access to Cirehe

Walikale is composed of 14 health areas and has a total population of 156,876 among 143 villages. Due to insecurity and ongoing conflict only eight health areas of the 12 implementation health areas chosen by Heal Africa could be surveyed. [35] Obaye and Bisie could only be accessed on foot over a two-day walk, and Kumbwa and Mundindi had recent incursions of rebel fighting just prior to the survey, therefore six health areas were randomly selected from the remaining seven accessible health areas where five villages were subsequently randomly selected (Table 6). Villages removed from sampling included Mpina and Mpito in Sacre Coeur, Kuele in Cepac, Kilambo, Buringa, Tusangwa, Bubhere and Isea from Mutakato, Omate, Shempika, Omate tabaro, Omate shikago and Omate mafilo in Bilobilo, and

[35] Ndjingala and Mpofi of the 14 health areas have other implementing partners not associated with Ushindi.

Elibia II in Eliba, all of which were only accessible on foot. Kalale and Shabunda in Mutakato were inaccessible due to bridge destruction, and Base Militaire was not accessed as it serves as a temporary village for military wives. Therefore, the total population represented in Walikale, among the implementation areas by the survey, taking into account inaccessible areas and substitutions, was 106,335 persons.

Table 6: Randomly selected villages for Walikale

Walikale Health Zone				
Health Area	**Total Population**	**Village**	**Village Code/Disposition**	**Village Population**
Sacre Coeur (2 km)	17,600	Cite Iowa	W1-1	849
		Kasima Centre	W1-2	1,066
		Kasima Sutukutu	W1-3	1,512
		Kalenge	W1-4	464
		Mubanda	W1-5	478
Mutakato (22 km)	5,058	Nyamianda	W3-1	824
		Miti/Ngora	W3-2	1,016
		Itambo	W3-3	379
		Mutakato I	W3-4	489
		Mutakato II	W3-5	610
Bilobilo (30 km)	40,301	Mubi II	W4-1	8,181
		Mubi Kopa	W4-2	510
		Indijiki	W4-3	481
		Kilambo	W4-4	1,131
		Boboro	W4-5	2,410
Eliba (36km)	6,381	Wenga II[1]	W5-1	1,880
		Kabusa	W5-2	891
		Eliba I	W5-3	1,051
		Shemakongolo	W5-4	92
		Osokari	W5-5	1,266
Biruwe (72km)	6,704	Biruwe	W6-1	1,607
		Nkuba	W6-2	1,107
		Mafombi	W6-3	288
		Obyanda	W6-4	679
		Tengeneza	W6-5	651
Cepac (2km)	18,622	Nyalusukula	W2-1	5,798
		Kangambili	W2-2	1,748
		Nyamitaba	W2-3	750
		Kirundu	W2-4	1,985
		Mutoyo	W2-5	729

[1]Wenga II substituted for Nyandakala due to the killing of a 17 year old girl the night before the survey

Karisimbi, unlike Katana or Walikale, is an urban and semi-urban area. This health zone is composed of 16 health areas and has a total population of 469,362 among 254 avenues. Six health areas and five avenues from each health area were all randomly selected from the all of the health areas (not just the implementation areas) (Table 7). Due to the size of this health zone, two extra avenues were chosen

(one each in Majengo and Marara). Therefore, the total population represented in Karisimbi was 469,362 persons.

Table 7: Randomly Selected Avenues for Karisimbi

Karisimbi Health Zone				
Health Area	**Total Population**	**Avenue**	**Avenue Code/Disposition**	**Avenue Population**
Albert Barthel	27,721	Géomètres	G1-1	1,278
		Bukonde	G1-2	1,059
		Kasindi II	G1-3	2,210
		Kisibangi	G1-4	2,837
		Des plateaux	G1-5	2,294
Kasika	15,594	Bahizi	G3-1	2,320
		Mikundi II	G3-2	2,052
		Basunga	G3-3	3,396
		Biteko	G3-4	2,314
		Cirambo	G3-5	4,342
Katoyi	53,655	Salongo II	G4-1	3,233
		Salongo III	G4-2	1,790
		Salongo I	G4-3	3,721
		Kindu II	G4-4	8,147
		Lubango	G4-5	2,937
Mabanga	27,771	Mutakato	G5-1	5,710
		Mushunganya	G5-2	1,580
		Mulinga	G5-3	2,065
		Vitwaiki	G5-4	2,741
		Ikobo	G5-5	1,554
Majengo	46,226	Maendeleo	G6-1	1,791
		Mapinduzi	G6-2	2,087
		Bitwaiki	G6-3	2,111
		Mulumba	G6-4	2,172
		Mugara	G6-5	1,900
		Bwisha	G6-6	2,048
Murara	13,471	Mukosasenge	G2-1	441
		Tshela	G2-2	579
		Coopérative	G2-3	153
		Palmier	G2-4	655
		Ruwenzori	G2-5	644
		Commerce	G2-6	539

Survey Instruments

Instruments were developed in collaboration with IMA and its implementing partners and included a quantitative survey and qualitative survey to capture the nuance and social norms in regard to SGBV (Annex III and IV).

Quantitative Instrument

We used survey-research techniques modeled on epidemiological instruments previously developed for a similar study in DRC and from instruments used in Liberia, Sierra Leone, and Sudan. [36]

The survey was written in English and translated to Kiswahili to account for culturally sensitive wording while holding true to the survey intent. Although French is the *lingua franca* of DRC, the Eastern Region is Kiswahili speaking. The Swahili version was back-translated for consistency and correctness by four local translators and pilot-tested to establish clarity of questions and for cultural appropriateness among 14 local Congolese in a rural village in Katana, DRC. The major domains of the quantitative instrument are presented in Table 8.

Time periods used included in the "last 4 weeks," "in the last year," and "in your lifetime." In pre-testing, the yearly time period was the hardest to be understood, therefore "since the last dry season" or "since the end of the school year" was allowed to be added by data collectors to all questions that needed a yearly time frame. [37]

Mental health is assessed using PTSD and major depressive disorder scales previously tested, validated and used in DRC.[38] Questions about suicidal ideation and suicide attempts among respondents were reported as yes or no responses.[39]

[36] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562. ; Johnson K, Asher-Resnick J, Rosborough S, Raja A, Panjabi R, Beadling C, Lawry L. Association of Combatant Status and Sexual Violence with Health and Mental Health Outcomes in Post-Conflict Liberia. JAMA. 2008 Aug 13;300(6):676-90, Amowitz LL, Reis C, Hare-Lyons K, Vann B, Mansaray B, Akinsulure-Smith A, Taylor L, Iacopino V. A Letter from Sierra Leone: Prevalence of War-Related Sexual Violence and Other Human Rights Abuses Among Internally Displaced Persons in Sierra Leone. JAMA 287 (4): 513-521, 2002 and Kim G, Torbay R, Lawry L. Basic, mental, and women's health among internally displaced persons in Nyala province, South Darfur, Sudan. American J of Pub Health. 2007;97(2):353-61.

[37] Walikale does not have a dry season as the climate is tropical rainforest. During the dry season, rain occurs frequently and does not change dramatically during the year.

[38] Bass J, Annan J, Murray SM, Kaysen D, Griffiths S, Cetinoglu T, Wachter K, Murray LK, Bolton PA. Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. N Engl J Med 2013; 368:2182-2191. DOI: 10.1056/NEJMoa1211853.

[39] National Institutes of Health. Suicide and suicidal behavior. http://www.nlm.nih.gov/medlineplus/ency/article/001554.htm#Definition. Accessed April 3, 2005.

Table 8: Major domains of the quantitative instrument

Demographics	Sex Age Ethnicity/tribe Marital status[40] and number of children Household composition Education Job training Occupation Household financial contribution
Health Care/Access	Basic health services Mental health services Community services Social support
Morbidity	Mental health Substance abuse Health consequences of SGBV Reproductive health
Violence	Sexual and gender based violence (adults and children) Interpersonal Violence Trafficking Perception of security/safety
Mental Health	Post-Traumatic Stress Disorder (PTSD) Anxiety Depression Suicidal ideation Suicide
Opinions	Community acceptance of SGBV survivors Sexual and gender-based violence Women's rights Justice Rape myths

In order to standardize the survey, and in keeping with IMA's commitment to capacity building, locally hired trained data collectors were used to conduct the survey. Data collectors learned to administer the survey in other local languages as needed.[41] These translations were checked for accuracy by members of the research team and a locally hired translator fluent in all of the other languages potentially needed. The final version of the translated questionnaire (Annex IV) was immediately sent to data entry staff so

[40] In Swahili, there is no word for marital status, therefore "what is your marital status" was translated to "are you married or not married." In doing so, this required data collectors to probe those who were married to understand if the participant was a widow/widower, had a spouse missing or working away, or if they were separated for any other reason.

[41] Mashe language was used in the Katana Health Zone.

that an optimal data entry interface could be created while the survey was completed.

Training

Locally trained interviewers were hired through Ushindi. Local implementing partners (Panzi Foundation, Health Africa and PPSSP) selected 12-14 potential data collectors on the basis of education, language skills and their experience with previous surveys. Data collectors were fluent in French, Swahili and at least one other local language. Fourteen data collectors continued to field surveying in Katana, ten in Walikale and ten in Karisimbi. In Katana, five data collectors were also part of USAID's Integrated Health Program (IHP) and were participants of IHP's Champion Community.

Training occurred in the field over the course of three days and included the basics of ethical guidelines for surveying and especially for survivors of SGBV. Data collectors were needed to administer the questions, as written, due to high levels of illiteracy in villages surveyed. We used a standardized published protocol for training that has been used and adapted to a variety of settings.[42] The basic training schema included classroom teaching and experiential and observed role-play followed by field observation. The style of the program was participatory and interactive with the trainers. At the end of the training, trainees were tested on content in the field to assess their ability to conduct an interview that incorporated real-time difficulties encountered in field surveys. The basic schema of the training was as follows:

On the first day, training began by introducing participants, trainers, and local partners to each other and an overview of the project and the training course. It included providing basic understanding of confidentiality (research protections), consent and expectations for interviewer conduct, including professional integrity and dignity, reporting accuracy, and adhering strictly to rules for sharing information. The definition of SGBV was discussed at length. The better part of the day was spent administering the consent statement and demographic questions in the survey instrument. Interview skills were taught through exercises in which trainers act out both poor and good interview techniques. Interviewers are given instructions on how to introduce themselves, present themselves with positive body language (such as open posture) and avoid negative body language (such as eye-rolling), and ask questions without leading respondents, while maintaining privacy and confidentiality.

The second day began with a summary of the previous day's exercises followed by a question and answer period. A discussion of cultural, traditional and societal myths of SGBV followed. Technical terms were defined so that all data collectors would be working with the same definitions and concepts. The remainder of the day involved reviewing the understanding of each question and role-playing each newly learned section of the survey. Data collectors broke down into groups of two where one was the interviewer and one was the respondent (Figure 3). Each were asked to take notes on how to improve the interviewer's skills to help each other improve their interviewing skills. During the role-playing exercises trainers circulated among the groups observing, giving feedback, and gathering information. Common problems were highlighted and addressed; from time to time, trainers called the group together to discuss and clarify issues. The closing of each day included addressing common problems, observation of a mock interview among groups, and addressing questions from the day's exercises.

[42] Reis C, Amowitz LL, Hare-Lyons K, Iacopino V. The Prevalence of Sexual Violence and Other Human Rights Abuses Among Internally Displaced Persons in Sierra Leone: A Population-based Assessment, Physicians for Human Rights, Boston, MA, January 2002.

Figure 3: Observed Interviewing Role Play during Trainings

Photo Credit: Lynn Lawry

On the final day, a complete review of the survey ensued with data collectors practicing the complete survey as a role-play exercise. During the training, trainers became familiar with each data collector's strengths and weaknesses. At the end of the third day, two villages were surveyed by all 12-14 data collectors. Trainers observed interviews and how well the methodology was mastered by data collectors. Finally, trainers discussed and reviewed the field testing results individually with each data collector to identify errors and areas of concern, provided feedback on problems observed and in particular evaluated:

- Appropriate and accurate introduction, and explanation of survey purpose
- Complete and accurate questioning and corresponding documentation
- Ability to elicit information about private, shameful, and traumatic events in a warm and respectful manner
- Correct and simple explanation of terms
- Appropriate requests to interview other household members
- Complete and accurate closing statement
- Ability to accomplish the above in rapid fashion while maintaining warmth and respect
- Accurate counting and selection of households in accordance with sampling method at each field site
- Ability to find and maintain privacy for interviews in very crowded settings

Data collectors who had not successfully mastered the skills above were excused (see Table 9).

Field Team

Table 9: Field Teams

HZ	Data Collectors Trained			Data Collectors Used in Survey		
	Men	Women	Total	Men	Women	Total
Katana	8	6	14	8	6	14
Walikale	6	6	12	6	4	10
Karisimbi	5	5	10	5	5	10

The study occurred between June 20 and July 20, 2016. The field teams in each health zone were composed of the data collectors that successfully completed the training and were supervised by Dr. Lawry and the Ushindi staff. In each health zone, the field teams surveyed 300 households from 30 villages in six health areas. In Walikale and Karisimbi, we deployed two teams composed of five data collectors and one supervisor. [43] In Katana, Dr. Lawry and Dr. Mudekereza supervised three teams, two teams of five data collectors and one team of four data collectors. Each team covered one health area and five villages per day with each data collector completing 10 surveys per day; each taking approximately 25 minutes if no sexual violence was reported, and approximately 35 minutes if sexual violence was recorded.

Household Sampling

Households within villages are sampled according to the World Health Organization Expanded Programme on Immunization (WHO EPI) Method.[44] That is, data collectors began in the geographic center of the village and used a randomization device (Figure 4) to pick a direction to reach the first sampling unit. Each subsequent survey was conducted in the household whose door was nearest (to the right) of the door of the previous household. This continued until all 10 surveys within the cluster were completed, with records kept of refusals, ineligible households, and lack of availability.

The survey teams dealt with a number of constraints during the data collection period, some of them requiring to adapt the household sampling methods. One of the most significant constraints was the limited time to be spent in each village due to distance, poor access, and the necessity to return to lodgings before dark (6:00 pm).

[43] Supervisors were as follows in Katana: Dr. Lawry and Dr. Mudekereza; Walikale: Dr. Lawry, Cherubin Sadiki, Daniel Mbungu; Karisimbi: Dr. Lawry, Patrick Bahati and Manka Banda.

[44] World Health Organization. Facilitator Guide For The EPI Coverage Survey: Training For Midlevel Managers. WHO Expanded Program on Immunization (EPI). 1991;WHO/EPI/MLM/91.11.

Figure 4: Spinning a pen to determine direction of the first sampling unit

Photo Credit: Lynn Lawry

Limited information on village characteristics and lack of accuracy on the side of village chiefs when asked about the sizes of villages and their population required flexibility in adapting household selection methods by the teams. Therefore, a purposive transect selection was used to cover as many different zones of the village as possible. In most cases data collector transects were selected either from the village center or a village main gathering point (Figure 5), or from different points of main road crossing the village (Figure 6). In villages in which population was said to be very large (greater than 1,000), data collectors were encouraged to reach households that were further from village center, skipping one or two households for every household on their transect. This did not happen often, as most villages were not very large and transects did not have more than seven households (reachable and surveyed within the timeframe). In other cases, the team reached villages in which the distribution was even more scattered than average and population size small (usually the more isolated villages). In those cases, most of the village was sampled. In Karisimbi, to ensure sampling did not cover only areas near the main avenue, randomly selected skip patterns[45] were used to allow surveying to occur deeper into the avenue (Figure 7). In most cases, only one side of the street was considered the Avenue "block."

[45] For example, if 4 was randomly chosen as a skip pattern number, the data collector would spin a pen to determine the starting household but count 4 houses past that starting household and continue to the second household after 4 more houses.

Figure 5. Example of household selection transects at a gathering point from Buhehe village, Mushweshwe Katana

Figure 6: Example of household selection transects picked from the main road in Bumera, Kadjuca Katana

Figure 7: Example of Avenue sampling with a skip pattern of two households; Bahizi Avenue, Karisimbi health zone

Data Collection

Data collectors interviewed one adult (≥18 years and or an emancipated minor) per household in the sample. At each house, the data collector requested to speak with an adult household member, a randomly chosen male or female who could give accurate information about the household. If that person was unavailable, then the next adult in the household was approached. An assertive attempt was made to ensure that men and women were included as respondents by alternating male or female interviews for each household approached. If only one adult or one sex was present at the time a household was visited, that person was interviewed regardless of sex.

Data collectors were taught how to approach individuals about the survey. If they were allowed in, they assessed the ability to have a private interview and if privacy was assured they verbally administered the consent. One-to-one interviews were conducted anonymously in a setting that offered privacy and confidentiality, typically inside the housing unit but in some cases outside of a full household (Figure 8). Oral rather than written consent was obtained because of the high illiteracy rate. However, a verbal "yes" or "no" had to be given by the respondent and their answer marked on the survey to allow for data entry.

Figure 8: Interviewing outside of a household to ensure privacy

Photo Credit: Lynn Lawry

Although a referral system was established for respondents who displayed emotional distress, no referrals were necessary during the survey period. Supervisors were present in each village during the survey to complete spot checks, sit in on surveys periodically and to check all of the surveys at the end of each cluster to avoid systematic errors. Participants did not receive any material compensation and were informed of this in the consenting process. They were also informed that participation or lack thereof would not affect their access to or the quality of the care they receive, and were explicitly given the right to refuse participation, skip, stop or not answer questions.

Semi-Directed Qualitative Instrument and Sampling

The semi-structured directed qualitative instrument was developed in cooperation with IMA and its stakeholders (Annex V). These interviews were used to add nuance to very complicated issues such as SGBV and mental health in the areas surveyed. They covered both women and men who may be considered key informants including community leaders (religious and/or tribal/ethnic), survivors, NGO personnel in the area, and community members (young and old). To contextualize the data gathered during the qualitative sampling from the field portion of the study, the information gathered was summarized as narrative testimonies and used to provide additional insights and triangulation into the themes and findings that emerged from the desk review and quantitative survey. Adults and emancipated minors were interviewed; parents/guardians and/or family members could report on child-related experiences or conditions in the qualitative study. Convenience, purposeful, and snowball sampling (non-probability sampling) was used to allow flexibility in accessing individuals who might be important for informing the quantitative data. A total of 37 key informant interviews were completed, and included village and avenue chiefs, male and female community members, survivors, a witch doctor, a traditional birth attendant, and Ushindi program staff.

Data Entry and Quality Control

Quantitative

Quantitative survey data was collected on paper forms. All questionnaires were reviewed for completeness and correctness of recording after the interview by the data collectors themselves, and subsequently reviewed by the principal investigators or appointed field supervisors at the end of each day. Immediately after field survey implementation, data was entered into an Access based online platform. Three data entry personnel were used to enter data and supervised throughout the process to ensure data integrity. A number of coherence checks and cross check analyses were conducted for data cleaning prior to data analysis.

Qualitative

Qualitative information was collected through a semi structured interview guide. Interviews were recorded onto a word document whereby themes were coded, analyzed and used to add nuance to the quantitative data.

Data Analysis

Quantitative

Data analysis was performed using the "Survey" module within the statistical software package R, an open-source version of S-plus.[46] Analysis involved the estimation of weighted population and subpopulation means and percentages, as well as the development of logistic regression models for the calculation of weighted odds ratios. Confidence intervals (95%) were calculated using jackknife variance estimation to account for the complex sample design, and *p* values for bivariate comparisons were calculated using the adjusted Wald test of association (a test that is robust to multi-stage clustered sampling). *P* values less than 0.05 were considered significant.

Weighting of the data was necessary due to differences in the probabilities of selection of health areas and individual villages. Data were weighted to account for both the sampling scheme and response rates. By creating these weights, each household member represented a certain number of persons in the total population of the health areas sampled and controlled for over-and/or underestimation of proportions.

The following describes the formulas for determining the weighting for village, household, adult female and adult male weights:

$$village\ weight = \frac{relative\ weight\ of\ village \bullet number\ of\ villages\ sampled\ in\ zone}{sum\ of\ relative\ weights\ for\ villages\ sampled\ in\ zone} \bullet \frac{number\ of\ villages\ in\ zone}{number\ of\ villages\ sampled\ in\ zone}$$

$$household\ weight = village\ weight \bullet \frac{estimated\ number\ of\ households\ in\ village}{households\ sampled\ in\ village}$$

Where number of households in village was estimated by dividing the total population of the village by the average household size of the sample taken for the village.

[46] Lumley T. Survey Analysis in R. 2008. http://faculty.washington.edu/tlumley/survey. Accessed June 15, 2008.

$$adult\ female\ weight = estimated\ number\ of\ adult\ females\ in\ household\ \bullet household\ weight \bullet adjustment\ factor$$

$$adult\ male\ weight = estimated\ number\ of\ adult\ males\ in\ household\ \bullet household\ weight \bullet adjustment\ factor$$

Where number of adult females in household was estimated as 20.6% of household members in urban areas and 20.8% of household members in the rural areas (DHS 2013), and the number of male adults in household was estimated as 20.6% of household members in urban areas and 17.9% of household members in rural areas (DHS 2013). The number of children in the represented area was estimated as 61.3% of the represented area population in rural areas and 58.8% in urban areas.

There was a single value for the adjustment factor used for adult women, and a single value for the adjustment factor used for adult men, calculated using the formulas listed below

$$adjustment\ factor\ for\ females = \frac{estimated\ number\ of\ females\ in\ represented\ area}{\sum estimated\ number\ of\ adult\ females\ in\ household\ \bullet household\ weight}$$

$$adjustment\ factor\ for\ males = \frac{estimated\ number\ of\ males\ in\ represented\ area}{\sum estimated\ number\ of\ adult\ males\ in\ household\ \bullet household\ weight}$$

Multivariate logistic regression models were developed to examine the relationships among exposure to violent or traumatic events and indicators of mental health. For each model, the dependent variable was a binary indicator of one of the following: PTSD symptoms, depression, anxiety, or suicide attempt.

The Hopkins Symptom Checklist (HSCL-25) was used to assess depression (15 items) and anxiety (10 items) and the Harvard Trauma Questionnaire (HTQ) to assess PTSD symptoms (16 items). The checklists were adapted and pilot-tested in each language group by Bass et al in DRC.[47] Both the HSCL-25 and the HTQ have been used internationally with sexual-violence survivors and have solid psychometric properties with conflict-affected samples. [48] Participants rated the frequency of each symptom in the prior 4 weeks on a four-point Likert scale (with 0 denoting not at all, 1 a little bit, 2 a moderate amount, and 3 a lot). Average per-item scores were generated for each measure, with scores ranging from 0 to 3 and higher scores indicating greater severity. An average HSCL-25 score of 1.75 or higher and an average HTQ score of 1.75 or higher were considered to be predictive of clinically significant depression or anxiety and PTSD, respectively, on the basis of data from other conflict-affected populations.[49]

[47] Hesbacher PT, Rickels K, Morris RJ, Newman H, Rosenfeld H. Psychiatric illness in family practice. J Clin Psychiatry 1980;41:6-10 and Winokur A, Winokur DF, Rickels K, Cox DS. Symptoms of emotional distress in a family planning service: stability over a four-week period.Br J Psychiatry 1984;144:395-399.; Mollica RF, Caspi-Yavin Y, Bollini P, Truong T,Tor S, Lavelle J. The Harvard Trauma Questionnaire. Validating a cross-cultural instrument for measuring torture, trauma, and posttraumatic stress disorder in Indochinese refugees. J Nerv Ment Dis 1992;180:111-116.; Bass J, Annan J, Murray SM, Kaysen D, Griffiths S, Cetinoglu T, Wachter K, Murray LK, Bolton PA. Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. N Engl J Med 2013; 368:2182-2191. DOI: 10.1056/NEJMoa1211853

[48] Tsutsumi A, Izutsu T, Poudyal AK, Kato S,Marui E. Mental health of female survivors of human trafficking in Nepal. Soc Sci Med2008;66:1841-1847; Conybeare D, Behar E, Solomon A, Newman MG, Borkovec TD. The PTSD Checklist -- Civilian Version: reliability, validity, and factor structure in a nonclinical sample. J Clin Psychol2012;68:699-713; Ruggiero KJ, Del Ben K, Scotti JR, Rabalais AE. Psychometric properties of the PTSD Checklist -- Civilian Version. J Trauma Stress2003;16:495-502; and Ventevogel P, De Vries G, Scholte WF, et al. Properties of the Hopkins Symptom Checklist-25 (HSCL-25) and the Self-Reporting Questionnaire (SRQ-20) as screening instruments used in primary care in Afghanistan. Soc Psychiatry Psychiatr Epidemiol 2007;42:328-335.

[49] Mollica RF, Wyshak G, de Marneffe D, Khuon F, Lavelle J. Indochinese versions of the Hopkins Symptom

The odds ratios were calculated via separate multivariate logistic regressions for each type of violence or trafficking and are controlled for current age, sex, household size, and primary education attainment. In each of the models, additional independent variables were selected via backward elimination until all remaining variables are significant at the 5% level. Those independent variables were then combined to create a common final model for the mental health outcomes. Most model variables were binary, resulting in prevalence odds ratios.

Odds ratios were calculated from the coefficients in the logistic regression models, and both standard errors for the coefficients and *p* values for two-sided tests of significance of the coefficients relied on variance estimation via linearization. Confidence intervals for the odds ratios were formed from the model coefficients and their standard errors.[50]

Checklist-25: a screening instrument for the psychiatric care of refugees. Am J Psychiatry 1987;144:497-500; McDonald SD, Calhoun PS. The diagnostic accuracy of the PTSD Checklist: a critical review. Clin Psychol Rev 2010;30:976-987; and Bass J, Annan J, Murray SM, Kaysen D, Griffiths S, Cetinoglu T, Wachter K, Murray LK, Bolton PA. Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. N Engl J Med 2013; 368:2182-2191. DOI: 10.1056/NEJMoa1211853

[50] Lehtonen R, Pahkinen EJ. Practical Methods for Design and Analysis of Complex Surveys, Revised Edition. New York, NY: John Wiley and Sons; 1994.

Results

Comprehensive data tables can be found in Annex VII. Only the most salient or interesting data are presented in this section.

Household Characteristics

Of the 930 households surveyed, respondents from 900 households completed the survey, yielding a response rate of 96.8%. Of the 30 non-respondents (3.2%), 11 refused to participate due to lack of time, 3 refused to participate because they were opposed to the study, 1 person refused to participate for an undisclosed reason, 6 were ineligible due to age (<18 years and not an emancipated minor), 4 were not available after two visits, and 4 were interviewed but could not complete the survey. A total of 578 respondents were female and 322 were male.

Demographics

Household Composition

The overall mean household size in the sample was 11.3 persons in Walikale, 9 persons in Katana, and 7.6 persons in Karisimbi. The mean number of years living in the "current location" (sampled village or avenue) was 16.7 years for Karisimbi, 21.5 years for Katana and 10.1 years for Walikale. Households had a mean of 3.8 children (< 18 years) in Karisimbi, 4.6 children in Katana and 6.2 children in Walikale.

Age

Stratified by health zone, the following data represents the mean age in years of the sample (Table 10).

Table 10: Mean age of respondents by health zone

Health Zone	Mean Age (years) for Women	Mean Age (years) for Men	*p*-value
All Health Zones	35	41	0.02
Katana	33	41	0.21
Walikale	42	41	0.12
Karisimbi	32	41	0.08

The women in Walikale were on average 10 years older than other women in the sample.

Marital Status

Most of the respondents reported being married. The following shows marital status for the entire sample (Women in Figure 9, Men in Figure 10). Health zone differences can be found in Annex VII, Tables 2-4.

Figure 9: Marital Status for the 576 Female Household Respondents

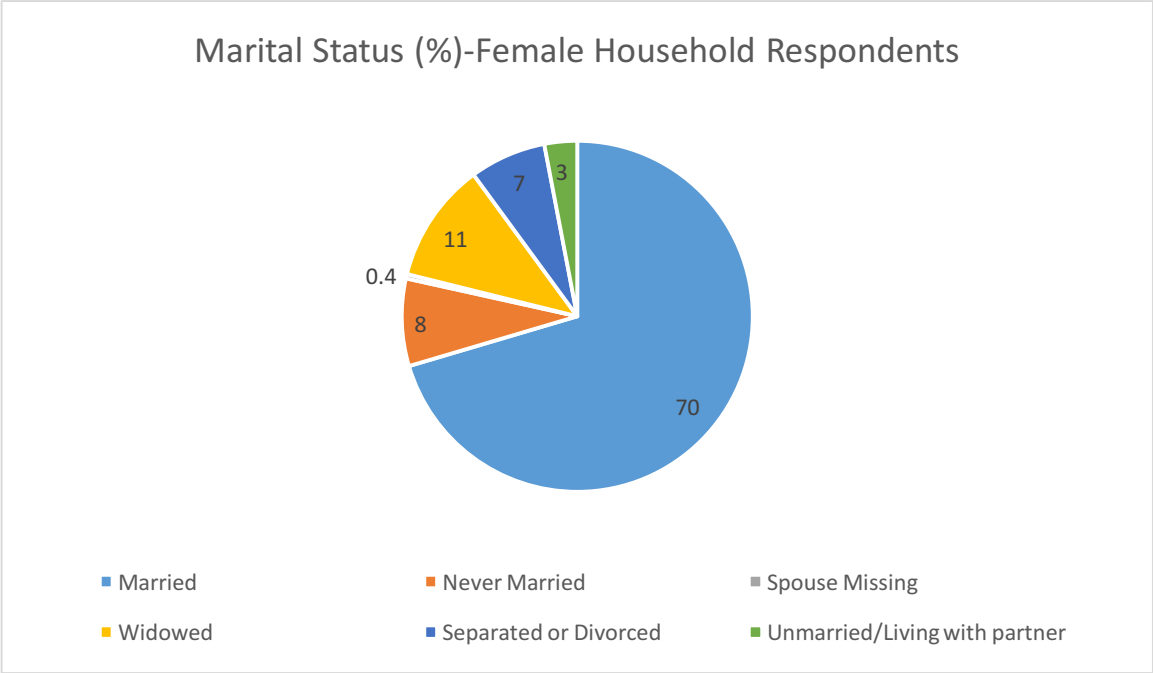
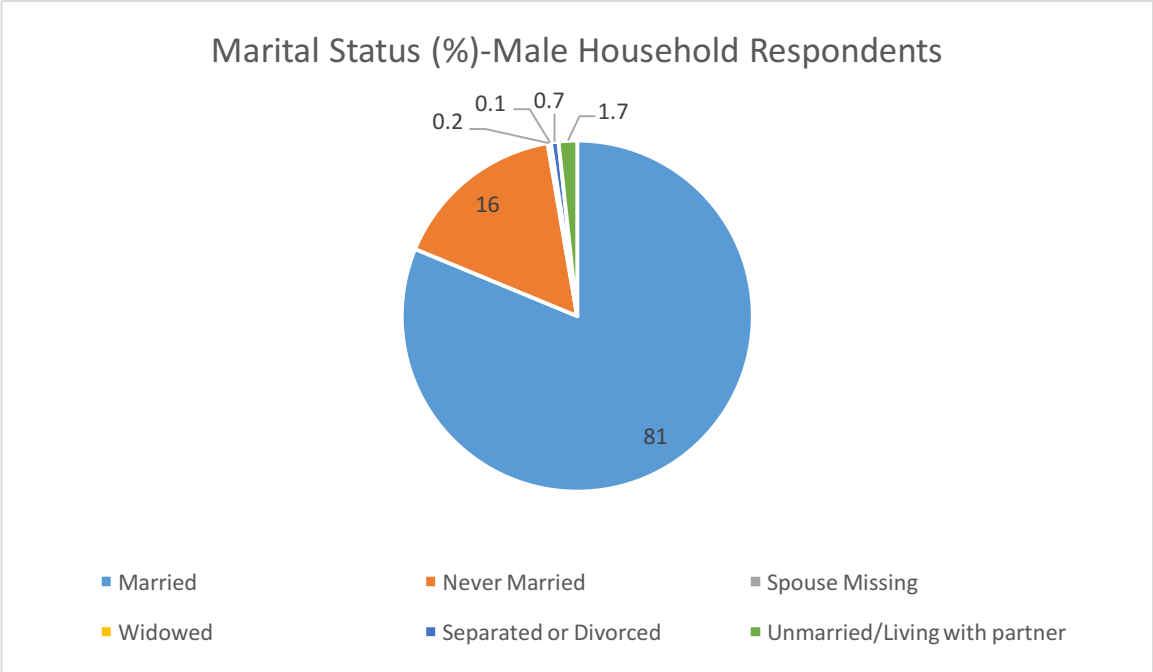


Figure 10: Marital Status for the 319 Male Household Respondents



Ethnic Group

Table 11 presents the top three ethnic group affiliation stated by respondents and sub-grouped by sex for each health zone. The full distribution of all ethnic group affiliations (total and by health zone) stated by respondents listed can be found in Annex VII, Tables 1-4.

Table 11: Ethnic Group Affiliations by Health Zone

Health Zone	Women	Men
All Health Zones	Batwa Nande Lega	Batwa Nande Holoholo
Katana	Batwa Lega Bantu (mixed)	Batwa Lega Bantu (mixed)
Walikale	Holoholo Lega Kongo	Holoholo Kongo Bantu (mixed)
Karisimbi	Batwa Nande Bantu (mixed)	Nande Hutu Holoholo

Religion

More than 90% of households listed their religion as Christian. Muslim was listed by respondents in less than 5% of households.

Education, Literacy, and Job Training

Less than half of women (45.6%) and just about half of men (49.7%) had secondary school as their highest level of education. A fifth of women (21%) and 8.8% of men had no formal schooling at all (Annex VII, Table 1).

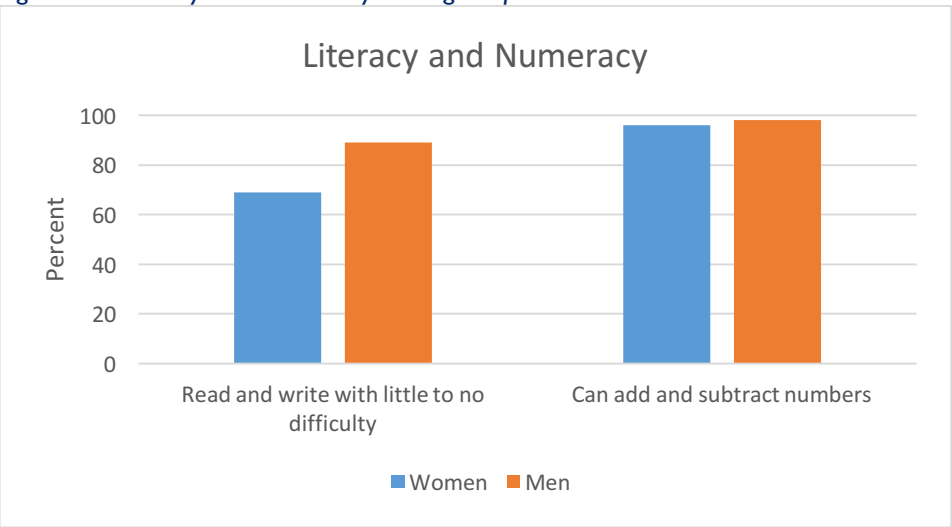
Qualitative interviews revealed (especially in more rural areas) that education for girls was withheld in favor of having them work.

> *"Young girls because they are not educated. Once the parents see that a girl is interested in boys, they take her out of school (12-14 y/o) and she works in the house or in the fields"*[51]

Among women, 69% could read and write with little to no difficulty and 96% could add and subtract numbers. Among men, 89% could read with little to no difficulty and 98% could add and subtract numbers (Figure 11).

[51] Chief of Muroc-Muhala village, Ciranga HA, Katana HZ

Figure 11: Literacy and Numeracy among Respondents



Thirty-one percent of women and 44% of men had some type of job training. Among women, 70% found the job training useful compared to 88% of the men.

Occupation

The following figures represent the breakdown of listed occupations of female respondents (Figure 12) and make respondents (Figure 13). Health zone differences can be found in Annex VII, Tables 2-4. Notably, the top three occupations listed for women included farmer/herder, small business, and "not working." Among men, the top three occupations listed included farmer/herder, "miscellaneous work" and "not working."

Figure 12: Occupations among Female Respondents

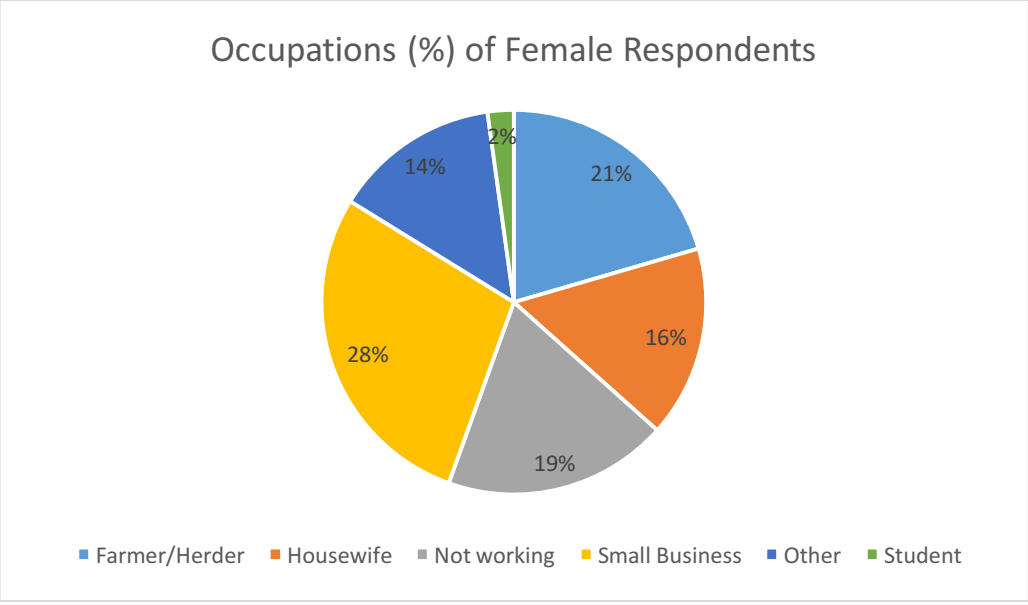
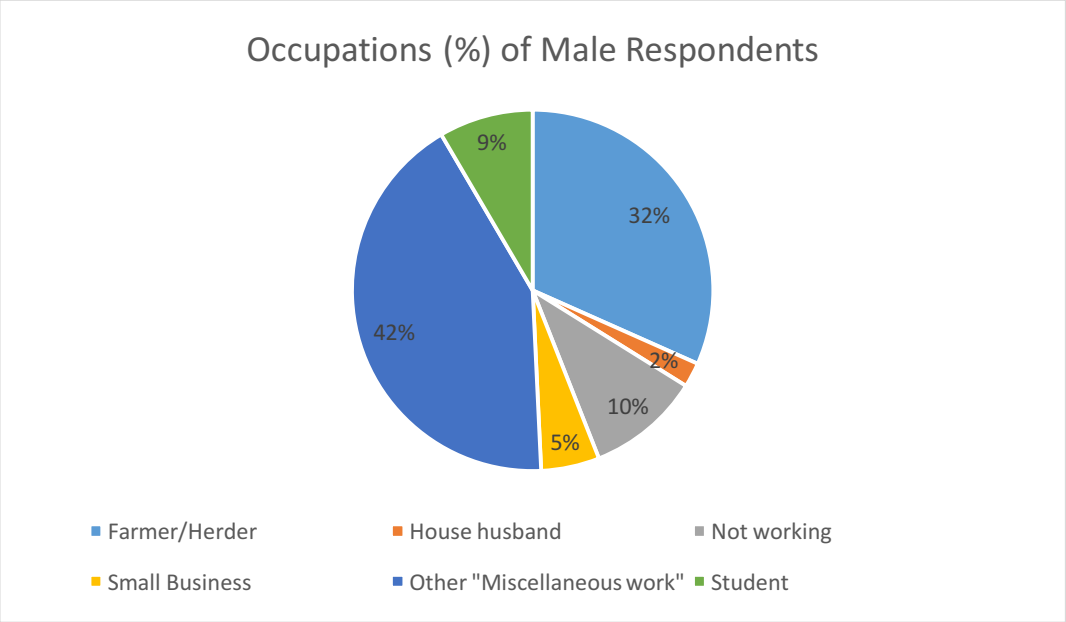


Figure 13: Occupations of Male Respondents



Household Income and Land Ownership

Average household income, particularly for women included a mix of Congolese francs (CDF) and goods supplied to the household by women's work. Using the average local value for goods, the average they brought to the household monthly was 68,096 CDF (69 USD) compared to 83,728 CDF (85 USD) reported by men. Survivors of SGBV had an average monthly household income of 68,768 (70 USD) Congolese francs compared with 89,720 (92 USD) for non-survivors (p = 0.0960).[52]

When respondents were asked if any household member owned land, 71% of women and 68% of men stated this was the case for their household.

Sexual Gender Based Violence

SGBV rates were not different by health zones (Annex VII, Table 5). The following table presents prevalence data for SGBV among men and women (Table 12):

[52] Exchange rate used (982CDF/1USD) is the average ask price for the period 07/01/2016-08/01/2016 accessed on 08/26/2016 on oanda.com.

Table 12: Prevalence of SGBV among All Respondents

VIOLENCE TYPE	WOMEN (% HOUSEHOLDS)	MEN (% HOUSEHOLDS)	*P*-VALUE
SGBV	31.6	32.9	0.88
LIFETIME SV	11.8	3.1	**0.03**
SV WITHIN THE LAST YEAR[53]	5.3	6.1	0.81
CONFLICT-RELATED SV	12.7	68.1	**0.008**
COMMUNITY-RELATED SV	87.4	31.9	**0.009**
LIFETIME IPV	22.6	25.0	0.81
IPV WITHIN THE LAST YEAR	12.0	12.9	0.88

There were no statistical differences for the prevalence rate of SGBV among women or men (p = 0.88) with the exception of lifetime SV (higher among women) and conflict-related SV which was far more prevalent among men in the sample. However, community based SV was much more prevalent (87% among women and 32% among men) for those who reported SV. In addition, the perpetrators listed were primarily immediate and extended family members (79%) (Annex VII, Table 6).

Population Estimates

Extrapolating the prevalence to population numbers the following number of individuals are at risk for each type of SGBV (Table 13).

Table 13: Population Estimates of Violence within Survey Area

VIOLENCE TYPE	TOTAL NO. WOMEN AFFECTED	TOTAL NO. MEN AFFECTED
SGBV	54,384	38,514
IPV	43,544	29,779
SEXUAL VIOLENCE	30,313	12,789

Perpetrators included both men and women, although largely men among female survivors and male survivors but it was not uncommon to find female perpetrators in male sexual violence cases. The most common forms of reported included rape (but not gang rape) and forced undressing among women and forced undressing and abduction/sexual slavery among men (Annex VII, Table 6).

Trafficking

Twelve percent of households self-reported trafficking. Based on population estimates, 30,719 adults are affected by trafficking; including 18,286 women and 12,432 men.

The most common forms of trafficking among adults included forced to work in a bar/bistro, forced to be domestic help and forced indebtedness in Karisimbi; forced indebtedness, held against will and forced to carry goods form a mine in Katana and in Walikale. (Annex VII, Table 7)

Dividing the abuses into the categories of debt bondage, labor trafficking and sex trafficking, and taking

[53] In Katana and Karisimbi the last year was defined as dry season to dry season, in Walikale, due the climate differences and lack of a true "dry" season, end of the school year to end of the school year was used to define "within the last year"

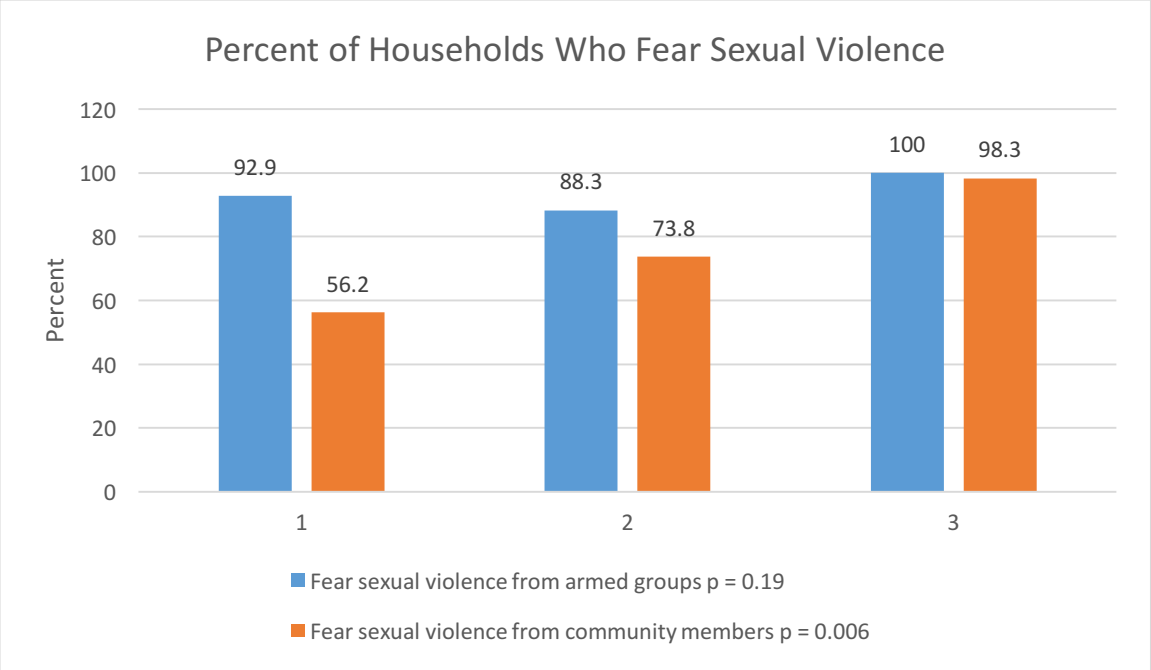
into account that respondents could list more than one type of trafficking, 1/3 of respondents listed a form of trafficking in each of the categories.

The most commonly listed recruitment techniques used for adults included threats to personal security, abduction (mostly for men), family subjected them to trafficking or they wanted to participate due to the incentives offered such as food or money. More than a third of survivors stayed because their personal security or family was threatened, the need for food, or they were in an unfamiliar environment (Annex VII, Table 7).

Fear of Sexual Violence

Respondents were also asked about fear of sexual violence from either combatants or community members. Overall the percent of households who expressed fear of sexual violence from either combatants or community members were greater than 55%. Virtually, all households feared sexual violence from armed groups. However, there were statistically significant difference for fear of community sexual violence. Figure 14 presents these data:

Figure 14: Percent of Households Who Fear Sexual Violence from Community Members and Armed Groups



Survival Sex

Survival sex was reported by adults in all three health zones surveyed at a rate less than 10% with the lowest rates in Walikale (0.09%) (Annex VII, Tables 5 and 6).

Community Acceptance of Survivors

Finally, respondents were asked to agree or disagree with the statement "my community will accept survivors of sexual violence back into the community." Among women, 70% agreed with this statement compared with 81% of men (p = 0.003) (Annex VII, Table 10).

Although not a majority view among respondents, based on quantitative data, one respondent remarked about community acceptance with the following statement which highlights the approximately 25% of individuals who do not agree that the community readily accepts survivors:

> *"Women will not say they are raped here. The community rejects them when they find out they have been raped. The community tells them to stay quiet and not to tell anyone what happened; it is a compromise that must happen"*[54]

Safety in the Community

Despite the high prevalence of violence in the communities surveyed, 77% of women and 85% of men stated they feel safe in their communities (Annex VII, Table 10).

Qualitative interviews on SGBV

In speaking with community members or Chiefs, it was not uncommon to ask a broad question such as "tell me about violence in your community" and to receive statements such as "we have no violence." Yet, when this broader question was followed up with more specific questions such as "how many young girls, under age 18, are pregnant", or "do men beat their wives", the answers were positive. This was usually followed with statements suggesting that SGBV was not common prior to the influx of Rwandans.

> *"Rape came with the refugees from Rwanda. Once they began raping our communities, they infected the Congolese and now they too rape…even boys and men in our villages raping minors"*[55]

When assessing "who is at risk", one community member expressed this as the following:

> *"…everyone here is at risk. They even take men and boys and rape them in the forest. Girls who walk to school or collect charcoal are at risk. When the come to the villages to take food and water, they rape us. No one can be safe here"*[56]

Intimate partner violence is normalized based on opinions expressed (see: opinions on gender roles) and given how prevalent this type of violence is within the respondent population. One women described this violence in detail:

> *"…we were ok until I was about 6 months pregnant. Then he began beating me. He was getting money that he was not telling me about and when I needed money he refused. This caused many fights. His father refused to help in this case and one night he came home when I was pregnant and he had a machete and threatened to kill me if I didn't leave. So, I took my baby and left. His father was happy and had him marry someone else. He does not support me or his baby. I think this is violence."*[57]

With regard to conflict related sexual violence, one very young girl (pictured below) told the following story which very descriptively reports what some young girls have gone through during the conflict in Katana HZ:

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[54] 21 year old female community member, Walikale HZ, Bilobilo HA, Boboro village
[55] Territorial Chief, Katana HZ, Mabingu HA
[56] 67 year old female community member, Katana HZ, Mabingu HA, Kangoko village.
[57] 23 year old female community member, Katana HZ, Birvava HA, Chishoke I village.

"The FDLR came into our village in the night. They burned our house and I ran with the other girls. It was very confusing and we were caught by the armed men. We stayed one night in the bush not far from the village but the next day, we moved for one week far into the forest to a place I did not know. I was only twelve years old. For the first year, I cooked and fetched water. In the second year one of the men came and said if I don't have sex with him, he will kill me. I had no option. Others came one-by-one and it continued….I fled [after 5 years] and got lost in the forest. It took a long time for me to find my way back to the village. I was pregnant then. My baby was born a few months ago. The girls in the village, when they see me, laugh at me. I was very sick when I returned. I had malnutrition."[58]

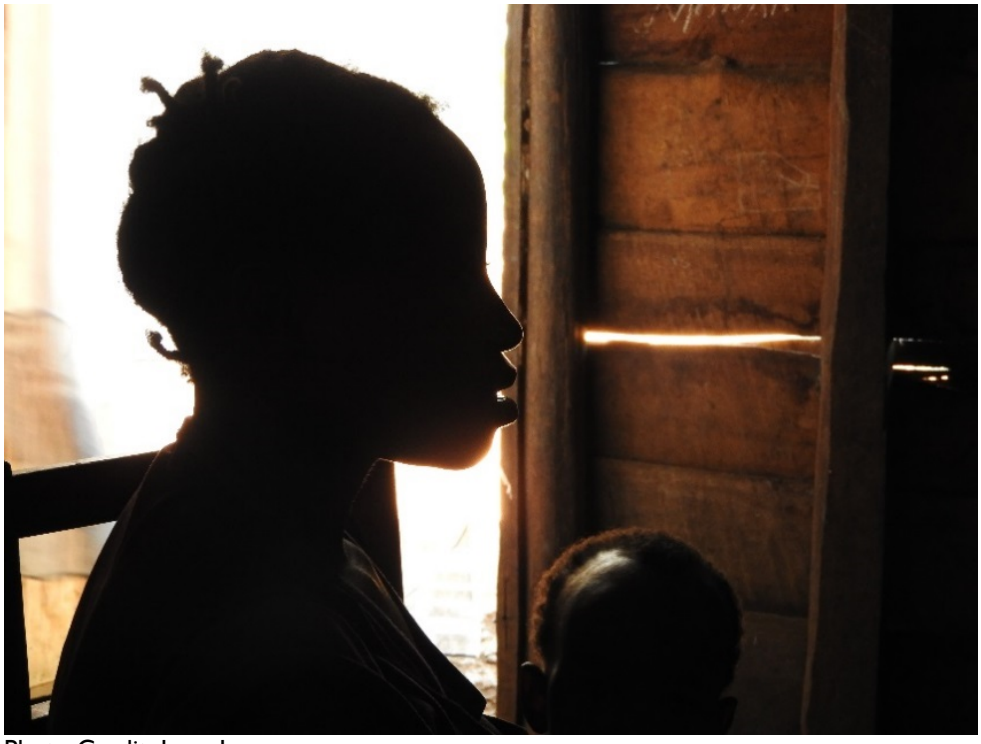


Photo Credit: Lynn Lawry

Another woman in Walikale, gave this story which highlights conflict related sexual violence and the mental health and health consequences that can ensue:

"In the middle of the night three years ago, I woke up thinking that children were pushing my door. Rebels broke open the door and told me to stand up. They asked for money but I didn't have any so they started beating me. They told me to go out of the house. I wasn't wearing anything. Then they asked me to gather all of my things and we started a three hour walk into the Bush. When we [4 other village girls] arrived they told us that we were to cook for them. But before we could start, five rebels began raping me, one after the other. When they had finished, they told me to cook. I don't know what happened after that except they raped me again. In the morning, we heard soldiers who gathered us up after they fought with the rebels and took us back to our village. We were put in a car and taken to Walikale to get medical treatment. The person who was arranging this was killed on his way to Goma and we were sent back to the village without treatment. When I tried to have sex with my husband after the rapes, an organ comes out so now I have self-control and [I] cannot have sex. My husband was killed two years ago by rebels. Now, I am alone. The community does not treat me well because they know of my case. I am stigmatized. When the sun is shining

[58] 17 year old community member (abducted at age 12) Katana HZ, Mabingu HA, Kangoko village

I am a mad person, I come to my house, close the door and lock myself in, I am not OK"[59]

Intimate partner violence was normalized in discussions with community members. One educated male who admitted he had watched his father beat his mother also stated he had beat his wife for the following reasons and justified by stating a hard life pushes men to beat their wives, which was not an uncommon reason given by males:

"She became prideful and impolite so I beat her…if people lived a good life, it would prevent violence…for women who are illiterate and don't behave well, they are subject to being beaten; especially when she continually complains [about the lack of household funds and food]"[60]

A Chief also expressed a similar view:

"Men beating their wives is normal here…if a woman is too proud, her husband will beat her. He believes she needs education and will learn from the beating to be better behaved"[61]

Logistic Regression Analysis Assessing SGBV Risk

The final logistic regression model created for SGBV, IPV and trafficking controlled for age, sex, mean household size and attainment of primary education (Table 14). Following backwards elimination of independent variables including health zone, being a farmer, not working, and substance abuse, the OR for being a student remained the only significant OR for SGBV (0.6; 95% CI, 0.4 – 0.8) and IPV (0.5; 95% CI, 0.3 – 0.9).

Separate models for SGBV among females and males were also created (Table 15). These models controlled for age, sex, mean household size and attainment of primary education. Independent variables included in the full models before backwards elimination included health zone, being a farmer, not working, being a student, substance abuse, agreeing with negative human rights opinions, and rape myths. In the final model for SGBV among females, significant ORs were for substance abuse (1.8; 95% CI, 1.0 – 3.0) and not working (0.3; 95% CI, 0.2 – 0.7). Women with substance abuse were 1.8 times more likely to suffer SGBV and if they were not working they were far less likely to suffer SGBV. Significant ORs in the final model for SGBV among males were living in Karisimbi (0.2; 95% CI, 0.1 – 0.6) and being a student (0.5; 95% CI, 0.3 – 0.8). Therefore, among males, living in Karisimbi and being a student were protective for SGBV.

[59] 29 year old female survivor, Walikale HZ, Elbia HA, Osakari village.
[60] 29 year old male community member, Katana HZ, Ihimbi HA, Kasongolere village
[61] Village Chief, Walikale HZ, Bilobilo HA, Boboro village.

Table 14: Logistic Regression Modeling for SGBV and Trafficking Outcomes 900 Adult Survey Respondents[a]

		SGBV		IPV		TRAFFICKING	
	Number of respondents (n = 893)	**Weighted OR[b] (95% CI)**	***P* Value**	**Weighted OR[b] (95% CI)**	***P* Value**	**Weighted OR[b] (95% CI)**	***P* Value**
Being a student	31	0.6 (0.4 - 0.8)	0.0184	0.5 (0.3 - 0.9)	0.043	0.6 (0.3 - 1.0)	0.0905
Current age	893	1.0 (1.0 - 1.0)	0.1931	1.0 (1.0 - 1.0)	0.6392	1.0 (0.9 - 1.0)	0.0585
Male sex	317	0.9 (0.4 - 2.1)	0.7832	0.8 (0.3 - 2.4)	0.7271	1.3 (0.8 - 2.2)	0.3187
At least some primary education	704	1.4 (0.8 - 2.4)	0.2106	1.5 (0.7 - 3.0)	0.3313	0.9 (0.5 - 1.7)	0.8619
Mean household size	893	1.1 (0.9 - 1.2)	0.3051	1.0 (0.9 - 1.1)	0.8537	1.1 (1.0 - 1.2)	0.2046

Abbreviations: CI, confidence interval; SGBV, sexual and gender based violence; IPV, intimate partner violence; OR, odds ratio;
[a] Survey results are representative of the adult household–based population of Karisimbi, Katana and Walikale health zones in July 2016.
[b]The ORs are calculated via separate multivariate logistic regressions for each type of violence or trafficking and are controlled for current age, sex, household size, and primary education attainment. Control variables are listed in the bottom of the table. Most model variables yield prevalence ORs. The 2 exceptions—household size and current age in years yield ORs that are interpreted as follows: each unit increase in the variable is associated with the given increase or decrease in likelihood of that type of violence. Analysis completed via the svyglm function in the survey package of R, which uses a design-based method for complex survey samples, in that sample weights are incorporated into the modeling procedure and a linearization
variance estimation procedure is used to calculate standard errors for model coefficients.

Table 15: Logistic Modeling for SGBV Outcomes by Gender among 900 Adult Survey Respondents[a]

	SGBV among females			SGBV among males		
	Number of respondents (n = 575)	**Weighted OR[b] (95% CI)**	***P* Value**	**Number of respondents (n = 317)**	**Weighted OR[b] (95% CI)**	***P* Value**
Not working	81	0.3 (0.2 - 0.7)	0.0166	-	-	-
Substance abuse	116	**1.8 (1.0 - 3.0)**	**0.0466**	-	-	-
Living in Walikale		-	-	124	0.5 (0.2 - 1.5)	0.2735
Living in Karisimbi		-	-	104	0.2 (0.1 - 0.6)	0.0209
Being a student		-	-	16	0.5 (0.3 - 0.8)	0.0119
Current Age	575	1.0 (1.0 - 1.0)	0.8972	317	1.0 (0.9 - 1.0)	0.0055
At least some primary education	420	**1.8 (0.9 - 3.5)**	**0.1398**	279	1.1 (0.4 - 2.8)	0.8012
Mean household size	575	1.1 (1.0 - 1.3)	0.1722	317	0.9 (0.8 - 1.1)	0.3565

Abbreviations: CI, confidence interval; MDD, SGBV, sexual and gender based violence;
[a] Survey results are representative of the adult household–based population of Karisimbi, Katana and Walikale health zones in July 2016.
[b]The ORs are calculated via separate multivariate logistic regressions for each type of violence or trafficking and are controlled for current age, sex, household size, and primary education attainment. Control variables are listed in the bottom of the table. Most model variables yield prevalence ORs. The 2 exceptions—household size and current age in years yield ORs that are interpreted as follows: each unit increase in the variable is associated with the given increase or decrease in likelihood of that type of violence. Analysis completed via the svyglm function in the survey package of R, which uses a design-based method for complex survey samples, in that sample weights are incorporated into the modeling procedure and a linearization variance estimation procedure is used to calculate standard errors for model coefficients.

Child Violence

More than 60% of respondent men and women agreed that they used beatings as a form of discipline for their children (Annex VII, Table 10).

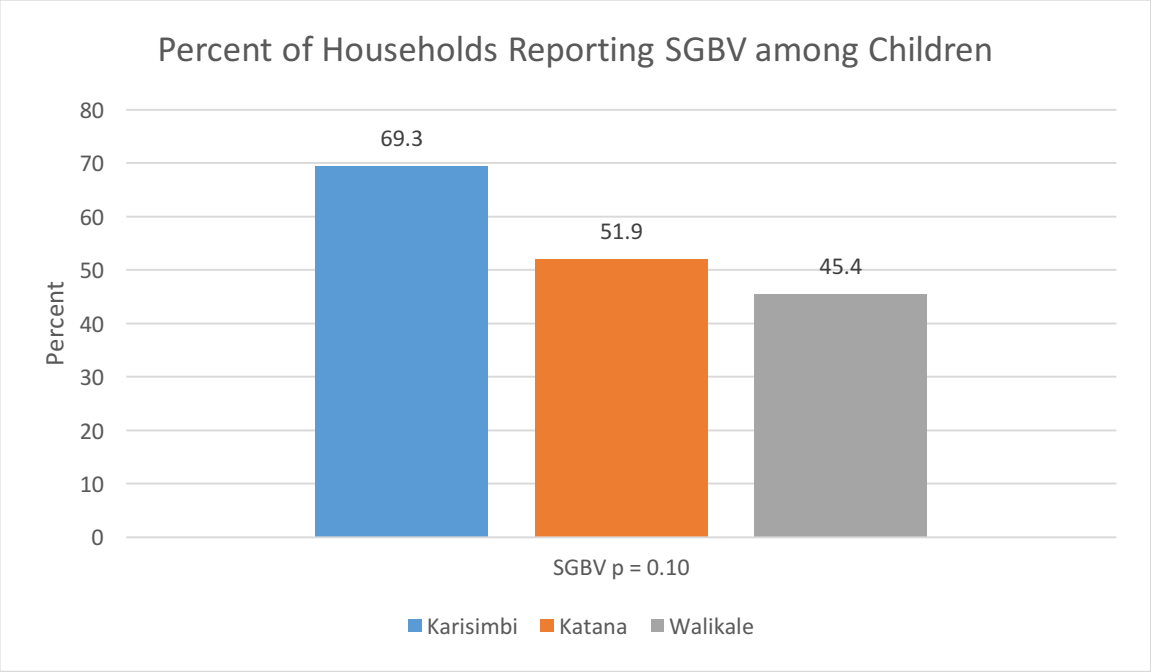
In one village International Medical Corps (IMC) implemented a program called Children's Parliament where children reported child violence to the police. Men in the village stated the following regarding

this program:

> *"Children's Parliament (IMC) continues to run but it has run into difficulty because it is not culturally appropriate. Children have turned their parents into the police. Beating our children will fix this"*[62]

SGBV rates of household children by health zone are presented in Figure 15.[63]

Figure 15: Percent of Households Reporting SGBV among Household Children by Health Zone

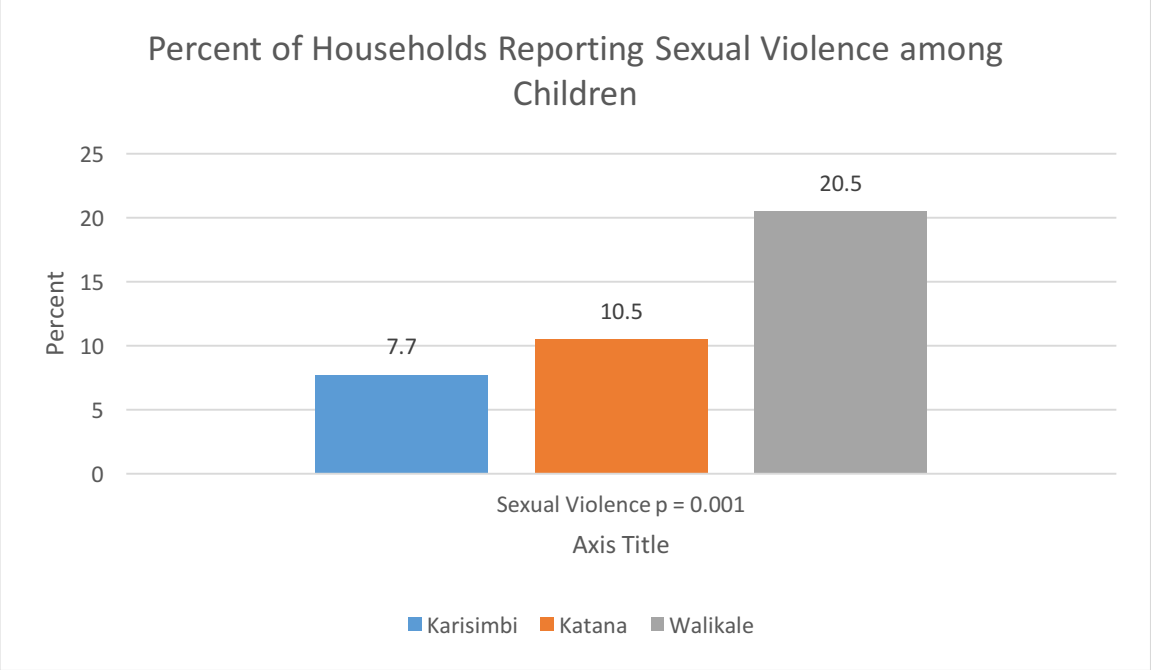


Sexual violence rates of household children by health zone are presented in Figure 16. Walikale has significantly higher rates of sexual violence among children; double or more than double the rates in the other two health zones.

Based on population estimates, 59,103 children are affected by sexual violence and 299,438 by SGBV.

[62] Community men (12) ages 30-57 years old, Walikale HZ, Bilobilo HA, Indjiki village
[63] Includes all forms of trafficking as well.

Figure 16: Percent of Households Reporting Sexual Violence among Household Children



Trafficking among Children

Five percent of households reported trafficking of household children (Annex VII, Table 6). There were no statistical differences among the rate differences in the health zones (Annex VII, Table 5).

The most common forms of trafficking among children included forced to work in a bar/bistro, forced to be domestic health and forced indebtedness in Karisimbi; forced indebtedness, held against will and forced to be a sexual servant in Katana; and forced indebtedness, forced marriage and held against will in Walikale (Annex VII, Table 7).

The most commonly listed recruitment techniques used for children and the same as adults included threats to personal security, abduction, family subjected them to trafficking or they wanted to participate due to the incentives offered such as food or money. More than a third of survivors stayed because their personal security or family was threatened, the need for food, or they were in an unfamiliar environment (Annex VII, Table 7).

Qualitative interviews revealed that in the mining areas of Walikale, young girls are being taken to the larger towns around the mine to work in bars and in some cases are forced to have sex with miners who may or may not be from the area.

> *"Minors in the village are working in bars and nightclubs after being taken to Mubi, and are badly dressed. Even authorities who visit this territory from other territories, visit the bars and nightclubs where girls are working and they have sex with them."*[64]

Based on population estimates (household respondents stating they had a child who was trafficked), 24,224 children are affected by trafficking.

[64] Community men (12) ages 30-57 years old, Walikale HZ, Bilobilo HA, Indjiki village.

Survival Sex

Walikale and Katana were the only health zones to report survival sex among children. During qualitative interviews, a Chief in Katana stated the following:

> *"…these young girls whose husbands have left and gone far away will give sex to any fisherman who offers them Sambaza [small fish from Lake Kivu]"*[65]

Underage Sexual Violence

Several forms of child sexual violence were identified in qualitative interviews and were different from those identified in the quantitative data.

In addition to the traditional kidnapping, boys in their teens are kidnapping girls because they want sex and it is easy to do so, especially with underage girls.[66]

In Kabushwa HA in the Katana HZ, there have been advocacy reports concerned about the rape of babies and very young children. [67] In these reports, the reason given for this disturbing practice was stated as "witchcraft" with little to no details regarding this practice. In an interview with a Witch Doctor from Kabushwa HA she described the practice as follows:

> *"There are people who want to have powers as a Witch Doctor. They come in the night and take girls ages 1 month-10 years old and rape them because they are virgins. This [sex with virgins] gives them the power to do good and bad spells. Some Witch Doctors also believe that by having sex with a virgin, their powers will be enhanced, even to kill…they don't leave them to be harmed, they return them to the house afterwards so they can be cared for."*

In Walikale, community members stated:

> *"…minors in the village are working in bars and nightclubs after being taken to Mubi, and are badly dressed. Even authorities who visit this territory from other territories, visit the bars and nightclubs where are girls are working and they have sex with them."*[68]

In Osakari village of Eliba HZ which is in mining areas, parents are also sending their minor girls to sell alcohol around 5km from the village. After some time, the girls return pregnant.[69]
Finally, every village Chief interviewed told researchers that men and boys were having sex with underage girls. Although they stated they reported these rapes to authorities, some community members stated that these cases were settled either between families or at the discretion of the Chief.[70]

In the urban area of Karisimbi, a female Avenue Chief stated the following regarding rape of young girls on her avenue:

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[65] Chief, Katana HZ, Birvava HA, Chishoke II village.
[66] 105 year old community male Indjiki village, Bilobilo HA, Walikale HZ and Community men (7) ages 27-61 years. old Bilobilo AS, Mubi Kopa village, Walikale HZ.
[67] This is not the only area with reports of these issues. See: https://iwpr.net/global-voices/congolese-infants-raped-black-magic-rituals.
[68] Group meeting with 12 community men (Ages 30-57 years old). Indjiki village, Bilobilo HA, Walikale HZ.
[69] Chief and community elders in Osakari village, Eliba HA, Walikale HZ.
[70] 28 year old male community member Kasongolere village, Ihimbi HA, Katana HZ.

"The problem [sexual violence of young girls] exists because of the market…by day this area serves as a meat market but at night, men and boys wait until they see a young girl and then they grab them as they walk by and rape them in the market"[71]

Upon viewing the market with the Chief, it was clear the cement walls hide areas where sex can happen unnoticed (Figure 17). From the main avenue, it is not possible to see into the stalls as the front of the rows are simple solid cement. Some of the stalls had debris from the night before such as makeshift pillows made of straw and leaves and a few condom wrappers.

Figure 17: Meat Market Stalls in Karisimbi

Photo Credit: Lynn Lawry

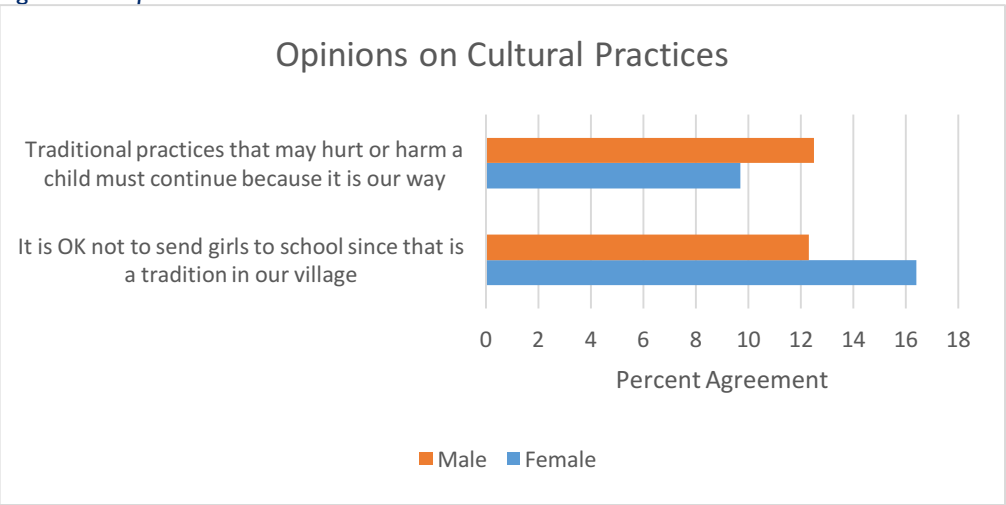
Harmful Traditional Practices

Opinions

A minority of women and men believe that harmful traditional practices should continue for the sake of tradition; 12% of men and 16% of women agreed that girls can be kept from school due to tradition (Figure 18).

[71] Chief, Makundi II Avenue, Karisimbi HZ, Kasika HA.

Figure 18: Opinions on Traditional Practices



Qualitative interviews revealed harmful traditional practices are largely still practiced in the villages. These traditional practices include other forms of SGBV not captured on the quantitative survey. They fall into four categories, each discussed below, and include forced marriages, male circumcision, and other SGBV practices.

Forced Marriage

Several forms of forced marriage were identified during interviews. These forced marriages were not limited to young girls, but included boys and older women. Many of these forced marriages were combined with kidnapping.

If a man dies, his brother is required to take his brother's wife in marriage regardless if the widow agrees or not. This practice is known as *Levirat*. Conversely, *Sororat* is practiced if a woman dies whereby the widower is allowed to take her younger sister. The reason given for these practices was to keep "the peace" between families.[72]

The accepted bride price in Katana and Walikale is 12 goats; however, few if any can afford 12 goats and therefore kidnappings have become more normalized to lessen the burden of the bride price. Known as *Kumbora*, this tradition, commonly practiced and mentioned in multiple interviews, was described as the following:

> *"When a boy or a man decides he wants to marry a girl, if she declines, he kidnaps her and takes her to his village. The family of the girl then comes to the village and sets the price to be paid for their daughter. This can include compensation of money, goats, food, beer, and/or clothes, for instance a new dress or a new suit. In some cases, the price is dependent on the girl's education; the higher the education, the higher the asking price. For example, for a girl who has completed primary school, the price asked includes all of her fees for the years she finished in primary school. If a girl is illiterate, the price is determined by her virginity and includes goats, money, food and beer. Even the price of the moto for transportation and the gas for the moto to the village is asked. For unmarried single mothers, they have no value and therefore the best a family can ask for is two goats, maybe three."*[73]

[72] 105 year old community male Indjiki village, Bilobilo HA, Walikale HZ
[73] Chief, Shemakonogolo village, Elbia HA, Walikale HZ

If a girl is kidnapped and the family of the boy cannot meet the demands of the girl's family, the girl is taken back to her village in the hope they will be able to find someone who can meet the bride price demands.[74]

In other cases, families lie about the age of their daughters so they can get money (or goats) and they try to find a potential husband for their daughter. The new husband must continue to provide after the marriage and if he cannot, the parents take back the girl and marry her to someone who has money.[75]

Male Circumcision

Known as *Yando*, boys around 13-15 years of age, are taken to the bush by older village men or by the Witch Doctor where they are circumcised.[76] Details were not given regarding this type of circumcision but those who mentioned it stated it was *"not healthy for the boys"* suggesting that the methods for this were unhygienic.[77] In addition to the circumcision, these boys are taught about sexual intercourse and are *"trained to complete the act so once they come back, they practice on little girls [ages 12-14] in the village."*[78]

Other Harmful Traditional SGBV Practices

The Chief and community elders in Osakari Village, Elbia HA in the Walikale HZ reported a practice whereby when a woman's husband dies, she is considered to have cursed him as a Witch. Once this is believed by the community, as punishment, she is told she must carry enough water to the village for 10 men to bathe each day for an unspecified period of time.[79] She is also demanded to give chickens to her husband's family and if she cannot do that, the community takes her neighbors chickens thereby further alienating her in the community. Her clothing and clothing can also be taken. In severe cases where mediation from the Chief and her family is unsuccessful, she is "chased" back to her family, her children are not allowed to go with her and are left to fend for themselves in the village. These children become street children, lose their access to education and starve.

A less abusive practice involving widows is known as "40 days" where after the death of husband, a woman is required to stay in her house for the entire 40 days. During this time, she cannot farm, find food, bathe or complete any activities of daily living. After the 40 day period, her head is shaved and she is allowed to resume her activities. It was unclear why this practice had evolved or the significance around the practice but during these 40 days, many women have become ill. The practice is not done by men who lose their wives.[80]

[74] Community men (7) ages 27-61 years old Bilobilo AS, Mubi Kopa village, Walikale HZ

[75] Community men (7) ages 27-61 years old Bilobilo AS, Mubi Kopa village, Walikale HZ

[76] Previously documented in Ushindi's old health zones, there is a similar practice called *Kumbi Kanji* which is common among mostly Bantu ethnic groups.

[77] 105 year old community male Indjiki village, Bilobilo HA, Walikale HZ and the Chief of Chishoke I, Kabushwa HA, Katana HZ.

[78] 105 year old community male Indjiki village, Bilobilo HA, Walikale HZ.

[79] Osakari community members stated this can go on as long as five years.

[80] 105 year old community male Indjiki village, Bilobilo HA, Walikale HZ

Mental Health

Substance Abuse

Respondents were asked:

- If they were taking drugs or alcohol more than two times per week or to excess each time
- If there were any changes in intake over the last year
- If drugs or alcohol led to violence being perpetrated against them from spouses, partners, relatives or community members.

Self-reported substance abuse rates overall were 28% with much higher rates of substance abuse among men (39%) or double the rates of women. A fifth of women reported substance abuse. There were however health zone differences in substance abuse rates. Karisimbi (33%) had significantly higher rates (p = 0.02) of substance abuse when compared to the rural health zones of Katana (23%) and Walikale (16.9%) (Annex VII, Table 6).

Eleven percent of women and 17% of men stated their intake in the last year had not changed, while 17% of men and 10% of women stated their intake had decreased. Few if any reported an increase in substance use (1% of women versus 3% of men). Sixty-six percent of women and 53% of men stated they had never used drugs or alcohol (Annex VII, Tables 9).

Using these data to extrapolate and generalize to our total survey population of 727,754 persons, we estimate that 64,081 males and 30,240 females have current substance abuse.

When respondents were asked if substance abuse was a contributing factor to violence against them, only two percent of women and eight percent of men (p = .03) reported alcohol related violence. Alcohol shops were prevalent, especially in semi-urban areas such as Mubi, Walikale, and Karisimbi where beer, hard liquor of all types and local brews were sold. However, the cost of beer or other bottled liquor is unaffordable for most therefore a maize-based white liquor is made and sold, particularly in the villages, by women. In some cases, this is alcohol is found in old bottles but for the most part, it is sold in small quantities in plastic bags. Researchers were told in Karisimbi that these small bags are illegal due to associated methanol poisoning deaths from drinking the alcohol. Depending on the area, this liquor is called *Kanynaga, Mangwende,* or *Lutuku* among other names. The cost is anywhere from 350 CDF (~35 cents) to 500 CDF (~50 cents). During interviews, it was not uncommon to smell alcohol or *Bangi* on respondents, even early in the morning. Interviews revealed there are several types of alcohol available. [81]

Qualitative interviews showed a significant concern over alcohol induced violence. This was mentioned by Chiefs and community members.

> *"…although alcohol makes more violence, Bangi just makes people want to do nothing"*[82]

> *"When men use alcohol and Bangi, they become violent and beat their wives. Sometimes they take their money and use it on other women in Mubi instead of making sure there is money for their house"*[83]

[81] *Bangi* is the local name for marijuana
[82] Chief of Boboro Village, Walikale HZ, Bilobilo HA
[83] 105 year old community member, Walikale HZ, Bilobilo HA, Indjiki village

"…our husbands get drunk and come home and beat us. They tell us they are beating us because we don't cook better food but how can we do that when we don't have the money to buy better food?"[84]

Both men and women remarked that women who work in the fields use alcohol and among some of the men's opinions, this use during their time in the fields is why they suffer violence.

"Sometime though, women drink and therefore they are beaten. Women do have one bottle [white alcohol] they take to the fields but for the most part no one can afford beer in this village so it [beer] is not a problem."[85]

Youth were also singled out as users of alcohol.

"Community violence is also a problem. Men beat their wives. The youth especially seem to have this problem because they do not listen to what the parents have to say and they have started using alcohol."[86]

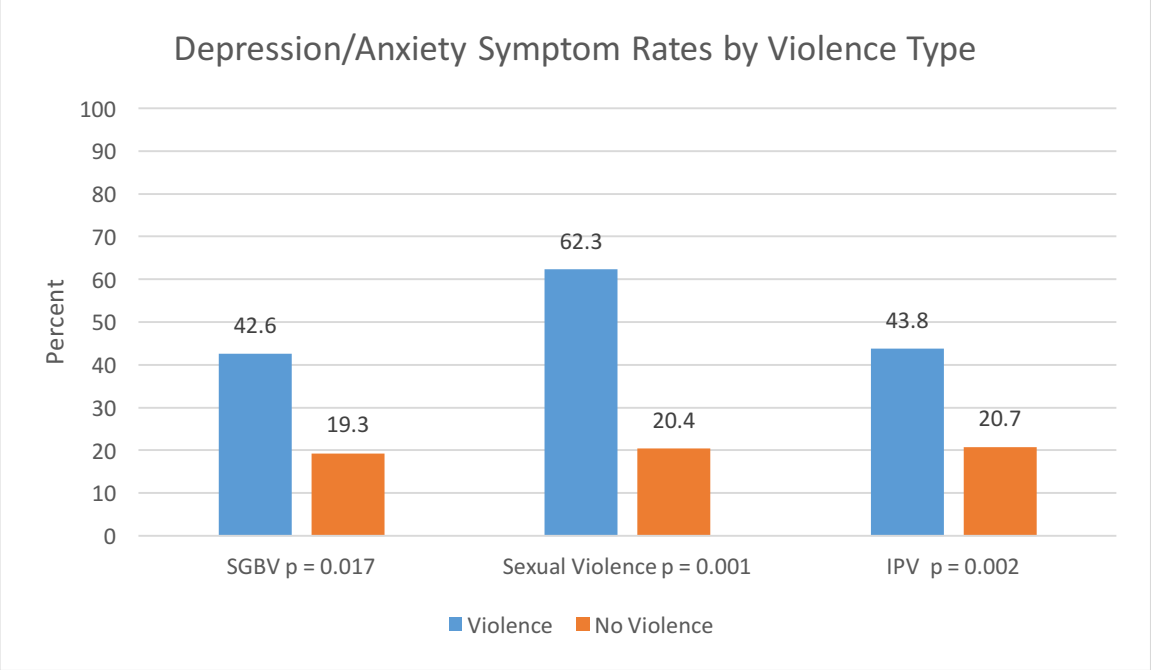
Finally, rates of substance use were not different among those who had/had not suffered SGBV, sexual violence, IPV or were trafficking survivors or from the overall baseline rate.

Depression/Anxiety

The population rate of symptoms consistent with depression/anxiety was 27%. Overall, women trended towards higher symptom rates of depression/anxiety (31% versus 20%; $p = 0.27$) than men but there was no statistical difference in these numbers (Annex VII, Table 8). However, there were statistically significant higher rates of depression/anxiety among respondents who reported SGBV, sexual violence and IPV (Figure 19). Trafficking was not associated with higher rates of depression/anxiety. Walikale had the highest rates with an overall prevalence of 59% (Annex VII, Table 6). Overall, and extrapolated to population figures, 50,237 women and 17,544 men make symptom criteria for depression/anxiety among the implementation areas of Katana and Walikale and in the entire health zone of Karisimbi.[87]

[84] 50 year old community female Walikale HZ, Bilobilo HA, Boboro village
[85] 56 year old community female, Chief's wife, Katana HZ, Birvava HA, Chishoke I village
[86] Chief of Mabanda village, Walikale HZ, Sacre Coeur HA
[87] The nature of this study (a multistage clustered random sample survey) allows for the determination of association of population characteristics but not causality. It is therefore not possible to state that the violence was a cause of the mental health symptoms

Figure 19: Depression/Anxiety symptom rates sub-grouped by violence type for all respondents

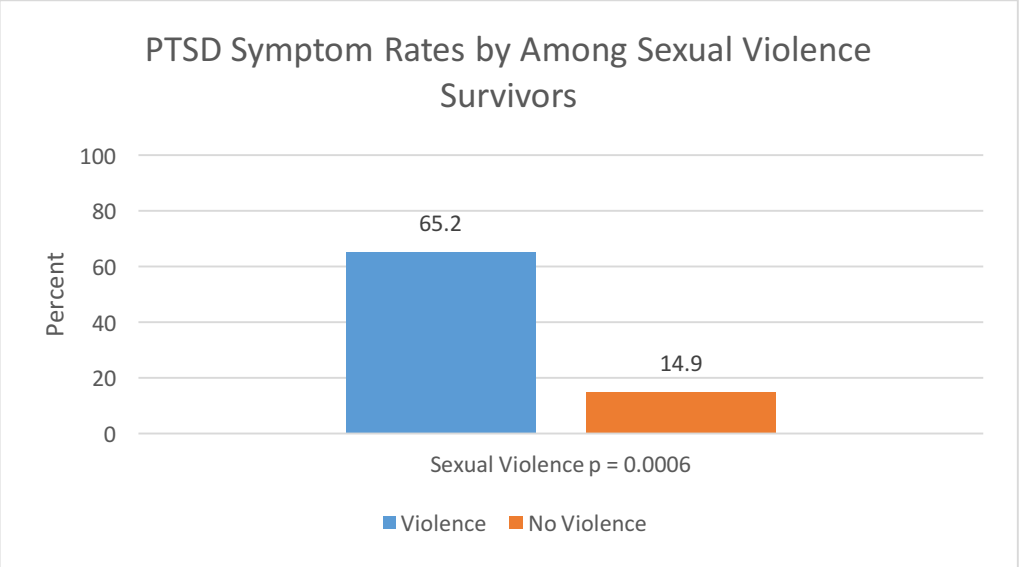


PTSD

The population rate of symptoms consistent with PTSD was 23%. There were no symptom rate differences between men and women. Only those who reported sexual violence had statistically significant differences in rates; whereby survivors had rates of 65% compared with only 20% of those who did not report sexual violence (Figure 20). SGBV, IPV and trafficking was not associated with higher symptom rates of PTSD. Walikale had much higher symptom rates of PTSD (50% versus 16% in Katana and 14% in Karisimbi) when compared with other health zones (Annex VII, Table 6). When these household rates are extrapolated to population figures, an estimated 45,235 women and 14,865 men make symptom criteria for depression/anxiety among the implementation areas of Katana and Walikale and in the entire health zone of Karisimbi.[88]

[88] The nature of this study (a multistage clustered random sample survey) allows for the determination of association of population characteristics but not causality. It is therefore not possible to state that the violence was a cause of the mental health symptoms.

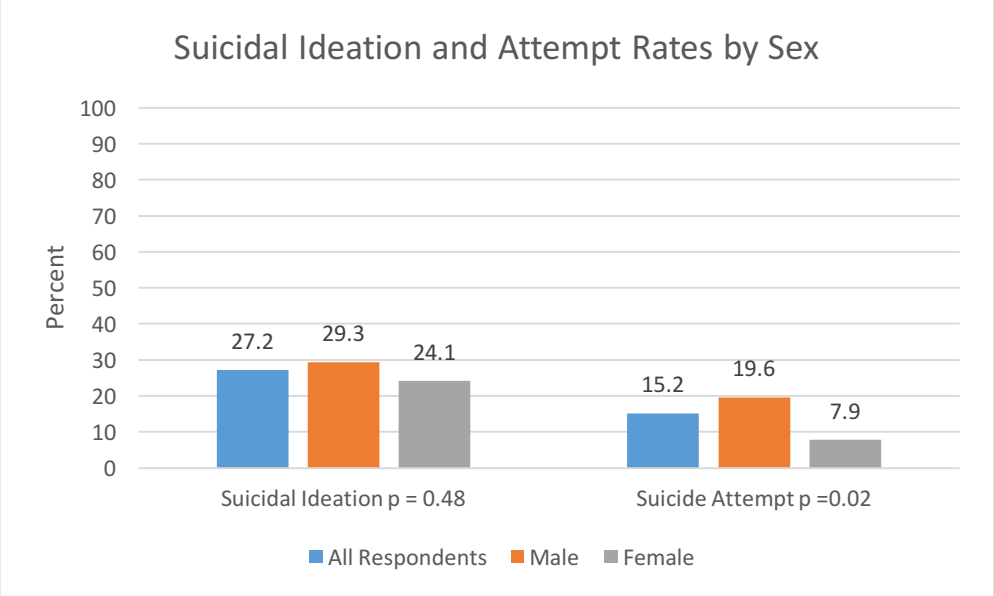
Figure 20: PTSD symptom rates sub-grouped by sexual violence survivors and non-survivors for all respondents



Lifetime Suicidal Ideation and Suicide Attempt

Twenty-seven percent of respondents reported suicidal ideation and 15% reported a previous suicide attempt in their lifetime. With regard to suicidal ideation, although not statistically significant, women trended towards higher rates whereby women had more than double the rates of suicide attempts compared to men (Figure 21). There were no differences between health zone rates.

Figure 21: Suicidal Ideation and Attempt Rates by Sex



However, there were highly statistically significant differences of suicidal ideation (Figure 22) and suicide attempt rates (Figure 23) among survivors of SGBV, sexual violence, and IPV. Statistically significant higher rates of suicide attempts were found among those who reported being trafficked (Figure 23).

Figure 22: Lifetime Suicidal Ideation rates sub-grouped by violence type for all respondents

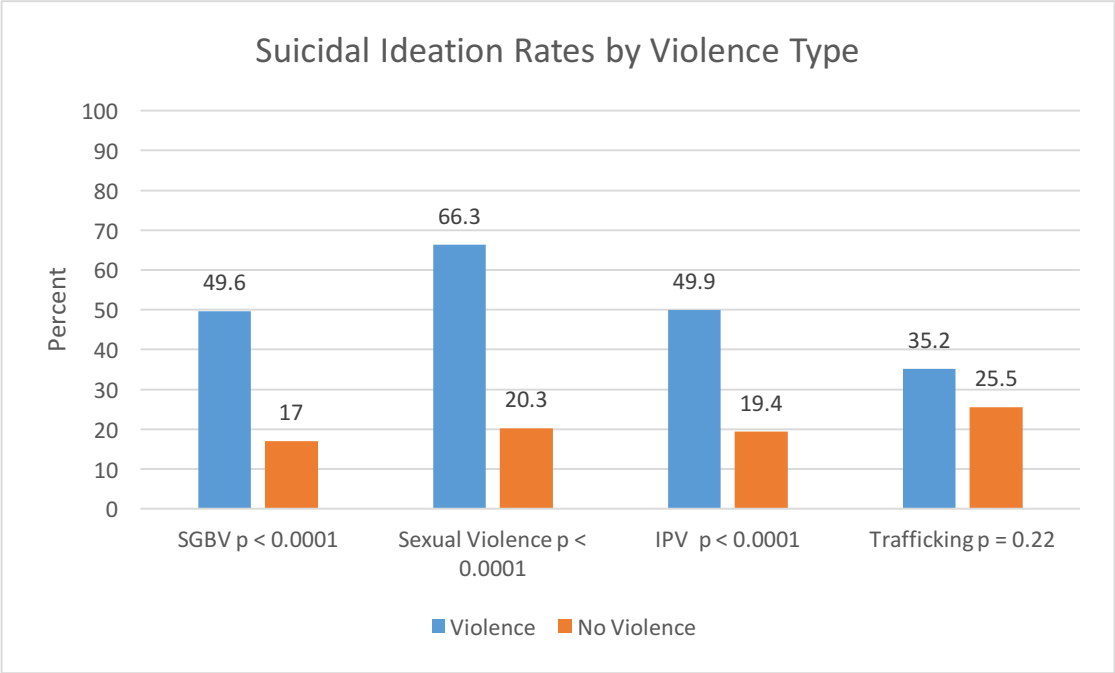
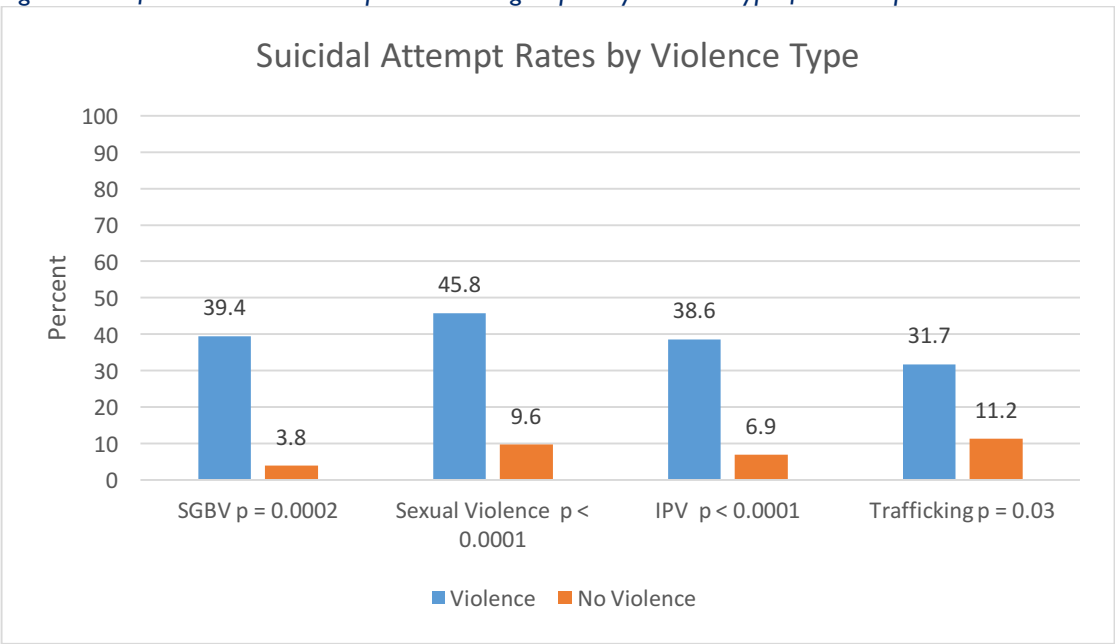


Figure 23: Lifetime Suicide Attempt Rates sub-grouped by violence type for all respondents



Extrapolating to the survey population, an estimated 48,235 women and 34,761 men have had suicidal ideation and 33,593 women and 15,966 men have attempted suicide. However, and as previously stated, a multistage clustered random sample survey allows for the determination of association of population characteristics but not causality. It is therefore not possible to state that the violence was a cause of the suicidal ideation or suicide attempts.

Respondents remarked on male survivors and mental health:

> *"Most of these men have mental disorders when they return [from the Bush], they do not do well."*[89]

> *"There are men in the village who were raped by the Mai-Mai. They were taken very far in the bush to carry things for the Mai-Mai and they came back, they were not right and suffered greatly; not leaving the house or going to the fields…not wanting to see anyone"*[90]

Logistic Regression Modeling to Assess Risk of Mental Health Disorders among Survivors

The ORs for MDD and PTSD symptoms as well as suicide ideation, developed via logistic regression and controlled for demographic characteristics such as age and sex, underscore the relationship between sexual violence, substance abuse and mental health (Table 16).

When compared to someone with no history of SGBV, the odds of MDD symptoms in SGBV survivors are 4.6 (95% CI, 2.0 – 10.6) times greater, the odds of PTSD are 5.8 (95% CI, 1.5 – 23.1) times greater and the odds of suicide ideation 5.7 (95% CI, 3.9 – 8.3) times greater. Significant ORs for suicide ideation also include substance abuse (1.8; 95% CI, 1.2 – 2.7). Additionally, when compared to living in Katana, living in Walikale is associated with worse mental health outcomes on all three measures. The OR for MDD symptoms and Walikale residency 19.8 (95% CI, 5.2 – 75.2), the OR for PTSD and Walikale residency is 10.9 (95% CI, 3.4 – 35.6) and the OR for suicide ideation and Walikale residency is 3.5 (95% CI, 1.8 – 6.8).

Table 16: Logistic Regression Modeling to Assess the Relationship of SGBV and Mental Health Disorders among 900 Adult Survey Respondents[a]

		MDD		**PTSD**		**SUICIDE IDEATION**	
	Number of respondents (n = 893)	**Weighted OR[b] (95% CI)**	***P* Value**	**Weighted OR[b] (95% CI)**	***P* Value**	**Weighted OR[b] (95% CI)**	***P* Value**
History of SGBV	364	4.6 (2.0 - 10.6)	0.0092	5.8 (1.5 - 23.1)	0.0401	5.7 (3.9 - 8.3)	<0.0001
Living in Walikale	301	19.8 (5.2 - 75.2)	0.0032	10.9 (3.4 - 35.6)	0.0054	3.5 (1.8 - 6.8)	0.0076
Living in Karisimbi	320	1.5 (0.6 - 3.6)	0.4511	0.9 (0.5 - 1.6)	0.7739	1.6 (0.7 - 3.8)	0.3134
Substance Abuse	242	1.0 (0.5 - 1.9)	0.9801	1.4 (0.7 - 2.9)	0.4208	1.8 (1.2 - 2.7)	0.0318
Current Age	893	1.0 (1.0 - 1.1)	0.0102	1.0 (1.0 - 1.0)	0.5949	1.0 (1.0 - 1.1)	0.2226
Male sex	317	0.2 (0.1 - 0.5)	0.0109	0.2 (0.1 - 0.4)	0.0022	0.5 (0.4 - 0.8)	0.0152
At least some primary education	704	0.5 (0.2 - 1.4)	0.2249	0.7 (0.3 - 1.4)	0.3073	0.6 (0.1 - 3.3)	0.5377
Mean household size	893	0.9 (0.8 - 1.1)	0.2930	1.0 (0.9 - 1.1)	0.7822	1.1 (1.0 - 1.1)	0.157

[89] 67 y/o female community member, Katana HZ, Mabingu HA, Kangoko village
[90] Village Chief, Walikale HZ, Bilobilo HA, Boboro village

Abbreviations: CI, confidence interval; MDD, major depressive disorder; OR, odds ratio; PTSD, posttraumatic stress disorder.
[a] Survey results are representative of the adult household–based population of Karisimbi, Katana and Walikale health zones in July 2016.
[b] The ORs are calculated via separate multivariate logistic regressions for each type of violence or trafficking and are controlled for current age, sex, household size, and primary education attainment. Control variables are listed in the bottom of the table. Most model variables yield prevalence ORs. The 2 exceptions—household size and current age in years yield ORs that are interpreted as follows: each unit increase in the variable is associated with the given increase or decrease in likelihood of that type of violence. Analysis completed via the svyglm function in the survey package of R, which uses a design-based method for complex survey samples, in that sample weights are incorporated into the modeling procedure and a linearization variance estimation procedure is used to calculate standard errors for model coefficients.

Reproductive Health

The mean number of pregnancies among female respondents was 5.8 with a mean number of live births of 5.0. Women also reported on violence during pregnancy. In this regard, the mean number of resulting pregnancies from violence was 1.1 and the mean number of miscarriages as a result of violence was 1.8 (Annex VII, Table 9).

Health and Mental Health Care Access

Services Accessed

Respondents were asked what medical services they had accessed. Only a fraction of respondents stated they had not accessed any medical services (4% of women and 3% of men).

Clinics were the most commonly used medical services (71% women; 66% men). The pharmacy was also used heavily (39% of women and 42% of men). Just under a third of men (28%) and women (35%) sought care at a hospital. Sixteen percent of women and 20% of men stated they used medical services from traditional healers and/or witch doctors (Annex VII, Table 9).

Reasons for Not Accessing Services

Reasons women gave for not accessing services at any time are presented in Figure 24. Men's main reasons for not accessing medical care are presented in Figure 25.

Figure 24: Main Reasons for Not Accessing Medical Services (%) - Women

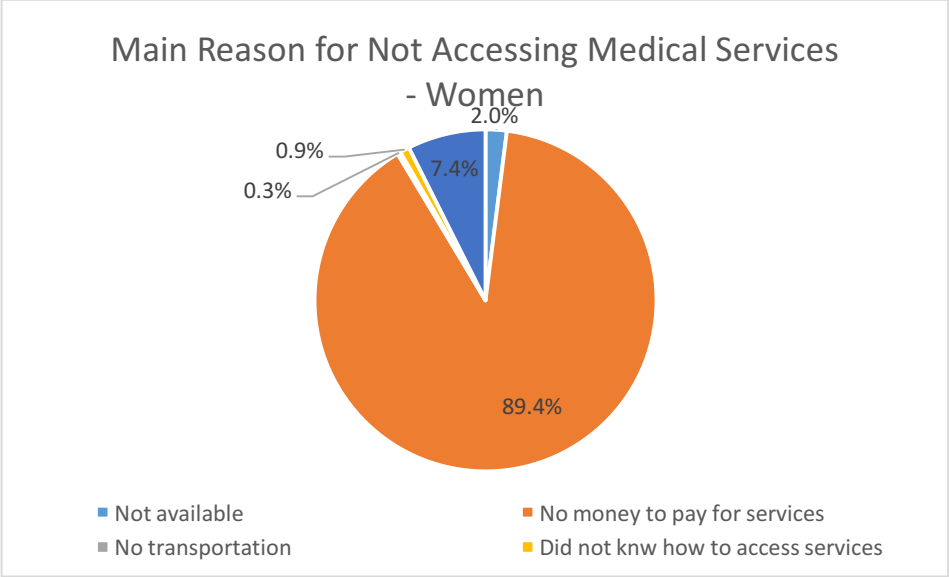
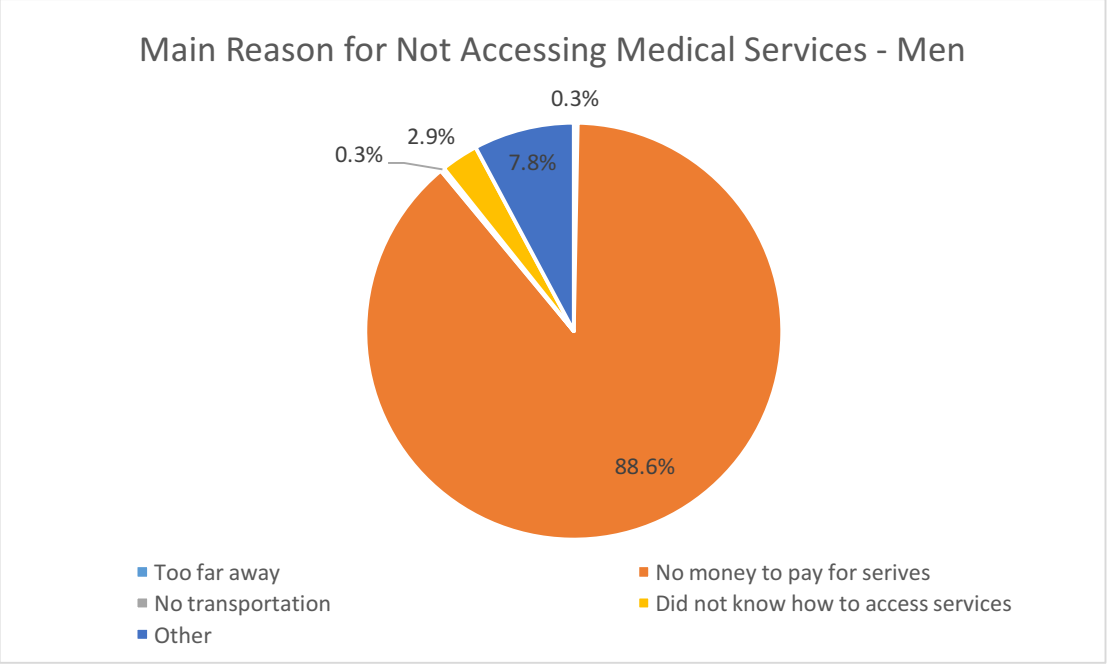


Figure 25: Main Reason for Not Accessing Medical Services (%) – Men



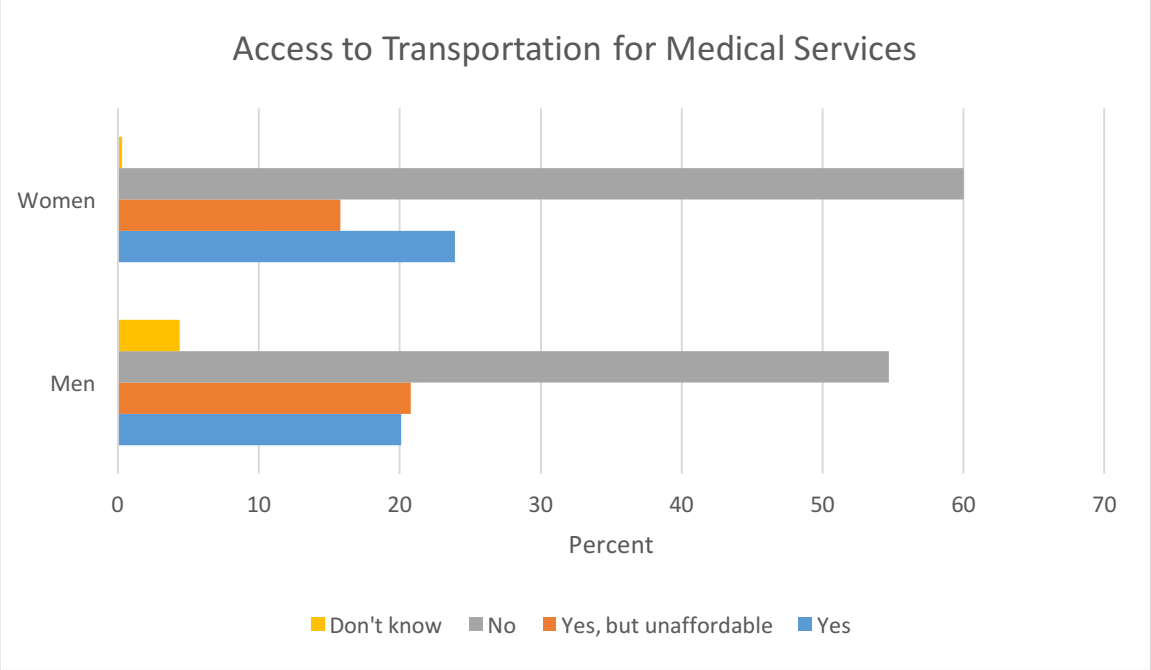
Distance to Medical Services on Foot

The majority of women (69%) and men (75%) stated that medical services were less than an hour's walk. One quarter of women and 18% of men stated that one could reach medical services in 1-2 hours on foot. Less than six percent of both men and women stated medical services were more than 2 hours away on foot.

Transportation for Medical Services

Respondents were asked whether there was access to medical services in their area. The following figure presents the data (Figure 26). Overall, the majority did not have access to transportation or could not afford such transportation.

Figure 26: Available Access to Transportation for Medical Services



Most Needed Medical Services

In the views of the respondents (Annex VII, Table 9), women listed the following as the most needed medical services in their communities (ordered most to least identified):

1) **Education**
2) **Medical Care**
3) **Rehabilitation Centers**
4) Support Groups
5) Vocational/Skills Training
6) Mental Health Counseling
7) Religious Counseling/Support
8) Income Generation Projects

For men, the list is similar with a few changes in the order:

1) **Medical Care**
2) **Rehabilitation Centers**
3) **Vocational/Skills Training**
4) Education
5) Support Groups
6) Mental Health Counseling
7) Religious Counseling/Support
8) Income Generation Projects

The two of the top three listed most often are similar with women listing education first and men listing vocational/skills training in their top three.

Mental Health Counseling and Reasons for Not Accessing Services

A small proportion of women (17%) and men (18%) stated they had used mental health counseling. Only 3% of women and 38% of men agreed that the mental health programs offered in their area were sufficient to meet the needs of the community (Annex VII, Table 10).

When respondents were asked what would stop them from accessing mental health services, 60% of women and 50% of men stated that "nothing" would stop them. "Feeling ashamed" was listed by less than 10% of women and men as a barrier to counseling. Four percent of women and 6% of men stated they did not believe that counseling would be of benefit. Seven percent of women listed concerns about confidentiality and only 2% of women and 1% of men stated "stigma" as a reason for not accessing mental health services (Annex VII, Table 9).

Opinions on Gender Roles and Justice

Respondents were asked about their agreement or disagreement with rights, gender roles, justice and cultural practices. The following figure represents data pertaining to justice opinions. Among these statements, there were no statistical differences between men or women's agreement to any statements presented below.

Gender Roles

With regard to gender roles women (36% women vs. 28% men) were more likely to agree that a man has a right to beat his wife if she disobeys and that a "good wife" obeys her husband even if she disagrees (68% women vs 60% men). Forty-three percent of women and just under 31% of both men agreed that it is a wife's obligation to have sex with her husband even she doesn't want to (Annex VII, Table 10).

In qualitative interviews, one woman explained why not refusing is important:

> *"Many women will not say no to sex even if they don't want it because they are afraid they will push the husband to another wife"*[91]

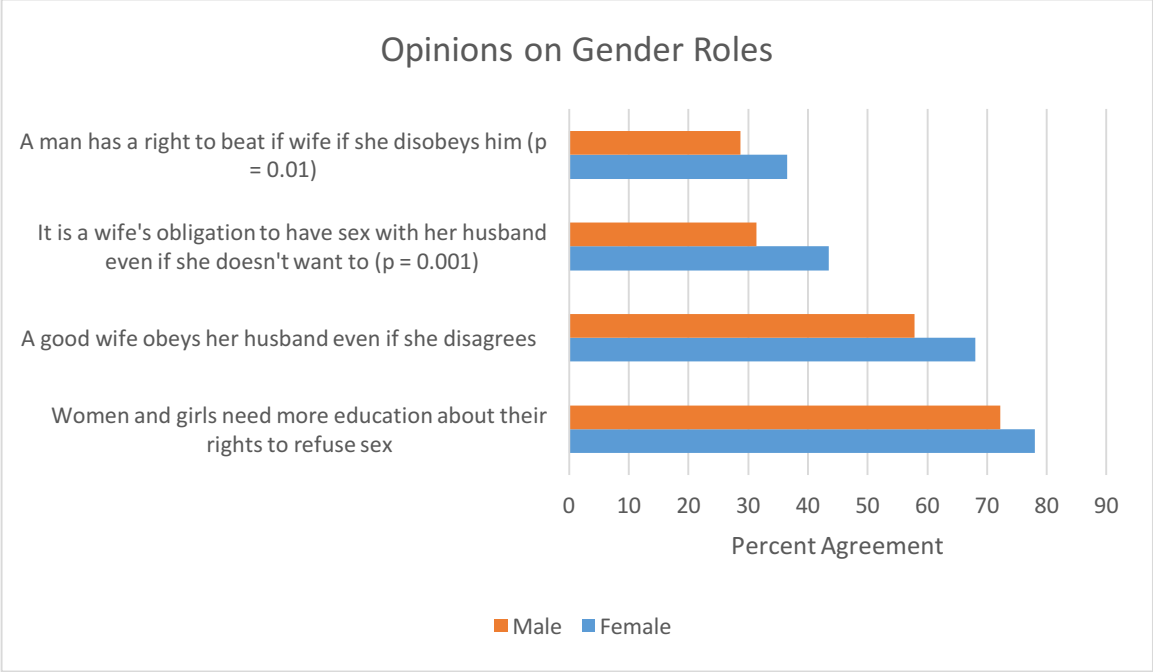
A village elder explained why physical violence happens which included when women refused sex:

> "Physical violence happens because men are not respected, their orders are not respected but mostly if they [wives] refuse sex"[92]

There was overwhelming agreement that women and girls need more education to about their rights to refuse sex (Figure 27).

[91] 23 year old female community member, Katana HZ, Birvava HA, Chishoke I village
[92] 105 year old community male (village elder), Walikale HZ, Bilobilo HA, Indjiki village

Figure 27: Opinions on Gender Roles Disaggregated by Sex

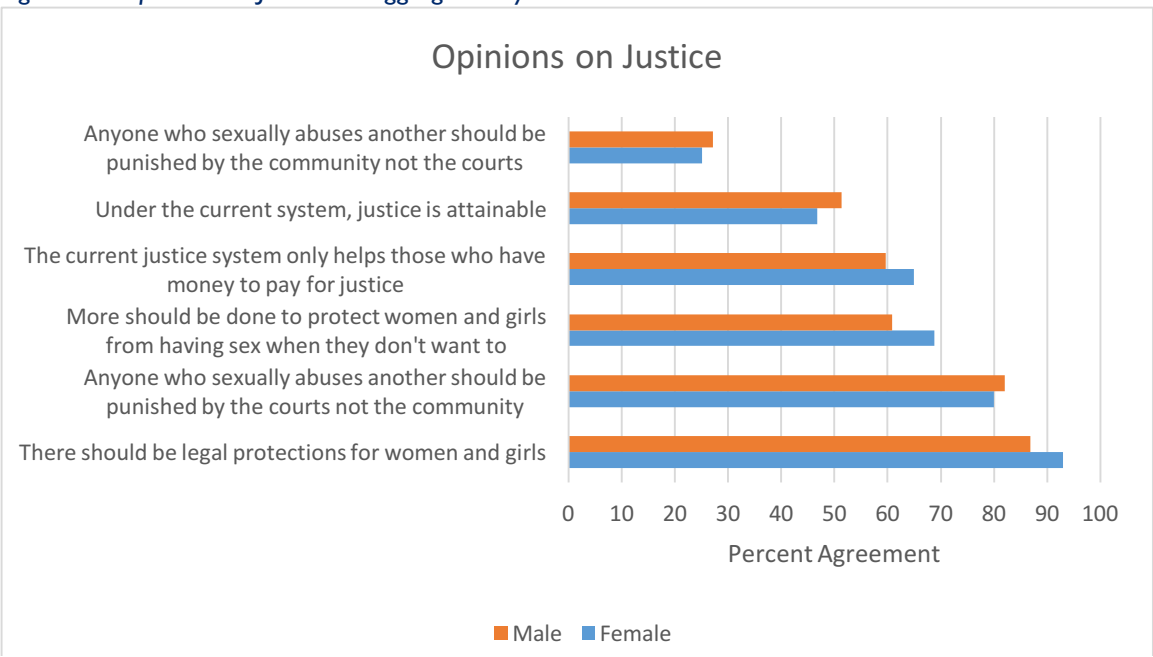


When data were stratified by health zone, only Walikale had statistically higher rates for agreement with "It's a wife's obligation to have sex with her husband even if she doesn't want to." (Annex VII, Table 12)

Justice

Although there was a majority consensus that perpetrators should be punished by the courts, less than half of men and women believe that under the current system, justice is attainable. Over a quarter of men and women agreed that "street justice" should be used. A significant portion also agree that the system works for those who have money. More than 90% of both stated there should be more legal protections for women while more than 60% of both men and women thought more should be done to protect women and girls from having sex when they don't want to. There was overwhelming agreement that women and girls need more education to about their rights to refuse sex (Figure 28; Annex VII, Table 12).

Figure 28: Opinions on Justice Disaggregated by Sex



When data were stratified by health zone, community justice and court punishments were more acceptable in Katana when compared with other health zones. Households in Katana were also more likely to suggest that more should be done to protect women and girls from having sex when they don't want to (Annex VII, Table 12).

In qualitative interviews and with regard to a need for money to pay for justice, a group of men stated the following during a group meeting:

> *"Sexual violence has become a business for officials. The perpetrator family only needs to offer money and he [perpetrator] is released. It is easy because even the officials are not getting paid."*[93]

Rape Myths

Sex Differences

More than 60% of men and women supported statements that would be considered "victim blaming." Men (74%) were far more likely to state that women provoke rape by appearance or behavior but 62% of women also agreed with this statement, however statistically there was no difference in the rates. Far more women (47%) agreed that "good girls" are less likely to be raped than "bad" girls compared with 29% of men (p = 0.003). When respondents were asked whether women may claim rape to "protect their reputations", 35% of women and 38% of women agreed (Annex VII, Table 11).

Both men and women believed that wearing short skirts or tight shirts invites rape. This was also a common theme in qualitative interviews.

> *"The rates of violence will not go down because girls are wearing short skirts and tight shirts. When they show their thighs, it makes us crazy and we lose all self-control. When I see a girl in such clothing, I take her immediately to the Bush to rape her. She should not have been wearing those clothes."*[94]

> *"Girls don't dress properly. They wear too many short skirts that show their thighs. This pushes boys to rape."*[95]

However, when respondents were asked if rapes happen because women entice men, only 25% of women agreed versus 41% of men. Less than a third of women (30%) and even less men (16%) agreed that "men, not women, are responsible for rape."

Respondents were asked if a "raped woman is usually an innocent victim." Half of men agreed with this statement whereas just over half of women (54%) agreed. Less than 10% of women and men agreed that rape is deserved in most cases.

More than a third of women (37%) and man (35%) agreed that even when women say no, they are really saying yes. This sentiment was highlighted during qualitative interviews:

> *"We rape girls because we love them. We know that when girls say no, they are just playing a game and we*

[93] Community men (12) ages 30-57 years old, Walikale HZ, Bilobilo HA, Indjiki village
[94] 18 year old male community member, Walikale HZ, Bilobilo HA, Indjiki village
[95] Female Chief, Walikale HZ, Sacre Coeur HA, Kasima Centre village

should continue because they really want to."[96]

Overwhelmingly, both women (79%) and men (74%) agreed that "if women didn't want to be raped, they could fight off the attacker. However, only a fraction of women (17%) and a larger proportion of men (24%) agreed that "women can enjoy sex even when it is forced." (Figure 29)

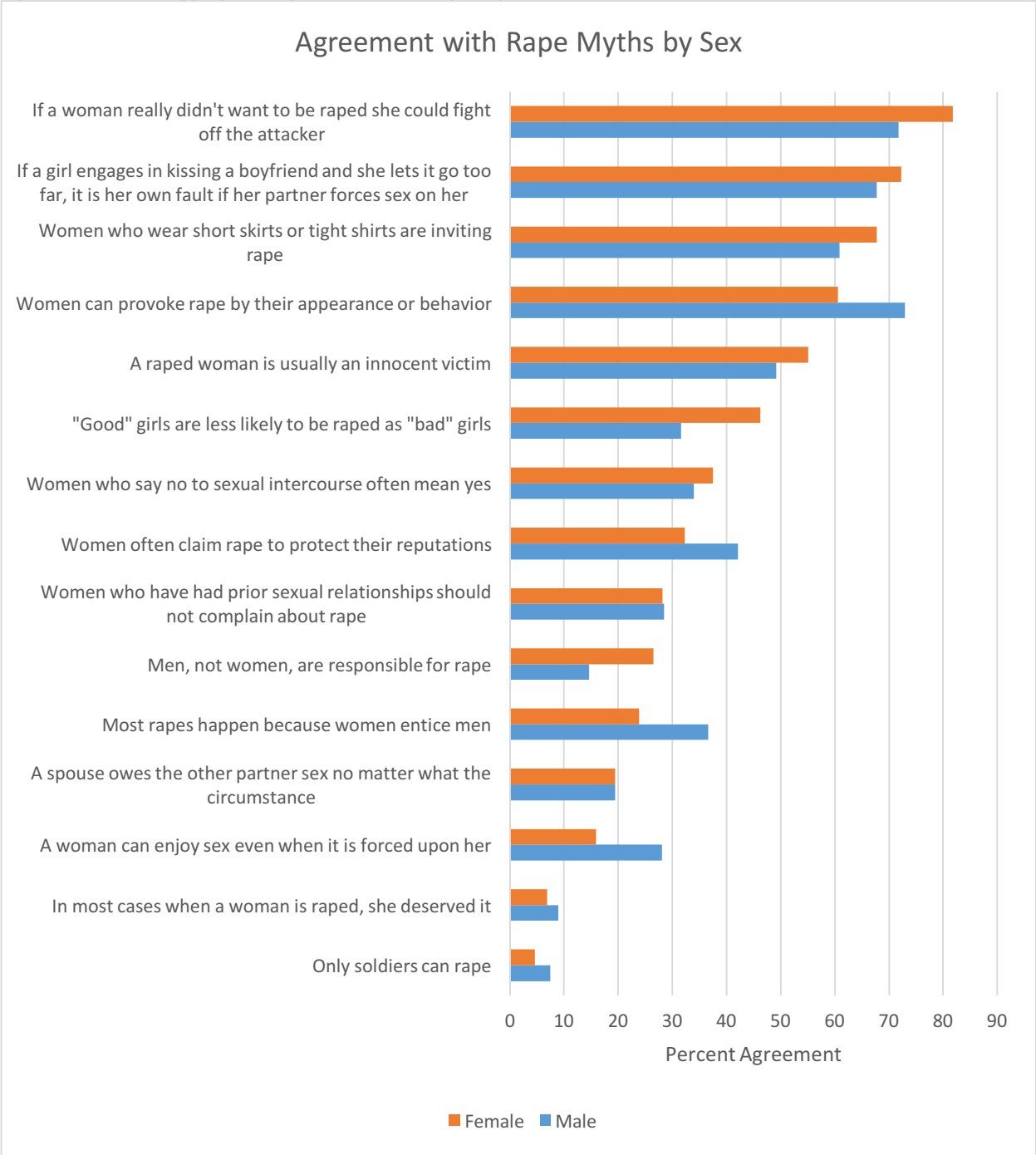
Nearly a fifth of women (20%) and men (19%) agreed that a spouse "owes the other partner sex no matter what the circumstance" and more than a fifth of women (26%) and men (30%) agreed that women who had prior sexual relationships should not complain about rape (Annex VII, Table 11).

Less than 10 % of men and women agreed that "only soldiers can rape."

Stratification by health zone shows statistically significant differences particularly for Walikale. Household respondents were more likely to agree that soldiers are more likely to rape, that when a woman is raped she deserves it (18% vs. <5% in the other two health zones), that a spouse owes sex, a woman can enjoy sex even when it is forced on her, good girls are less likely to be raped, women often so no when they mean yes, that wearing short skirts and tight shirts invites rape, and that women often claim rape to protect their reputations, but Walikale households were also more likely to agree that rape victims are innocent (Annex VII, Table 13).

[96] 18 year old community male, Walikale HZ, Bilobilo HA, Indjiki village

Figure 29: Sex Disaggregated Agreement with Rape Myths



Limitations

Although data collectors were careful to explain that there will be no material or other gain by participation in the assessment, respondents might have exaggerated or underestimated responses if they believed it would be in their interest to do so.

In some instances (e.g., when interviewing intended beneficiaries), responses might have been constrained due to fear of reporting or stigma such as with questions around SGBV, however, based on our qualitative study, it was noted that SGBV was normalized and responses were less likely to be constrained. Although it is possible that differences within the interviewer due to ethnicity, sex, or overall comfort level during the interview could bias the results, this was largely mitigated through the use of local data collectors, properly trained in interviewing techniques who did not interview in areas they were familiar with.

The quantitative household survey represents adult men and women as well as children in the accessible health areas within Katana, Walikale, and Karisimbi health zones of North and South Kivu, DRC. It will not be possible to extrapolate the data to represent other health areas not within the sampling frame or other provinces. Furthermore, individual and group semi-structured qualitative interviews represent individual experiences of those most willing to speak, and cannot be generalized beyond those interviewed.

Finally, as identified by Bass et al.[97] the use of mental health measures of unknown validity for identifying clinical cases of PTSD and combined depression and anxiety, could be non-pathologic reactions to extreme circumstances, and it is therefore unclear what proportions of participants actually met clinical criteria. And although the clinical meaning of standard cutoff scores is therefore uncertain, the score itself can still be meaningfully interpreted; 1.75 indicates that respondents are reporting that symptoms occur, on average, nearly a "moderate" amount of the time (a score of 2.0). Furthermore, this study used these screening tools to estimate the proportion and/or burden (not diagnosis) of possible mental symptoms within the specific population and not individuals. The nature of this study (a multistage clustered random sample survey) allows for the determination of association of population characteristics, but not causality.

[97]Bass J, Annan J, Murray SM, Kaysen D, Griffiths S, Cetinoglu T, Wachter K, Murray LK, Bolton PA. Controlled Trial of Psychotherapy for Congolese Survivors of Sexual Violence. N Engl J Med 2013; 368:2182-2191. DOI: 10.1056/NEJMoa1211853

Summary of Key Findings

This randomized population-based baseline survey was designed to determine the prevalence of all forms of SGBV for the health zones where Ushindi will be implemented. Based on the methodology used, the findings are generalizable to all health areas of Karisimbi, 12/14 health areas in Katana and 8/14 health areas in Walikale or 727,754 persons in the three health zones. In total, 900 households participated in the survey with an overall response rates of 96.8%.

The prevalence of all forms of SGBV including IPV, and trafficking were prevalent not just among women but also among men and children. Symptoms of depression/anxiety and PTSD were more prevalent among women and were elevated in association SGBV, sexual violence, and IPV. Substance abuse, especially alcohol, is a problem among women and men and is closely tied to violence as a precipitant and a consequence of the violence, especially IPV. Harmful traditional practices and negative cultural norms have become normalized and justified by the community. Although usually it is thought that these negative norms are perpetrated by men, it is clear from this study that women also hold some responsibility in propagating negative social norms in the areas surveyed and some of these negative social norms affect men and boys in addition to women and girls. The key findings of the study with population estimates of those affected are summarized in the following table 17.

Table 17: Summarized Key Findings

Finding	Weighted Prevalence Rate[98]	Weighted Prevalence Rate of mental health associated with SGBV[99]	Estimated Population Affected
SGBV			
Women	31.6%		54,384 Women
Men	32.9%	NA	38,514 Men
Children	61.0%		299,438 Children
Sexual Violence			
Women	11.8%		30,313 Women
Men	3.1%	NA	12,789 Men
Children	11% overall 7.7% Karisimbi 10.5% Katana 20.5% Walikale		59,103 Children
IPV			
Women	22.6%	NA	43,544 Women
Men	25.0%		29,779 Men
Trafficking			
Women	12.9%	NA	18,286 Women
Men	7.2%		12, 432 Men
Children	5.0%		24,224 Children
Substance Abuse			
Women	21.1%	NA	64,081 Women

[98] Lifetime rates for SGBV, SV and IPV, suicidal ideation and suicide attempts. Trafficking and Substance abuse represent rates in the last year. PTSD and depression/anxiety rates represent rates in the month prior to the survey.

[99] Presented for statistically significant differences between those who report an abuse compared with those who do not report the abuse.

Men	38.9%		64,081 Men
Depression/Anxiety **Women** **Men**	 31.0% 19.7%	42.6% SGBV 62.3% SV 43.8% IPV	 50,237 Women 17,544 Men
PTSD **Women** **Men**	 26.6% 15.9%	62.3% SV	 45,285 Women 14,865 Men
Suicidal Ideation **Women** **Men**	 29.3% 24.1%	49.6% SGBV 66.3% SV 49.9% IPV	 48,235 Women 34,761 Men
Suicide Attempts **Women** **Men**	 19.6% 7.9%	39.4% SGBV 45.8% SV 38.6% IPV 31.7% Trafficking	 33,593 Women 15,966 Men

Major differences among health zones included symptoms of depression/anxiety and PTSD which were four times higher in Walikale than all other health zones and substance abuse which was highest in Karisimbi (50% higher than Katana and twice as high as Walikale).

Discussion and Recommendations

Sexual Gender Based Violence

There is growing recognition of the larger public health impact SGBV has on communities in addition to being a gross violation of human rights. The findings of this study indicate widespread sexual violence in Karisimbi, Walikale, and Katana health zones, among men, women, and children through multiple forms of SGBV. The prevalence of SGBV among men and women is similar, if not the same, as the rates obtained during a previous study, using the same methodology and survey in Eastern DRC in 2010.[100] These rates of SGBV also appear consistent with global rates for women and DHS rates, but lower than rates of 45% across Africa. [101] Global rates of SGBV against men are largely unknown (Table 18).

Table 18: SGBV Rate Comparisons across Population-Based Studies

Population-Based Randomized Study	Lifetime SGBV Rate	Comment
WHO Global Study	35% regional; (45% across Africa)	Violence against women only
DHS 2013 (North and South Kivu)	28-34%	Limited to reproductive age women
2010 JAMA Eastern DRC Study	40% women/24% men	All of North and South Kivu except Walikale, Men and women included, all ages
Current Study	32% women/33% men 61% children	Men and women included, all ages, All of Karisimbi, 12/12 implementation areas of Katana and 8/12 implementation areas of Walikale (4 HA not included due to safety and/or distance)

The majority of the sexual violence reported in this study is community based with more than half of all cases reported as rape and close to 80% of the perpetrators, reported within the family. Only a fraction of the reported sexual violence was conflict-related in the health zones surveyed. Based on population estimates calculated from the prevalence rates and among the three health zones surveyed, nearly 100,000 men and women are at risk for sexual violence which is more than four times the number of survivors reached during the Ushindi project in 10 health zones from 2010-2015.

Despite recognition that men suffer sexual violence and a previous study documenting the rates of male SGBV in Eastern DRC, USAID programming, six years later, has not met the unique needs of male

[100] Johnson K, Scott J, Rughita B, Asher J, Kisielewski M. Ong R, Lawry L. Association of Sexual Violence and Human Rights Violations with Physical and Mental Health in Territories of Democratic Republic of Congo. JAMA. 2010. 304(5):553-562.

[101] Demographic Health Survey. DRC 2013. http://dhsprogram.com/pubs/pdf/FR300/FR300.pdf.; World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1

survivors. Inclusion of men in sexual violence definitions, policies and protections in addition to targeted programs to address their needs is a necessity.

SGBV Recommendations

- Better identification of SGBV survivors within families with recognition of both conflict and the largely community-based SGBV identified in this study
- Improved SBCC to address the community-based violence, harmful traditional practices, rape myths and gender roles in order to adjust negative norms into positive behavior change using the tenants of SBCC
- Increasing the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change
- Work with the Ministry of Health (MOH) and traditional leaders to discourage early marriage, all forms of SGBV and to understand the health and protection consequences of SGBV based on these data
- Integrate SGBV services in maternal, newborn, child health (MNCH) programs to increase referral and identification of those at risk and/or survivors[102]
- Adapt SGBV medical guidelines to include men which is a unique opportunity to be the "first" to develop such guidelines
- Adapt already developed SGBV services to include men and boys
- Improve identification of children at risk for SGBV especially in Walikale
- Further develop child friendly services and guidelines that meet the developmental needs of child survivors
- Consider school-based programs to reach children with SBCC especially in Walikale where child violence rates are exceedingly higher than the other health zones
- Given the elevated numbers of children who have suffered SGBV and sexual violence, the justice sector will need to implement child protections for children in the justice system Intimate Partner Violence

There is growing recognition of the linkages of IPV to the cascade of health consequences that occur with this type of violence and especially among pregnant women.103 These non-fatal consequences include higher levels of depression, anxiety and stress, suicide attempts, lack of attachment to a child which predicts children's behavioral and emotional problems up to four years later, intrauterine growth retardation, preterm labor, miscarriage, abortion, antepartum hemorrhage and perinatal deaths.[104] There is also growing evidence that IPV is an important contributor to women's vulnerability to HIV and sexually transmitted infections (STIs).[105] The emotional consequences of IPV in our study are clear with statistically significant increases in symptoms consistent with depression/anxiety and PTSD as well as higher rates of suicidal ideation and suicide attempts.

This survey shows that not only is intimate partner violence in Karisimbi, Walikale, and Katana is widespread, but is normalized and justified, not only by men but also women within these societies. And

[102] In this study 17% of women reported a pregnancy related to SGBV.

[103] World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1

[104] World Health Organization. Intimate Partner Violence During Pregnancy. http://apps.who.int/iris/bitstream/10665/70764/1/WHO_RHR_11.35_eng.pdf

[105] World Health Organization. Intimate Partner Violence During Pregnancy. http://apps.who.int/iris/bitstream/10665/70764/1/WHO_RHR_11.35_eng.pdf

similar to our rates for SGBV, IPV rates in this study are also consistent with previous studies. Global and regional rates for IPV against males are unknown (Table 19).

Table 19: IPV Rate Comparisons across Population-Based Studies

Population-Based Randomized Study	Lifetime IPV Rate	Comment
WHO Global Study	23–40%	Violence against women only
DHS 2013 (North and South Kivu)	25-48%	Limited to reproductive age women
2010 JAMA Eastern DRC Study	46% women/31% men	All of North and South Kivu except Walikale, Men and women included, all ages
Current Study	22% women/25% men	All of Karisimbi, 12/12 implementation areas of Katana and 8/12 implementation areas of Walikale (4 HA not included due to safety and/or distance)

Given that 43,544 women and 29,779 men are at risk in the areas surveyed based on population estimates, the following serve as recommendations to address this issue in the three health zones surveyed.

IPV Recommendations

- Identification and follow up with pregnant women to evaluate SGBV/IPV risk in the community and at MNCH services to provide early intervention services to at-risk families
- Work with the MOH traditional leaders to address the widespread IPV in these health zones and the accepted normalization and justification of this type of violence
- Through community based programs, such as the *Noyaux Communitaire*, and in concert with local partners, develop an SBCC approach to address normalization of IPV within the community among women and men
- Develop programs to identify and treat community members with substance abuse as means to decrease risks for substance related violence
- Continue to promote social and economic empowerment of women and girls through education, village saving and loans programs (VSLA) especially for those who have suffered violence
- Increasing the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change
- Consider school based programs to decrease violent behavior in children associated with IPV later in life[106]

Trafficking

Human trafficking is a fundamental violation of human rights. Due to the secretive nature of trafficking, prevalence rates are unknown but it is thought that millions of people are trafficked globally.[107] Studies

[106] Evidence suggests that programs aimed at parents, including home visits and education, can reduce or prevent child abuse and maltreatment which has the potential to reduce child conduct problems and violent behavior later in life, which may be associated with IPV perpetrated by men. See: Maas C, Herrenkohl TI, Sousa C. Review of research on child maltreatment and violence in youth. Trauma, Violence & Abuse, 2008, 9(1):56–67.

have shown that trafficked people often suffer from physical injuries and long-term mental, physical, and reproductive health concerns including exposure to HIV and other STIs, physical and sexual violence, exposure to infectious diseases and substance abuse.[108] Documentation of associated mental health consequences is not available.

DRC is considered a tier 3 country with respect to human trafficking. Tier 3 countries are those countries "whose governments do not fully comply with the U.S. Trafficking Victims Protection Act's minimum standards and are not making significant efforts to do so."[109] The 2014 State Department Report on trafficking within DRC revealed internal trafficking by armed groups in the eastern provinces as the most pressing problem.[110] Population rates (prevalence) of trafficking and its forms are unknown in DRC or in Eastern DRC. A USAID report assessing trafficking related to or in an around mines revealed the forms of trafficking most commonly reported were forced labor among those associated with mines. However, these data cannot be generalized to the region. This study is the first to document the prevalence of trafficking and its forms in Walikale, Katana, and Karisimbi among men, women and children in the survey areas. Among respondents the most common forms included debt bondage, labor trafficking and sex trafficking in equivalent proportions. By far, the most common form of labor trafficking was forcing women and girls to work in bars and bistros where they were at risk for sexual violence. The fact that there was a statistically significant risk for suicide attempts associated with trafficking suggests the trauma associated with this act is devastating. With an estimated 18,286 women, 12,432 men and 24,224 children affected in the last year and in the areas surveyed, the programmatic implications and services needed to address this in these three health zones is not insignificant.

Trafficking Recommendations

- Increasing the capacity of local partners to adapt their traditional communications programs to SBCC that focuses on behavior change for trafficking
- Promote community engagement through the *Noyaux Communitaire* to increase awareness of trafficking rights, laws and government responsibilities through a contextualized SBCC campaign using local partners
- Target mining operations to extend the reach of Ushindi and identify and treat women, men and children who are at risk for trafficking or have been trafficked
- Support community-level savings and loans and microfinance programs to protect against exploitative lending practices that put communities at risk for trafficking as a means for survival and push parents to "give" their children into situations that are exploitative
- Consider income generation projects through the *Noyaux Communitaire*, especially agriculture production to lessen the need for food which was an important reason reported for staying or being recruited into forced labor and sex trafficking
- Work with traditional leaders to identify, report, refer and address potential cases of human trafficking
- Identified trafficking cases will need referral to the justice system through ABA

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[107] USAID. Assessment of human trafficking in artisanal mining towns in Eastern Democratic Republic of the Congo. 2014. http://pdf.usaid.gov/pdf_docs/PA00K5R1.pdf

[108] Cannon A, Arcara J, Graham L, and Macy R. Trafficking and Health: A Systematic Review of Research Methods. Trauma, Violence and Abuse. 2016. DOI: 10.1177/1524838016650187

[109] USDOS. Trafficking in Persons Report. 2014. http://www.state.gov/j/tip/rls/tiprpt/2014/

[110] USDOS. Trafficking in Persons Report. 2014. http://www.state.gov/j/tip/rls/tiprpt/2014/

Mental Health

In late September 2015, mental health was included as an integral part of the United Nations' Sustainable Development Goals to promote mental health and well-being, and the prevention and treatment of substance abuse.[111] Mental disorders are among the leading causes of ill-health and disability worldwide.[112] Even with treatments available, nearly two-thirds of people with a known mental disorder will never seek help from a health professional.[113] Gender based violence, socioeconomic disadvantage, low income and income inequality, low or subordinate social status and rank and unremitting responsibility for the care of others will tend to disproportionately affect women and are touted to be gender specific risks. However, men can also be at risk based on these risks, especially in DRC.[114]

SGBV, and IPV all had significant associations to mental health disorders in this study including depression/anxiety, PTSD, suicidal ideation and suicide attempts. This is consistent with our previous study and with a large body of literature showing associations between violence, substance abuse and other mental health disorders (Table 16).

This study cannot show causality, and assesses the prevalence of mental health symptom criteria (not diagnosis). However, the strong and persistent associations implore health care providers to deliver a health care strategy that addresses those who have experienced sexual violence in addition to mental health services as necessary components of recovery and rehabilitation for survivors.

Respondents clearly stated that the mental health programs offered in their area were insufficient to meet the needs of the community. They had few barriers to accessing mental health care with the majority stating that "nothing would stop them." The perception of stigma as a barrier to care was quantitatively insignificant and therefore is not an issue in reality for those who need care.

To date, programs that address SGBV have not been comprehensive in addressing substance abuse. It is clear the communities interviewed saw a link between alcohol use and SGBV in addition to substance abuse as a consequence of violence. And, there is data to suggest they are correct. Women who have experienced IPV are 2.3 times more likely to have alcohol use disorders and 2.6 times more likely to experience depression or anxiety.[115] Therefore any SGBV program going forward needs to not only focus on the mental health disorders associated with violence but concomitantly should also address substance abuse in the community as a risk for violence and a consequence of violence.

Mental Health Recommendations

- Continued integration of lay counselors and mental health services for survivors with Cognitive Processing Therapy (CPT) in Walikale given the significantly elevated rates of mental health disorders
- Substance abuse programming in all health zones to address the risk of substance use and subsequent violence and the potential likelihood of substance abuse among survivors but especially in Karisimbi given the exceptionally high rates of substance abuse in this health zone

[111] World Health Organization. http://www.who.int/mental_health/en/
[112] World Health Organization. http://www.who.int/mental_health/en/
[113] World Health Organization. Mental Health. http://www.who.int/whr/2001/media_centre/press_release/en/
[114] World Health Organization. Gender and Mental Health. http://www.who.int/mental_health/prevention/genderwomen/en/
[115] World Health Organization. Gender and Mental Health. http://www.who.int/mental_health/prevention/genderwomen/en/

- Community outreach programming to identify at risk individuals
- Substance abuse training for health care providers, local Ushindi partners, lay counselors and members of the *Noyaux Communitaire*

Gender Roles, Justice and Rape Myths

Social norms and values influence how women and children are protected or harmed. Social norms do not function in isolation but are defined in local culture and tradition as a type of cultural identity. Changes to these norms, requires engagement and consensus over time to make positive changes in social norms with regard to women, early marriage, protection of women and children, and SGBV[116]And although usually it is thought that these negative norms are perpetrated by men, it is clear from this study that women also hold some responsibility in propagating negative social norms in the areas surveyed and some negative social norms affect men and boys in addition to women and girls.

A social cognitive approach to promoting behavior change recognizes that both individuals and their environment shape behaviors, and its core tenets of observational learning, environmental influences, self-regulation, and moral engagement/disengagement offer clear levers for affecting this change.[117] Interventions focused on boosting self-efficacy through persuasion, social modeling, and experience mastery need to be combined with the higher level communications interventions to form a comprehensive set of strategic engagements that will affect significant behavior change to decrease the rates and consequences of SGBV.

The roots of sexual violence are multifaceted, pervasive, and interrelated. Inequality, marginalization, and other causes of interpersonal violence operate at the societal, community, relational, and individual levels simultaneously. Thus, these multiple levels of influence must be explicitly considered, and a comprehensive, multi-pronged set of interventions developed to address the network of individual and environmental/policy level barriers to effective behavior change in this arena. Interventions to strengthen policy advocacy and information dissemination at the national and municipal level must be combined with interventions designed to strengthen community mobilization and interpersonal communication.

Social Norm Recommendations

- Enhanced SBCC to address the community-based violence, harmful traditional practices, rape myths and gender roles in order to adjust negative norms into positive behavior change using the tenants of SBCC
- Increase the capacity of local partners to adapt their traditional communication programs to SBCC that focuses on behavior change especially around victim blaming and harmful traditional practices
- SBCC programming focused on social norms will need to be emphasized in Walikale given the significant difference in agreement with rape myths compared with the other health zones

[116] World Health Organization. Changing cultural and social norms that support violence. Available at: http://www.who.int/violence_injury_prevention/violence/norms.pdf

[117] See: Attitudes, Attributions and Social Cognition. http://www.blackwellpublishing.com/intropsych/pdf/chapter17.pdf and World Health Organization. Violence Prevention: The Evidence. Changing Social and Cultural Norms that Support Violence. http://www.who.int/violence_injury_prevention/violence/norms.pdf.

Conclusion

SGBV in DRC is prevalent and has unique cultural factors that put men, women, girls and boys at risk for all forms of SGBV. The physical, sexual, reproductive, and mental health consequences are many. Normalized and justified, negative cultural norms have created an environment for SGBV to flourish and continue from generation to generation. This study shows that SGBV is not a small problem in the areas surveyed and requires urgent and contextualized action. Ushindi which has been effective in addressing the overwhelming needs of survivors, should expand to include the inclusion of men and boys as survivors and address other facets of risk such as harmful traditional practices, substance abuse and myths concerning rape. In doing so, it is likely that the interventions designed to strengthen community mobilization and interpersonal communication will have a positive effect on barriers to effective behavior change and ultimately decrease the prevalence and scope of SGBV.

Annex I: Ethics Approval

Université Libre des Pays des Grands Lacs ULPGL GOMA

COMITE D'ETHIQUE ULPGL

P.O.BOX 368 GOMA

LETTER OF APPROVAL

The Comité d'Ethique de l'Université Libre des Pays Grands Lacs (ULPGL Research Ethics Committee) in Goma hereby certifies having reviewed the research proposal for "USHINDI Project, OVERCOMING SEXUAL AND GENDER-BASED VIOLENCE IN EASTERN DRC" that will be conducted by IMA World Health.

The ethical review focused on the project research methodology, strategies of implementation, the specific area of intervention, and the research tools to be used. After our exchange with two delegates from IMA, the Ethics Committee has provided some important suggested changes to the project proposals which they have agreed to integrate into the final proposal. After reviewing this final proposal, the Ethics Committee members have found that this project and research study complies with the ethical standards and regulations for conducting research and evaluation study in social and behaviors, specifically, in Gender-based violence within the context of Eastern DR Congo.

Therefore, the Ethics Committee supports that IMA World Health pursue her research related to the project with respect to all of the discussed and reviewed methodology and research tools.

Issued in Goma, on June 16, 2016

Professor Dr. MUTEHO KASONGO Marina

Mutekho Kasongo

Coordinator

UNIVERSITE LIBRE DES PAYS DES GRANDS LACS • ULPGL-GOMA •

Please contact:

COORIDINATOR OF THE COMITE D'ETHIQUE ULPGL GOMA

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Annex II: Data Weighting Summary

Village	Population	Relative Village Weight	Villages in HZ	Village Weight	Average Household Size	Estimated Households per Village	Households Sampled	Household Weight
	A	B = A / 152, 057	C	D = (B • C) / ΣB	E	F = A/E	G	H = (D • F)/G
K4-1	3682	0.024214604	85	5.738778055	5.7	645.9649123	10	370.7049263
K4-2	3930	0.025845571	85	6.125311721	10.6	372.3157738	9	253.3944637
K4-3	3233	0.021261764	85	5.038965087	6.8	475.4411765	5	479.1462979
K4-4	2864	0.018835042	85	4.463840399	8.6	333.0232558	10	148.6562663
K5-2	588	0.003866971	85	0.916458853	6.5	90.46153846	10	8.290427777
K5-3	2180	0.014336729	85	3.397755611	8.6	253.4883721	10	86.12915386
K5-4	637	0.004189219	85	0.992830424	5.8	109.8275862	10	10.9040169
K5-5	6870	0.045180426	85	10.70760599	6.7	1025.373134	10	1097.929151
K1-1	1256	0.00826006	85	1.957605985	7.3	172.0547945	10	33.68154955
K1-2	1729	0.011370736	85	2.694825436	8.6	201.0465116	10	54.17852534
K1-3	2166	0.014244658	85	3.375935162	8.8	246.1363636	10	83.09404047
K7-1	1195	0.007858895	85	1.862531172	7.8	153.2051282	10	28.5349327
K1-5	2137	0.01405394	85	3.330735661	6.9	309.7101449	10	103.1562624
K6-1	1856	0.012205949	85	2.89276808	8.4	220.952381	10	63.91639948
K6-2	1668	0.010969571	85	2.599750623	6.6	252.7272727	10	65.70278848
K6-3	1298	0.008536273	85	2.023067332	7.4	175.4054054	10	35.48569455
K6-4	1125	0.007398541	85	1.753428928	7.6	148.0263158	10	25.95536242
K6-5	1202	0.00790493	85	1.873441397	7.4	162.9830508	10	30.53391944
K2-1	5669	0.037282072	85	8.835723192	7.7	736.2337662	20	325.2578882
K2-2	1560	0.010259311	85	2.431421446	7.6	205.2631579	10	49.90812443
K2-4	393	0.002584557	85	0.612531172	7.2	54.58333333	10	3.343399314
K2-5	831	0.005465056	85	1.295199501	5.0	166.2	10	21.52621571
K3-1	839	0.005517668	85	1.307668329	8.8	95.58227606	9	13.88776836
K3-2	415	0.00272924	85	0.646820449	6.4	64.39655617	9	4.628112152
K3-3	365	0.002400416	85	0.568890274	5.7	64.12161816	13	2.806012688
K3-4	759	0.004991549	85	1.18298005	6.3	120.4761905	10	14.25209298
K3-5	451	0.002965993	85	0.702930175	8.5	53.30000291	13	2.882013873

Village	Population	Relative Village Weight	Villages in HZ	Village Weight	Average Household Size	Estimated Households per Village	Households Sampled	Household Weight
	A	B = A / 144, 659	C	D = (B • C) / ΣB	E	F = A/E	G	H = (D • F)/G
W1-1	849	0.005868975	124	2.572601535	7.1	119.7307708	11	28.0017786
W1-2	1066	0.007369054	124	3.230145154	7.4	143.1940384	9	51.39305881
W1-3	1512	0.010452167	124	4.581594252	9.1	166.4587217	12	63.55386022
W1-4	464	0.003207543	124	1.405991887	8.1	57.10769231	8	10.03661901
W1-5	478	0.003304323	124	1.448414056	7.3	65.18182114	12	7.867522162
W3-1	824	0.005696154	124	2.496847661	9.8	84.08163265	10	20.99390279
W3-2	1016	0.007023414	124	3.078637408	10.0	101.6	10	31.27895606
W3-3	379	0.002619955	124	1.148428718	6.5	58.30769231	10	6.696222833
W3-4	489	0.003380363	124	1.48174576	8.8	55.56818182	10	8.233791781
W3-5	610	0.004216813	124	1.848394507	7.9	77.21518987	10	14.27241328
W4-1	8181	0.056553688	124	24.78969747	7.7	1062.467532	10	2633.824871
W4-2	510	0.003525532	124	1.545379014	7.0	72.85714286	10	11.25918996
W4-3	481	0.003325061	124	1.457504521	8.4	57.26190476	10	8.345948506
W4-4	1131	0.007818387	124	3.427105225	7.9	143.164557	10	49.06400011
W4-5	2410	0.016659869	124	7.302673379	9.6	251.0416667	10	183.3275296
W5-1	1880	0.01299608	124	5.696691266	8.4	222.6315907	9	140.9181598
W5-2	891	0.006159313	124	2.699868042	6.4	140.0142937	11	34.36546518
W5-3	1051	0.007265362	124	3.18469283	8.3	126.626506	10	40.32665259
W5-5	92	0.000635978	124	0.278774253	7.0	13.14285714	10	0.366389019
W5-6	1266	0.008751616	124	3.83617614	9.0	140.6666667	10	53.96221104
W6-1	1607	0.011108884	124	4.869458971	8.6	186.0736764	11	82.37073933
W6-2	1107	0.007652479	124	3.354381506	7.6	145.6578947	10	48.85921483
W6-3	288	0.001990889	124	0.87268462	9.1	31.64835165	10	2.761902972
W6-4	679	0.004693797	124	2.057475197	7.4	91.75675676	10	18.87872512
W6-5	651	0.004500238	124	1.972630859	8.3	78.12000312	9	17.12243654
W2-1	5798	0.040080465	124	17.56883828	8.4	690.2380952	10	1212.668147
W2-2	1748	0.01208359	124	5.296710816	10.8	161.8518519	10	85.72824542
W2-3	750	0.005184607	124	2.272616197	8.4	89.28571429	10	20.29121604
W2-4	1985	0.013721925	124	6.014857534	7.7	257.7922078	10	155.0583403
W2-5	729	0.005039438	124	2.208982943	10.1	72.17821782	10	15.9440452

Village	Population	Relative Village Weight	Villages in HZ	Village Weight	Average Household Size	Estimated Households per Village	Households Sampled	Household Weight
	A	B = A / 469, 432	C	D = (B • C) / ΣB	E	F = A/E	G	H = (D • F)/G
G1-1	1278	0.002722439	254	4.527364017	7.8	163.8461538	10	74.17911812
G1-2	1059	0.002255918	254	3.751548117	7.5	141.2	10	52.97185941
G1-3	2210	0.004707817	254	7.829009763	7.0	315.7142857	10	247.1730225
G1-4	2837	0.006043474	254	10.05018131	6.9	411.1594203	10	413.2226722
G1-5	2294	0.004886757	254	8.126582985	6.6	347.5757576	10	282.4603237
G2-1	2320	0.004942143	254	8.218688982	6.8	341.1764706	10	280.40233
G2-2	1052	0.002241006	254	3.726750349	7.3	144.109589	10	53.70604612
G2-3	3396	0.007234275	254	12.03046025	7.2	471.6666667	10	567.4367085
G2-4	2314	0.004929361	254	8.197433752	6.6	350.6060606	10	287.4069955
G2-5	4342	0.009249476	254	15.38170153	7.3	594.7945205	10	914.8951789
G3-1	3233	0.006887046	254	11.4530265	7.7	419.8701299	10	480.8783724
G3-2	1790	0.003813119	254	6.341143654	6.2	289.558832	11	166.9212864
G3-3	3721	0.007926601	254	13.18178522	5.8	641.5517241	10	845.6797033
G3-4	8147	0.017355016	254	28.86105997	5.8	1400.265581	11	3673.922629
G3-5	2937	0.006256497	254	10.40443515	6.3	466.1904762	10	485.0448575
G4-1	5710	0.012163636	254	20.227894	7.8	732.0512821	10	1480.785574
G4-2	1580	0.00336577	254	5.5972106	6.7	235.8208955	10	131.9939216
G4-3	2065	0.004398933	254	7.315341702	6.8	303.6764706	10	222.1497149
G4-4	2741	0.005838971	254	9.710097629	7.5	365.4666667	10	354.8717013
G4-5	1554	0.003310384	254	5.505104603	4.4	353.1818182	10	194.4302853
G5-1	1791	0.003815249	254	6.344686192	7.2	247.984623	9	174.8205126
G5-2	2087	0.004445798	254	7.393277545	7.6	274.6052632	10	203.0232926
G5-3	2111	0.004496924	254	7.478298466	6.2	340.483871	10	254.624001
G5-4	2172	0.004626868	254	7.694393305	8.4	258.5714286	10	198.9550269
G5-5	1900	0.004047445	254	6.730822873	6.8	279.4117647	10	188.0671097
G5-6	2048	0.004362719	254	7.25511855	6.9	297.2903178	9	239.6529444
G6-1	441	0.000939433	254	1.562259414	8.5	51.88235294	10	8.105369431
G6-2	579	0.001233405	254	2.051129707	6.3	91.9047619	10	18.85085874
G6-3	153	0.000325926	254	0.542008368	7.0	21.85714286	8	1.480844292
G6-4	655	0.001395303	254	2.320362622	9.2	71.19565217	10	16.51997302
G6-5	644	0.001371871	254	2.2813947	7.5	85.86666667	10	19.58957583
G6-6	539	0.001148196	254	1.909428173	7.7	70.30434477	12	11.18675805

Annex III: English Version Quantitative Instrument

◀◀ ◀◀◀◀ Eastern DRC Health Assessment Survey – 2016 ▶▶▶▶▶▶

English Language Version

1. Case ID_____(1-5000) **2. Date of interview**_____(DD) _____(MM)

3. Interviewer code_____ **4. Location code**_____

5. Participation Outcome [CHECK ONE]:

☐ Eligible/Survey Complete (1) ☐ Not Eligible (2) ☐ Not Available after 2 Visits (3)

☐ Refusal: Lacks Time (4a) ☐ Refusal: Fear Reprisal (4b) ☐ Refusal: Opposed to Study (4c)

☐ Refusal: Other (4d)_____

☐ Unable to Complete: Interrupted (5a) ☐ Unable to Complete: Emotional (5b)

☐ Unable to Complete: Safety (5c) ☐ Unable to Complete: Request to Stop (5d)

☐ Unable to Complete: Other (5e) _____

Age (for refusals only): _____

Time Interview Started:_____

◀◀ ◀◀◀◀ INFORMED CONSENT STATEMENT ▶▶▶▶▶▶

We are working with IMA, a non-governmental organization from the United States. IMA has been working in DRC, and also works in other countries with the support of many governments, private donors and other international organizations to help us reach as many people as possible. However, we do not support any political or religious group.

We are conducting a brief survey of as many households as possible to assess the needs of people living in villages and towns like these as well as to understand what has happened to you personally and to those living in your household. We want to understand how the wars and other violence affected you as well as your family and what new programs or ideas may help you, your household and your community heal. We have tried to limit any consequences to your safety for answering these questions and feel that there is little risk to you and your family, however there may be risk that we are unaware of. If we felt there was risk, we would not have approached your household at all.

We are not here to provide humanitarian assistance at this time. We hope to use this survey to find out what the effects of war has had on mental health and how people in your community are functioning day to day. We hope to determine what the most important needs are so we can get better medical help to you and/or your community. We want you to understand there may be no benefit to you from this survey but your answers may help the government plan better health services for you, your family and/or your community in the future. We selected your home randomly among others. We realize that many people have suffered greatly since the war and may have much to tell. But this survey requires only BRIEF responses to a limited number of questions.

The findings of this study will be used to try to improve the situation for those who have survived the war. You do not need to give us your name at all. None of your answers will be shared with anyone else and it will not be possible to know your answers from anyone else's answers. If you do not understand a question, please ask me to explain it to you. Please note that some questions that we ask are sensitive, therefore it is important that we have some privacy for our conversation. You are free to stop at any time during the interview. If a question makes you uncomfortable, we will skip the question and go to the next question. If you have any questions about the survey, you can get more information from your community health worker in your area. Do you have any questions before we begin?

6. ***May I ask you some questions about what has happened to you?*** ☐ Yes (1) ☐ No (0)

7. Gender: ☐ Female (1) ☐ Male (2)

8. ***What is your age?*** _____(# years)

9. ***Where have you lived the most years of your life?***

☐ Current location (1) ☐ Other (2)_____

10. ***How long have you lived here in this village/town?*** _____months _____years

◀◀ ◀◀◀◀ **HOUSEHOLD COMPOSITION** ▶▶▶▶▶▶

11. ***How many people are presently living in your household (that is, share a cooking pot with you), including yourself?*** _____

12. ***How many of those people are UNDER the age of 18 years?*** _____

12a. ***In the last year, how many of these children have suffered sexual violence?*** _____

13. ***What is your current marital status?*** [CHECK ONE]

☐ Never married (1) ☐ Widowed (4) ☐ Living with partner /unmarried(7)
☐ Married (2) ☐ Husband missing (5) ☐ Other (8) _____
☐ Divorced or separated (3) ☐ Wife missing (6) _____

14. ***What ethnic group do you identify with most?*** **[CHECK ONE]**

☐ Batwa (1) ☐ Holoholo (6) ☐ Mangbetu (11)
☐ Balega (2) ☐ Hutu (7) ☐ Mongo (12)
☐ Baluba (3) ☐ Kongo (8) ☐ Nande (13)
☐ Boyo (4) ☐ Lega (9) ☐ Pere (14) ☐ Other (16) _____
☐ Hemba (5) ☐ Luba (10) ☐ Tutsi (15)

15. ***What religions do you identify with most?*** **[CHECK ALL THAT APPLY]**

☐ Muslim (1) ☐ Animist/Local beliefs (3) ☐ Other (5)_____
☐ Christian (2) ☐ Atheist (4) _____

◀◀ ◀◀◀◀ **INCOME** ▶▶▶▶▶▶

16. ***What is your main job for money?*** **[CHECK ONE]**

☐ Farmer/Herder (1) ☐ Small Business (5) ☐ Security Officer (9) ☐ Other (14)_____
☐ Housewife (2) ☐ Professional (6) ☐ Not working (10) _____
☐ Government (3) ☐ Military (7) ☐ Retired (11) _____
☐ Clerical (4) ☐ Driver (8) ☐ Student (12) _____

17. ***Does a member of your household (that is, sharing your cooking pot) own land?***

☐ Yes (1) ☐ No (0) ☐ Don't Know (2)

18. ***How much money DO YOU bring to the household weekly?*** _____ ***Francs***

◀◀ ◀◀◀◀ **EDUCATION** ▶▶▶▶▶▶

19. ***Can you read?***

☐ Yes with no difficulty (1) ☐ Yes with some difficulty (2) ☐ No (3)

20. ***Can you write a note?***

☐ Yes with no difficulty (1) ☐ Yes with some difficulty (2) ☐ No (3)

21. ***Can you add and subtract numbers?***

☐ Yes (1) ☐ No (0) ☐ Don't Know (2)

22. ***What is the highest level of schooling you attended?*** **[CHECK ONE]**

☐ Primary (1) ☐ Secondary(2) ☐ University (6)
☐ None (7)

23. ***Have you ever received any job training or completed a certificate program?***

☐ Yes (1) ☐ No (0) **[GO TO Q26]** ☐ Don't Know (2) **[GO TO Q26]**

24. ***What training have you received?*** _____

25. ***Has this training been useful?***

☐ Yes (1) ☐ No (0) ☐ Don't Know (2)

◀◀ ◀◀◀◀ **HEALTH CARE ACCESS** ▶▶▶▶▶▶

26. ***Which medical services have you used in your area?*** **[DO NOT READ, CHECK ALL THAT APPLY]**

☐ Traditional healer/Witch doctor (1) ☐ Clinic (5) ☐ Other (9) _____
☐ Midwives (2) ☐ Community health worker (6) _____
☐ Feeding center (3) ☐ Hospital (7) _____
☐ Pharmacy (4) ☐ None (8) _____

27. ***If medical services were needed but not used, what was the main reason?*** **[CHECK ONE]**

☐ No money to pay for services (1) ☐ Too far away (4)
☐ Did not know how to get medical services (2) ☐ Not available (5)
☐ No transportation (3) ☐ Other (6)_____

28. ***How far of a walk are you from the nearest health facility that you can use?*** **[CHECK ONE]**

☐ Less than 1 hour (1) ☐ 4-8 hours (4) ☐ More than 12 hours (6)
☐ 1-2 hours (2) ☐ 8-12 hours (5) ☐ Don't know (7)
☐ 2-4 hours (3)

29. ***Do you have ready access to transportation (public or private) to a health facility?***

☐ Yes (1) ☐ Yes but can't afford it (3) ☐ No (0) ☐ Don't Know (2)

30. ***What mental health services are available in your area?*** **[DO NOT READ, CHECK ALL THAT APPLY]**

☐ None (0) ☐ Group counseling (3) ☐ Community health worker (6)
☐ Rehabilitation centers (1) ☐ Religious support (4) ☐ Witch doctor/traditional healer (7)
☐ One on one counseling (2) ☐ Clinic (5) ☐ Hospital (8) ☐ Don't know (9)

31. ***Which of the following services would be most helpful to you?*** **[READ ALL, CHECK ALL THAT APPLY]**

☐ ***Rehabilitation centers*** (1) ☐ ***Income generating projects*** (5) ☐ ***Nothing would be helpful*** (9)
☐ ***Support groups*** (2) ☐ ***Medical care*** (6)
☐ ***Education (primary/secondary)*** (3) ☐ ***Mental health counseling/ support groups*** (7)
☐ ***Vocational/skills training*** (4) ☐ ***Religious counseling/support*** (8)

32. ***Have you received mental health counseling since the war/fighting?***

☐ Yes (1) ☐ No (0) ☐ Don't Know (2)

33. ***What issue(s) would make it difficult for you to seek mental health counseling if it were available?***
[DO NOT READ, CHECK ALL THAT APPLY]

☐ Feeling ashamed (1) ☐ Fear of family non-acceptance (6)
☐ Fear of stigma or community non-acceptance (2) ☐ Access to a program or facility (7)
☐ Do not believe this would help (3) ☐ Nothing (8)
☐ Interfere with responsibilities at home (4) ☐ Other (9) _____
☐ Concerns about confidentiality (5) _____

◀◀ ◀◀◀◀ SUBSTANCE ABUSE ▶▶▶▶▶▶

34. ***Are you taking drugs or alcohol now on a regular basis (more than 2 times per week or to excess each time)?***

☐ Yes (1) ☐ No (0)

35. ***How has your intake of drugs or alcohol changed in the last year?*** **[CHECK ONE]**

☐ Increased (1) ☐ Remained the same (3) ☐ Don't know (5)
☐ Decreased (2) ☐ Never used (4)

36. Has drugs or alcohol from a partner/spouse/relative/community member/rebel led to violence against you?

☐ Yes (1) ☐ No (0)

◀◀ ◀◀◀◀ REPRODUCTIVE HEALTH ▶▶▶▶▶▶

[IF INTERVIEWING A MAN GO TO Q42]

37. ***How many times have you been pregnant?*** _____

[IF INTERVIEWING A WOMAN WITH NO PREGNANCIES/CHILDREN GO TO Q42]

38. ***How many miscarriages have you had?*** _____

39. ***How many of these miscarriages were the result of violence?*** _____

40. ***How many live births have you had?*** _____

41. ***How many of these pregnancies were the result of violence?***_____

42. ***IN YOUR LIFETIME, have you been subjected to violence, such as beatings, by a spouse or boyfriend/girlfriend?***

☐ Yes (1) ☐ No (0)

43. ***IN THE LAST YEAR, have you been subjected to violence, such as beatings, by a spouse or boyfriend/girlfriend?***

☐ Yes (1) ☐ No (0)

44. ***IN YOUR LIFETIME, have you experienced sexual violence such as molestation, being forced to undress or stripped of clothing, forced intercourse or other sexual acts?***

☐ Yes (1) ☐ No (0)

45. ***IN THE LAST YEAR, have you experienced sexual violence such as molestation, being forced to undress or stripped of clothing, forced intercourse or other sexual acts?***

☐ Yes (1) ☐ No (0)

[If "NO" to Q44 AND Q45, GO TO Q50]

46. ***We are interested in getting more detail about each incidence of molestation, being forced to undressed or stripped of clothing, forced intercourse and other sexual acts that you have experienced. I understand that much of what we will discuss may be quite difficult for you to talk about. If you do not understand a question, please ask me to explain it to you for clarification. You are free to stop at any time. If YOU DO NOT WANT TO ANSWER a question, we will skip the question and go to the next question. Do you have any questions before we go on?***

46. Continued [RECORD EACH INCIDENT AS A SEPARATE ENTRY. DO NOT READ CHOICES. LIST ALL THAT APPLY.]

	When	Where	Abuse Type(s)	By Whom / Group	# of Attackers	Gender of Attackers [CHECK ALL THAT APPLY]	Con-se-quen-ces	*Have you told anyone else about the incident before today?*	*Why did you not report the incident before today?↓*	*✦As a result of the incident, did you seek help for your health or your state of mind?*	*Where did you seek help for your health or state of mind? ↓*	*How long after the incident did you seek help for your health or state of mind at a clinic or hospital?*	*Did you tell the health care provider about the incident?*	*★ Why didn't you seek help?↓*
1						☐Male ☐Female		☐Yes[GO TO✦] ☐No		☐Yes ☐No[GO TO★]		dys____mhs____yrs____	☐Yes [GO TO Q57] ☐No	
2						☐Male ☐Female		☐Yes[GO TO✦] ☐No		☐Yes ☐No[GO TO★]		dys____mhs____yrs____	☐Yes [GO TO Q57] ☐No	
3						☐Male ☐Female		☐Yes[GO TO✦] ☐No		☐Yes ☐No[GO TO★]		dys____mhs____yrs____	☐Yes [GO TO Q57] ☐No	
4						☐Male ☐Female		☐Yes[GO TO✦] ☐No		☐Yes ☐No[GO TO★]		dys____mhs____yrs____	☐Yes [GO TO Q57] ☐No	
5						☐Male ☐Female		☐Yes[GO TO✦] ☐No		☐Yes ☐No[GO TO★]		dys____mhs____yrs____	☐Yes [GO TO Q57] ☐No	
6						☐Male ☐Female		☐Yes[GO TO✦] ☐No		☐Yes ☐No[GO TO★]		dys____mhs____yrs____	☐Yes [GO TO Q57] ☐No	
7						☐Male ☐Female		☐Yes[GO TO✦] ☐No		☐Yes ☐No[GO TO★]		dys____mhs____yrs____	☐Yes [GO TO Q57] ☐No	
1= within the last month 2=1-6 months ago 3= 7-12 months ago 4= 1-2 years ago 5=3-5 years ago 6=5-10 years ago 7=more than ten years ago		1=Home village/town 2=Outside DRC 3= IDP camp 4= Refugee/ transit camp 5=While fleeing 6= Non home village/ town residence 7=While abducted 8= Other [SPECIFY]	1=Molestation 2=Being forced to undress 3=Forced Prostitution 4=Inter-course/ rape 5=Vaginal intercourse 6= Oral intercourse 7= Anal intercourse 8=Forced marriage 9= Insertion of foreign object 10=Abduction 11= Sexual slavery 12= Gang rape 13= Forced to commit act with other civilian 14=other sexual acts [SPECIFY]	11=Boyfriend/ Girlfriend 12=Spouse 13=Parent 14=Offspring 15=Sibling 16= Uncle/ Aunt 17 = Other Relative 18= Other Non-relative known to individual 19= Stranger/ Not combatant 21=AFDL 22= ALiR 23=ANC 24=APC	25= FAPC 26=FAZ 27=FDLR 28=FDD 29=FIPI 30=FLC 31=FLN 32=FNI 33=FNL 34=FPDC 35=FRPI 36=Intera-hamwe 37=LRA 38=Mai-Mai 39=MLC 40=MONUC 41=MRC 42=NALU 43=PALU	44=PPRD 45=PRA 46=PUSIC 47=RCD-G 48=RCD-K 49= RCD-K-ML 50=RCD-NATIONAL 51=UDPS 52=UNITA 53=UPC 54=UPDF 55=TPD 98 = Other [SPECIFY] 99=mixed group combatants	1=Bleeding 2= Torn 3= Bruised 4= Beaten 5=Pregnant 6=Miscarried 7= STD 8= Fear of STD/AIDS 9= Stigmatized by family/community 10= Rejected by family/community 11=Anxiety 12= Depression 13=Reproductive complications 14= Physical disability not reproductive [SPECIFY] 15= Other [SPECIFY]	For "Why did you not report the incident before today?" [**DO NOT READ; LIST ALL THAT APPLY**] 1= Fear of being stigmatized by the community 2= Fear of rejection by my husband/ family 3= Fear of physical retaliation by perpetrator 4= No one asked 5= Does not trust anyone 6= Feelings of shame or social stigma 7=Other [SPECIFY]	For "Where did you seek help for your health or state of mind?" [**READ CHOICES, LIST ALL THAT APPLY**] 1= Hospital 2=Health center 3=Traditional healer 4=NGOs 5=Church/ Mosque 6=Other [SPECIFY]	For "Why didn't you seek help?" [**DO NOT READ; LIST ALL THAT APPLY**] 1=Fear of being stigmatized by my family/community 2=Fear of rejection by my husband 3=Fear of physical retaliation 4= Lack of money 5=Feelings of shame 6=Uncomfortable because only male health care workers 7=Other [SPECIFY]	

47. ***What would help you to feel safe in the future?*** **[DO NOT READ, CHECK ALL THAT APPLY]**

- ☐ End to the conflict (1)
- ☐ A change in the attitude/ education of men (2)
- ☐ Increased respect for rights of women (3)
- ☐ Clear laws against sexual violence (4)
- ☐ Enforcement of laws against sexual violence (5)
- ☐ Continued/increased international/UN presence in DRC(6)
- ☐ International/ domestic prosecution of perpetrators (7)
- ☐ Better protection of women and girls (8)
- ☐ Nothing (9)
- ☐ Other (10)_____

48. ***What has helped you through your experiences?*** **[DO NOT READ, CHECK ALL THAT APPLY]**

- ☐ Discussion with other survivors of sexual violence (1)
- ☐ Discussions with friends (2)
- ☐ Religion (3)
- ☐ Discussions with family members (4)
- ☐ Assistance from NGO workers (5)
- ☐ A medical care provider (6)
- ☐ Not telling anyone about the incident (7)
- ☐ Support of family (8)
- ☐ Country medicine/ traditional healer (9)
- ☐ Healing ceremonies (10)
- ☐ Work/job/employment (11)
- ☐ Taking care of household (12)
- ☐ Trying to forget about it (13)
- ☐ Other (14)_____

49. ***Which of the following types of help would you find useful to help your state of mind and to help you cope better with your experience?*** **[READ CHOICES, CHECK ALL THAT APPLY]**

- ☐ ***Women's support groups*** (1)
- ☐ ***Country medicine/ traditional healer*** (2)
- ☐ ***Traditional ceremonies*** (3)
- ☐ ***Religious counseling/support*** (4)
- ☐ ***Mental health counseling*** (5)
- ☐ ***Medical assistance*** (6)
- ☐ ***Income generating projects*** (7)
- ☐ ***Skills training*** (8)
- ☐ ***Education*** (9)
- ☐ ***Humanitarian assistance/ food & shelter*** (10)
- ☐ ***Nothing*** (11)
- ☐ ***Other*** (12)_____

50. ***Do you think punishment of perpetrators of violence may prevent this from happening to others?***

☐ Yes (1) ☐ No (2)

51. ***How much is sexual violence BY COMBATANTS something you fear for yourself and your family?*** **[READ ALL, CHECK ONE]**

☐ ***Not at all*** (1) ☐ ***A little*** (2) ☐ ***Quite a bit*** (3) ☐ ***Extremely*** (4)

52. ***How much is sexual violence by FAMILY MEMBERS, FRIENDS, OR CIVILIAN STRANGERS something you fear for yourself and your family?*** **[READ ALL, CHECK ONE]**

☐ ***Not at all*** (1) ☐ ***A little*** (2) ☐ ***Quite a bit*** (3) ☐ ***Extremely*** (4)

◀◀ ◀◀◀◀◀ MENTAL HEALTH ▶▶▶▶▶▶▶

◀◀ ◀◀◀◀◀ SURVEYOR – PLEASE CHECK AGAIN TO BE SURE YOU ARE SPEAKING IN PRIVATE▶▶▶▶▶▶

For Each symptom say: "In the last 4 weeks, how often have you experienced the problem of… »

Problems	not at all	a little bit	moderate amnt:	a lot
53. Feeling low in energy, slowed down	0	1	2	3
54. Blaming self for things	0	1	2	3
55. Crying easily	0	1	2	3
56. Loss of sexual interest or pleasure	0	1	2	3
57. Poor appetite	0	1	2	3
58. Difficulty falling asleep, staying asleep	0	1	2	3
59. Feeling hopeless about the future	0	1	2	3
60. Feeling sad	0	1	2	3
61. Feeling lonely	0	1	2	3
62. Thoughts of ending your life	0	1	2	3

Problems	not at all	a little bit	moderate amnt:	a lot
63. Feeling of being trapped or caught	0	1	2	3
64. Worrying too much about things	0	1	2	3
65. Feeling no interest in things/less interest in daily activities	0	1	2	3
66. Feeling everything is effort	0	1	2	3
67. Feelings of worthlessness- no value	0	1	2	3
68. Suddenly scared for no reason	0	1	2	3
69. Feeling fearful	0	1	2	3
70. Faintness, dizziness or weakness	0	1	2	3
71. Nervousness or shakiness inside	0	1	2	3
72. Heart pounding or racing	0	1	2	3
73. Trembling	0	1	2	3
74. Feeling tense/ keyed up	0	1	2	3
75. Headaches	0	1	2	3
76. Spells terror/panic	0	1	2	3
77. Feeling restless, can't sit still	0	1	2	3

Problems	not at all	a little bit	moderate amnt:	a lot
78. Recurrent thoughts or memories of the most hurtful or terrifying events	0	1	2	3
79. Feeling as though the hurtful or terrifying event is happening again	0	1	2	3
80. Recurrent nightmares (about the event)	0	1	2	3
81. Feeling detached or withdrawn from others	0	1	2	3
82. Unable feel emotions	0	1	2	3
83. Feeling jumpy, easily startled	0	1	2	3
84. Difficulty concentrating	0	1	2	3
85. Feeling on guard	0	1	2	3
86. Feeling irritable or having outbursts of anger	0	1	2	3
87. Avoiding activities that remind of the traumatic or hurtful event	0	1	2	3
88. Inability to remember parts of the most traumatic or hurtful events	0	1	2	3

Problems	not at all	a little bit	moderate amnt	a lot
89. Feeling as if you don't have a future	0	1	2	3
90. Avoiding thoughts of feelings associated with the traumatic or hurtful events	0	1	2	3
91. Sudden emotional or physical reaction when reminded of most hurtful/traumatic events	0	1	2	3
92. Feeling guilty	0	1	2	3

93. ***In your lifetime, have you ever attempted to take your own life?***

☐ Yes (1) ☐ No (2) **[GO TO Q95]**

94. ***Do you believe that exposure to the war is responsible for your thoughts and/or attempts of suicide?***
[CHECK ONE]

☐ ***Not at all*** (1) ☐ ***A little*** (2) ☐ ***Quite a bit*** (3) ☐ ***Extremely*** (4)

95. ***Has anyone in your household attempted to take their own life?***

☐ Yes (1) ☐ No (2)

96. ***Has anyone in your household taken their own life?***

☐ Yes (1) ☐ No (2)

◀◀ ◀◀◀◀ VIOLENCE ▶▶▶▶▶▶

◀◀ ◀◀◀◀ SURVEYOR – PLEASE CHECK AGAIN TO BE SURE YOU ARE SPEAKING IN PRIVATE▶▶▶▶▶▶

In the last year, were you or any of your children ever forced to do the following:	No	Yes	NR	Who? S=self C=child	Age Started
97. Forced to work in a bar/market or bistro?					
98. Forced into proxénétisme?					
99. Forced to work in someone's home?					
100. ***Forced to work in a mine?***					
101. Forced to work in someone else's field?(such as **ingamba)**					
102. Forced to carry goods from a mine to other towns?					
103. Repay a debt that was not possible to repay?					
104. Forced to pay illegal "taxes" or "fines"					
105. Forced to marry anyone (rebel/family member/miner/community member)? Who:					
106. Forced to work in the sex business by someone who threatened you?					
107. Forced to be a sexual servant or slave?					
108. Held against your will at anytime? Where:					
109. Trade sex for food, medicine, property, money or anything else needed?					

[IF NO TO ALL OF Q97-Q109, GO TO Q113]

110. *What technique was employed to recruit or enlist you?* [DO NOT READ, CHECK ALL THAT APPLY]

☐ Wanted to enlist (1) ☐ Family threatened with violence (4) ☐ Friends pressured you (7)

☐ Abducted/kidnapped (2) ☐ Personal security threatened (5) ☐ Promised money/drugs/incentive (8)

☐ Family gave me to them (3) ☐ Needed work/safety/shelter/food (6) ☐ Other (9)_____

☐ A woman in the village suggested it (10)

111. *What was your main reason for staying?* [DO NOT READ, CHECK ONE]

☐ Personally threatened (1) ☐ Friends were there (5) ☐ In unfamiliar environment/lost (9)

☐ Family threatened (2) ☐ Family were there (6) ☐ Stayed less than 2 weeks (10)

☐ Starving and needed food (3) ☐ Promised money/drugs/incentives (7)

☐ Homeless and needed safety/shelter (4) ☐ Afraid of stigmatization after going home (8) ☐ Other (11)_____

_____

☐ I had too much debt ☐ The "queen" insisted/forced

112. What incentives were offered to you to stay? [CHECK ALL THAT APPLY]

☐ Food (1) ☐ Money (4) ☐ Personal safety (7) ☐ None (10)

☐ Shelter (2) ☐ Friends/Safety of (5) ☐ Safety for my baby (8) ☐ Other (11)

☐ Drugs (3) ☐ Family/Safety of (6) ☐ I wanted to stay (9) _____

Please indicate if you agree or disagree with the following statements: **[CHECK ONE IN EACH ROW]**	AGREE	DISAGREE	NR	DK
113. *A good wife obeys her husband even if she disagrees*				
114. *My community will accept survivors of sexual violence back into the community*				
115. *It's a wife's obligation to have sex with her husband even if she doesn't want to*				
116. *A man has the right to beat his wife if she disobeys him*				
117. *Women and girls need more education about their rights to refuse sex*				
118. *There should be legal protections for women and girls*				
119. *More should be done to protect women and girls from having sex when they don't want to*				
120. *Anyone who sexually abuses another should be punished by the community not the courts*				
121. *Anyone who sexually abuses another should be punished by the courts not the community*				
122. *Under the current system, justice is attainable.*				
123. *The current justice system only helps those who have money to pay for justice*				
124. *The mental health programs offered in my area are sufficient to meet the needs of my community*				
125. *I feel safe living in my community*				
126. *I use beatings as a form of discipline for my children*				
127. *Traditional practices that may hurt or harm a child must continue because it is our way*				
128. *It is OK NOT to send girls to school since that is tradition in our village*				

Question	Agree	Disagree	NR	DK
129. In most cases when a woman is raped, she deserved it				
130. Women who say no to sexual intercourse often mean yes				
131. Most rapes happen because women entice men				
132. If a woman really didn't want to be raped she could fight off the attacker				
133. Only soldiers can rape				
134. A spouse owes the other partner sex no matter what the circumstance				
135. A woman can enjoy sex even when it is forced upon her				
136. A raped woman is usually an innocent victim				
137. Women often claim rape to protect their reputations				
138. "Good" girls are less likely to be raped as "bad" girls				
139. Women who have had prior sexual relationships should not complain about rape				
140. Women can provoke rape by their appearance or behavior				
141. Men, not women, are responsible for rape				
142. Women who wear short skirts or tight shirts are inviting rape				
143. If a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her				

144. *I have asked you many questions. Are there any additional comments you wish to make*?

ALL INTERVIEWS:

[READ THIS TO ANY PARTICIPANTS WHO ARE <u>EXTREMELY</u> UPSET OR DISTURBED, OR WHO YOU ARE VERY WORRIED ABOUT:] ***I can see that you are suffering because of what they did to you. I am concerned about you and want to be sure that you receive some help. I would like to give your name to the health and counseling NGOs working in this area.*** **[TELL HIM/HER THE NAMES OF NGOS FROM YOUR LIST]** ***Would it be all right if I gave them your name and asked someone to come and visit you?***

[READ THIS TO MOST PARTICIPANTS/THOSE WHO ARE <u>NOT</u> ESPECIALLY UPSET OR DISTURBED:] ***There are services available in this area from some NGOs, to help women with their health needs and other problems.*** **The community health worker in your village has the list if you think it would be helpful for you to seek help.**

Even if you don't feel you need such help now, perhaps you may meet someone who does need this help, or perhaps some time in the future you may feel the need for such help. I want you to know what is available.

[CLOSING STATEMENT FOR ALL PARTICIPANTS:]***Thank you for taking the time to talk with me. As I stated earlier, this information will be kept confidential, and we are gathering this information to learn how to better protect the health and human rights of women.***

We know that people in this area will be curious about all of us and wondering what we are doing here. We suggest that you do not give details about what we discussed, and that you simply say that it is a survey about health.

Again, thank you for your time.

Time Interview Ended:_____

INTERVIEWER, PLEASE PUT YOUR ADDITIONAL COMMENTS AND OBSERVATIONS HERE:

_____

_____

_____

_____

_____

_____

_____

_____

WHEN FINISHED WITH ALL INTERVIEWS IN THIS HOUSEHOLD:

- **BEFORE YOU LEAVE:** Make sure all answers are marked and the survey is complete.
- Say good bye and leave the house.
- Make note of any referrals needed.
- File the Questionnaire in your folder.

Annex IV: Kiswahili Version Quantitative Instrument

KIAMBATISHO **C**

◀◀◀◀◀◀ Eastern DRC Health Assessment Survey – 2016 ▶▶▶▶▶▶

Tafsiri ya Kiswahili {Congolese}

1. KITAMBULISHO cha kesi_____(1-5000) **2. Tarehe ya maulizo**_____(Tarehe)_____(Mwezi)

3. Namba ya Mchunguzil_____ **4. Namba ya mahali**_____

5. Matokeo ya muhusika [CHAGUA MOYA]:

☐ Alishiriki/alijibu yote (1) ☐ Haitaji uchunguzi huu (2) ☐ Hatukute mtu kisha kupita kwake mara mbili (3)

☐ Amekatala: Hana muda (4a) ☐ Amekatala: Anaoga kulipa kisasi (4b) ☐ Amekatala: hataki uchunguzi huu (4c)

☐ Amekatala: Sababu ingine (4d) _____

☐ Maulizo haikuisha: maongezi ilikatwa(5a) ☐ Hatukuweza kumaliza: uchungu (5b)

☐ Hatukuweza kumaliza: usalama mdogo (5c) ☐ Hatukuweza kumaliza: Aliomba tusimamishe (5d)

☐ Hatukuweza kumaliza: sababu nyingine (5e) _____

Kama AMEKATALA: Umri Yako (tafadhali uliza) _____
Wakati yenyi maulizo ilianza:_____

◀◀◀◀◀◀ UWAMUZI YA KUSHIRIKI KWENYI MAZUNGUMUZO ▶▶▶▶

Tunafanya kazi na IMA, shirika yenyi kutoka Amerika, na isio kuwa ya Kiserekali. IMA inatumika hapa Congo, na ndani nchi zingine kupitia msaada ya serekali nyingi, na msaada kutolewa na watu wanaojitegemea na zingine mashirika za kimataifa kwa kutusaidia kujibu kwa itaji za watu wengi kadiri iwezakanavyo. Atahivyo, sisi hatusaidii kundi lolote la kisiasa ao la kidini.

Tunaongoza utafiti mfupi kwenyi jamaa nyingi iwezekanavyo kwa kuchunguza itaji la watu wanao ishi vijijini na mijini ili tuweze kuelewa kitu gani kiliwatokea kwako binafsi na wale watu munao ishi nao pamoja nyumbani. Tuataka elewa namna gani vita na ujeuri inagusa maisha yako, jamaa lako na na mipango gani mipia ao mafikara inaweza kukuponya, yumba yako na jamii.

Tunajaribu kusitokee viyume vyote kwakujibu swali hizi juu ya ukingo yako na ujisikie wewe na familia kuwa huru na kama hakatukua tatizo, kwakuwa tatizo yenye sisi hatujui. Tungelijua kutatokea tatizo, hatungeliweza kukutembelea ku nyumba yako kabisa.

Kwa sasa hatukuje na msaada wa kiutu. Tunataka tumia matokeo ya utafiti huyu ili tufahamu namna gani vita ilisababisha vinyume kiakili na namna gani watu ndani ya jamii yako wanavyoishi kila siku. Tunatumaini kujuwa itaji zako za muhimu ili ituwezeshe kupangilia matunzo na msaada wako na ya jamii.

Tunataka ujue hautapata faida yoyote juu ya kuchangia kwenyi utafiti hii, ila majibu yako yataweza saidia serekali kuchukuwa mipango bora kwa huduma ya afia yako, ya jamaa ao jamii lote kwa siku zijazo. Tulichagula nyumba yako kati ya nyigi bila muongozo yoyote. Tumegundua kwamba watu wengi walikumbwa na shida nyingi na wanaweza kuwa na mambo mengi ya kueleza. Lakini hiti utafiti unaitaji ma jibu fupi kwa ma maulizo chache tulizo taharisha.

Matokeo ya utafiti hii itatusaidia kujaribu kuboresha hali ya watu waliopona vita. Hatuitaji kujuwa jina lako. Nahata majibu yako haitajulishwa kwa mtu mwengine na haitawezekana uelewa majibu zako kutokea kwamtu mwengine. Kama haukusikia ulizo vizuri tafazali uniulize nitakufasiria. Elewa kwamba kuna maulizo za kisiri ama zenyizinaweza kupenya moyo, ndiyo maana tuzunguzume kwa siri. Uko huru kukata hii maongezi wakati yoyote. Kama kuna ulizo yenyi itakusumbua, tutairuka na tutaenda ku ulizo ifwatayo. Kama unataka kuniuliza swali yoyote juu ya hii utafiti, utaweza kupata mafasirio kutoka kwa watu wanao fanya towa huduma kwenyi kijiji/ mujini yenyu. Je, una maulizo mbele tuanze mazungumuzo?

6. Naweza kukuuliza juu ya tukio ilikufikiya? ☐ Ndiyo (1) ☐ Hapana (0)

7. Jinsia: ☐ Mwanamuke (1) ☐ Mwamaume (2)

8. Uko na miaka ngapi? _____(# miaka)

9. *Ku maisha yako yote ulikuwa naishi wapi?*

☐Fasi unaishi sasa (1) ☐Fasi ingine (2)_____

10.

11. Unaishi hapa ku kijiji/muji tangu siku gani ? _____miezi _____miaka

◀◀◀◀◀◀ **Watu mu nyumba** ▶▶▶▶▶▶

12. *Kunyumba yako kunaishi munaishi watu ngapi (munao changia chakula pamoja) ukijisabia na wewe peke?* _____

13. *Katikati ya haba bangapi bako CHINI ya miaka kumi na munane?* _____

12a. *Kwa mwaka moja uliopita watoto chini ya miaka 18, wangapi nyumbani mwako waliweza kujeuriwa?*_____

13. *Unaolewa?* [CHAGUA MOJA]

☐Sija olewa/ sijaowa (1) ☐Niko mujane (4) ☐Naishi na mpenzi lakini siolewe(7)

☐Naolewa/naowa (2) ☐Mwanaume alipoteaka (5) ☐sababu zingine (8) _____

☐Nime funja ndowa ao tumeachana (3) ☐Mwanamuke alipoteaka (6) _____

14. *Kabila zitafwatazo, yako ni gani ?* [CHAGUA MOJA]

☐Bashi (1) ☐Nyanga (6) ☐Fulero(11)

☐Hunde (2) ☐Hutu (7) ☐Mongo (12)

☐Baluba (3) ☐Kumu (8) ☐Nande (13)

☐ Batwa (4) ☐Lega (9) ☐Pere (14) ☐Fasi ingine (16) _____

☐Luba (10) ☐Tutsi (15)

15. *Kanisa zifwatazo , ukomufwasi ya gani?* [CHAGUA YOTE YANAYOHUSIKA]

☐Muislamu (1) ☐ Anaabudu miungu/imani ya kiasili (3) ☐Ingine (5)_____

☐Mukristu (2) ☐Mutu mwenye anamukana Mungu (4) _____

◀◀◀◀◀◀ **KIPATO** ▶▶▶▶▶▶

16. *Kazi muhimu gani unafanya kwa kupata pesa?* [CHAGUA MOYA]

☐Nalimaka/nafuga (1) ☐Uchuruzi ndogo ☐Uhusika na ulinzi (9) ☐Mengine (14)_____

☐Nabaki nyumbani (2) ☐Mtaalamu (6) ☐Sifanyi kazi/shomeri (10) _____

☐Guverinemaa (3) ☐Askari (7) ☐Mstaafu (pansioni) (11) _____

☐Kazi ya ukarani (4) ☐Shoferi (8) ☐Mwanafunzi (12) _____

17. *Kuna mtu wa jamaa lako (mufamie yako) mwenyi kuwa na shamba?*

☐Ndiyo (1) ☐Hapana (0) ☐Sijuwe (2)

18. Unaleta pesa ngapi nyumbani kwa djuma ? _____Francs

◀◀◀◀ ELIMU/ MAFUNZO ▶▶▶▶▶▶▶

19. ***Unaweza kusoma?***

☐ Ndiyo bila shida (1) ☐ Naweza lakini kwa shida (2) ☐ Hapana (3)

20. ***Unaweza kuandika barua?***

☐ Ndiyo bila shida (1) ☐ Naweza lakini kwa shida (2) ☐ Hapana (3)

21. ***Unaweza kufanya esabu?***

☐ Ndiyo (1) ☐ Hapana (0) ☐ Shijuwe (2)

22. ***Ulisoma mpaka somo gani ?*** **[CHAGUA MOYA]**

☐ Primeri (1) ☐ Segondari (2) ☐ Chuo kikuu (6)
☐ Sikusomaka (7)

23. ***Ulishaka jifunza kazi yoyote ao ukapata sertifika?***

☐ Ndiyo (1) ☐ Hapana (0) **[NENDA SW26]** ☐ Shijuwe (2) **[NENDA SW26]**

24. ***Ulijifunza kazi gani?*** _____

25. ***Kazi ulijifunza Inakusaidia?***

☐ Ndiyo (1) ☐ Hapana (0) ☐ Shiyuwe (2)

◀◀◀◀◀◀ KUPATIKANA WA OPITALI ▶▶▶▶▶▶

26. ***Matunzo gani ulishaka pata kijijini?*** **[USISOME, CHAGUA YOTE YANAYOSITAILI]**

☐ wanganga ya asili (1) ☐ Kituoa cha afia ☐ Ingine (9) _____
☐ Wa mama husika na kuzalisha (2) ☐ Waimizaji husika na afia (6) _____
☐ Fasi ya chakula (3) ☐ Kwenyi hospitali (7) _____
☐ Kwenyi Farmasi (4) ☐ Hakuna (8) _____

27. ***Kama tuliitaji matunzo ya afia lakini hatukupata, sababu kubwa ilikuwa nini?*** **[CHAGUA MOYA]**

☐ Ukosefu wa franga ya kulipa matunzo(1) ☐ Kuko mbali (4)
☐ Sikujuwa kujua fasi yakupata matunzo(2) ☐ Hakuna kituoa cha afia (5)
☐ Ukosefu wa namna ya kusafiri (3) ☐ Ingine (6)_____

28. ***Kutoka hapa kwa mugulu mpaka kuopitali ni kutembeya saa ngapi?*** **[CHAGUA MOYA]**

☐ Chini ya saa moya (1) ☐ Masaa 4 - mpaka 8 (4) ☐ Zaidi ya masaa 12(6)
☐ Saa moya 1 – mpaka 2 (2) ☐ Masaa 8 – hadi kumi na mbili (5) ☐ Sijuwe (7)
☐ Masaa mbili 2 – mpaka ine 4 (3)

29. ***Unaweza pata haraka transport ya kukupeleka ku opitali ?***

☐ Ndiyo (1) ☐ Ndiyo lakini siwezi kulipa (3) ☐ Hapana (0) ☐ Shijuwe (2)

30. ***Huduma gani inatolewa kwa tutuliza shida za mafikara / matatizo la kichwa ndani ya kijiji kyenyu?***
[USISOME, CHAGUA YOTE YANAYOHUSIKA]

☐ Hakuna (0) ☐ Shauri kwa kikundi grupe(3) ☐ Waganga ndani ya jamii (6)

☐ Kituo chaa kutuliza akili (1) ☐ Shauri kanisani religezi (4) ☐ Waganga ya kienyeji/ wafumu (7)

☐ Tunapata mashauri ya kipekee mutu (2) ☐ Ku kituo cha afia (5) ☐ Opitali (8) ☐ Shijuwe (9)

31. ***Ni musaada gani katikati ya iyi itakuwa ya lazima sana kwako?*** **[SOMA YOTE, CHAGUA YOTE YANAYOHUSIKA]**

☐ ***Muradi ya kutowa faida*** (1) ☐ ***Muradi ya kutowa faida*** (5) ☐ ***Yote haiko ya lazima***(9)

☐ ***Grupu ya msaada*** (2) ☐ ***Matunzo*** (6)

☐ ***Masomo (primeri/segondari)*** (3) ☐ ***Mashauri kwa mwenye problemu ya akili/ vikundi vya msaada*** (7)

☐ ***Santre ya formatio*** (4) ☐ ***Mashauri/msaada ya kidini*** (8)

32. ***Ulishaka pata mashauri kwa kwa kutuliza shida ya akili tangu vita iliishaka?***

☐ Ndiyo (1) ☐ Hapana (0) ☐ Shijuwe(2)

33. ***Kitu gani inaweza kukukataza kutafuta opitali ya akili kama iko?***
[USISOME, ANGALIA YOTE YANAYOHUSIKA]

☐ Nasikia haya (1) ☐ Naogopa famiye yangu habaipendi (6)

☐ Naogopa kuchekelewa ao kubaguliwa na jamii (2) ☐ Kushirika kwenyi shirika ao kituo (7)

☐ Siku zani kama itanisaidia (3 ☐ Haiko kitu kinanikataza (8)

☐ Nahusika Zaidi na kazi ya nyumbani (4) ☐ Mengine (9) _____

☐ Naogopa wasinitangaze (5) _____

◀◀◀◀◀◀◀ UTUMIAJI MUBAYA WA MADAWA YA KULEVYA ▶▶▶▶▶▶▶

34. ***Sasa hivi unatumiaka dawa za kulevia ao pombe mara mingi? (Zaidi ya mara mbili kwa juma au kila mara kama unapata)?***

☐ Ndiyo (1) ☐ Hapana (0)

35. ***Gizi unakunywa pombe ao drogu ilibadilika namna gani tangu mwaka moja?*** **[CHAGUA MOJA]**

☐ Inaongezeka (1) ☐ Haikubadilika (3) ☐ Sijuwe (5)

☐ Inapunguka (2) ☐ Siyatumiyaka pombe ao dawa (4)

36. ***Kuna siku drogu ao pombe ilikuleteya ujeuri kutoka kwa mume wako (bibi yako), ndugu yako, memba wa kominote yako, ao ba rebele/basodaa?*** **[CHAGUA MOJA]**

☐ Ndiyo (1) ☐ Hapana (0)

◀ ◀ ◀ ◀ ◀ ◀ ULIZO KUUSU MATERNITEE ▶ ▶ ▶ ▶ ▶ ▶ ▶

[KAMA UNAMUULIZA MWANAUME, ENDA KU SWALI 42]

37. ***Ulishaka pata mimba mara ngapi?*** _____

[KAMA UNAMUULIZA MWANAMUKE BILA MIMBA NA BILA MUTOTO **ENDA KU SWALI 42]**

38. ***Mara ngapi mimba zimeondoka?*** _____

39. ***Mimba ngapi umeona zilitokaka juu ya ujeuri?*** _____

40. ***Ulizalaka batoto ngapi bazima?*** _____

41. ***Mimba ngapi ulipata kisha kitendo kya ubakaji?*** _____

42. ***Mu maisha yako kuko siku ulishaka ishi ujeuri yoyote (kwa mufano kupigwa na bwana wako ama mpenzi)?***

☐ Ndiyo (1) ☐ Hapana (0)

43. ***Mwaka unaopita, kuko siku uliishi ujeuri yoyote (kwa mufano kupigwa na bwana yako ao mchmba wako)?***

☐ Ndiyo (1) ☐ Hapana (0)

44. ***Mu maisha yako, kuko siku uliishi ujeuri kama kulazimishwa kuvula manguo ao inceste, kupasuliwa manguo, ubakaji ao kitendo kingine kya ngono?***

☐ Ndiyo (1) ☐ Hapana (0)

45. ***Mwaka unaopita, kuko siku uliishi ujeuri kama kulazimishwa kuvula manguo ao inceste, kupasuliwa manguo ,ubakaji ao kitendo kingine kya ngono?***

☐ Ndiyo (1) ☐ Hapana (0)

[KAMA JIBU NI HAPANA KWENYI SWALI 44 NA 45 NENDA KU SWALI 50]

46. ***Tulitaka kujua kwa urefu ujeuri gani kabisa ilikutokea, kwa mufano wakati banakulazimisha kuvula manguo au kukupasulia manguo, kukukazia tendo lolote la ndowa na la ngono uliopitia kwa makazo. Najua kama yote yenyewe tunaongea inaweza kuwa ngumu kuizugumuzia. Kama hausikiye ulizo, nakulomba uniulize nitakutafasiria. Uko huru kusimamisha ongozi wakati yoyote. Kama HAUTAKI KUJIBU ULIZO YOYOTE, tutairuka na tutaenda ku ulizo ingine. Una na ulizo lolote mbele tuendeleye?***

46. REKODI KILA AJALI YA UJEURI UKITIYA KILA MOJA KU MUSTARI MOJA; USISOME CHAGUA YOTE YANAYOUSIKA

	Siku gani?	Wapi?	Ujeuri gani?	Kutokea kwa nani?	Wajeuri wangapi?	Ginsiya ya mujeuri (Chagua yote ilio hitajika)	Vinyume	Ulishaka ongeya na mutu juu ya ujeuri huu mbele ya leo?	Kwa nini hauku sema mpaka leo?	✦ Ulitafuta msaada wa matunzo ya kimwili ao yakiakili?	Wapi ulitafuta msaada wa matunzo ya kimwili ao ya akili?	Siku ngapi kisha ujeuri ulitafuta msaada wa matunzoya kimwili ao ya kiakili kwenye kituo?	Uliambiyaka muganga tukio ilifikaka?	★]Kwa nini haukutafuta msaada?↓
1						☐Mwanaume ☐Mwanamuke		☐Ndiyo [Enda ku ✦] ☐Hapana		☐Ndiyo ☐Hapana [Enda ku ★]		Siku.....mwezi.....mwaka	☐Ndiyo ☐Hapana	
2						☐Mwanaume ☐Mwanamuke		☐Ndiyo [Enda ku ✦] ☐Hapana		☐Ndiyo ☐Hapana [Enda ku ★]		Siku.....mwezi.....mwaka	☐Ndiyo ☐Hapana	
3						☐Mwanaume ☐Mwanamuke		☐Ndiyo [Enda ku ✦] ☐Hapana		☐Ndiyo ☐Hapana [Enda ku ★]		Siku.....mwezi.....mwaka	☐Ndiyo ☐Hapana	
4						☐Mwanaume ☐Mwanamuke		☐Ndiyo [Enda ku ✦] ☐Hapana		☐Ndiyo ☐Hapana [Enda ku ★]		Siku.....mwezi.....mwaka	☐Ndiyo ☐Hapana	
5						☐Mwanaume ☐Mwanamuke		☐Ndiyo [Enda ku ✦] ☐Hapana		☐Ndiyo ☐Hapana [Enda ku ★]		Siku.....mwezi.....mwaka	☐Ndiyo ☐Hapana	
6						☐Mwanaume ☐Mwanamuke		☐Ndiyo [Enda ku ✦] ☐Hapana		☐Ndiyo ☐Hapana [Enda ku ★]		Siku.....mwezi.....mwaka	☐Ndiyo ☐Hapana	
7						☐Mwanaume ☐Mwanamuke		☐Ndiyo [Enda ku ✦] ☐Hapana		☐Ndiyo ☐Hapana [Enda ku ★]		Siku.....mwezi.....mwaka	☐Yes ☐No	
1= Mwezi uliopita 2= Miezi 1-6 iliopita 3=Miezi 7-12 iliopita 4= Miaka 1-2 iliopita 5=Miaka 3-5 6= Miaka 5-10 7= Zaidi ya miaka 10 iliopita		1=Hapa kijijini/ hapa mjini 2=indje ya Congo 3= Mu cammpi yaw a deplasés 4= Mu campi ya wa refigie 5=Wakati wakukimbiya 6=Mjini ao kijijini ingine 7=Wakati nilitekwa nyara (enlever) 8=Porini 9=Ingine [FASIRIYA]	1=Kubakwa na memba wa jamaa 2=Kilazimishwa kuvua manguo 3=Kushurtishwa kufanya ukaaba 4=Kubakwa 5=Kubakwa kwa njia ya mbele (vaginal) 6= kubakwa kwa kinwa (oral) 7= kunibaka kwa nyuma (anal) 8=Kunikaziya ndowa 9= Kiingiza vitu ndani ya umbo 10=kutekwa nyara 11= Utumwa wa ngono 12= Kubakwa na watu wengi 13= kukazanishwa kukutana kimwili na mwengine civile 14=Ingine tendo [FASIRIYA]	11=Rafiki 12=Muke/Mume 13=Muzazi 14=Mutoto 15=Kaka/Dada 16=Mjomba/Shangazi 17 = Ndugu mwengine 18= Mutu asiye ndugu lakini anayejulikana 19= Mutu asiyejulikana CIVILE 21=AFDL 22= ALiR 23=ANC 24=APIngineC	25= FAPC 26=FAZ 27=FDLR 28=FDD 29=FIPI 30=FLC 31=FLN 32=FNI 33=FNL 34=FPDC 35=FRPI 36=Intera-hamwe 37=LRA 38=Mai-Mai 39=MLC 40=MONUC 41=MRC 42=NALU 43=PALU	44=PPRD 45=PRA 46=PUSIC 47=RCD-G 48=RCD-K 49= RCD-K-ML 50=RCD-NATIONAL 51=UDPS 52=UNITA 53=UPC 54=UPDF 55=TPD 98 = Wengine [FASIRIYA] 99=Ma rebel wnaochangwa	1=Kutoka damu 2= Kupasuliwa kwenyi umbo 3= Kuvimba 4= Kupigwa 5=Mimba 6=Kupoteza mimba 7= magonjwa ya zinaa 8= Kuogopa UKIMWI na magonjwa ya zinaa 9= Kubaguliwa na jamaa/jamii (communauté) 10= Kutupiliwa na jamaa/jamii (communauté) 11=Wasiwasi 12= Unyogovu (Depression) 13=Troma 14=Matatizo ya uzazi 15= ulemavu sio kwa uzazi [FAZIRIYA] 16= Ingine [FASIRIYA]		Kwa ulizo "Kwa nini hauku ripoti tukio ilo mbele? [USISOME; CHAGUA YOTE INAYOFAA] 1= Kuogopa kubaguliwa mu jamii (communauté) 2= Kuogopa kutupiliwa na bwana/Bibi ao jamaa 3= Kuogopa kulipizwa kisasi na mujeuri 4= Hakuna mutu aliniuliza 5=Sitegemeye mutu yeyote (confiance) 6= Haya/ kuogopa kubaguliwa 7=Ingine FASIRIYA]	Kwa ulizo " Wapi ulitafuta msaada wa matunzo ya kimwili ao ya akili ?" [SOMA YOTE, UANDIKE YOTE ATACHAGUA] 1= Hospitali 2=Kituo cha afia 3=Mganga wakiasili 4=ONG 5=Kanisa/Muskiti 6=Ingine [FASIRIYA]		Kwa ulizo "Kwa nini haukutafuta msaada?" [USISOME; CHAGUA YOTE INAYOFAA] 1=Kuogopa kubaguliwa mu jamaa/jamii (communauté) 2=Kuogopa kutupiliwa na bwana/Bibi 3=Kuogopa kulipishwa kisasi na mujeuri 4= Kukosa pesa 5=HAYA 6=Wanaume tu njo waganga huku 7=Ingine [FASIRIYA]	

47. ***Kitu gani kitakufanya ujisikie vizuri baadaye?*** **[USISOME, CHAGUA YOTE ATAKAYOTAJA]**

☐ Mwisho wa vita (1) ☐ Kuendelea/kuongeza uwezo na huduma wa umoja wa mataifa (UN) hapa Congo(6)

☐ Kubadili tabia na elimu kwa banaume (2)

☐ Kustaki wajeuri mbele ya sharia inchini kwetu ao ku sharia ya mataifa (7)

☐ Kuheshimiya zaidi haki za mwanamuke (3)

☐ Kulinda zaidi banamuke na ma binti (8)

☐ Kutoa sharia za kuazibu ujeuri kwa mwanamuke (4)

☐ Hakuna kitu (9)

☐ Kukaziya sheria za kuazibu ujeuri kwa mwanamuke (5)

☐ Mengine (10) _____

48. ***Kitu gani kilikusaidia wakati wa ule ujeuri? [*USISOME, CHAGUA YOTE ATAKAYOTAJA*]***

☐ Kushiriki pamoja na wenginee wa hanga wa ubakaji (1)

☐ Kuzugumuza na marafiki(2)

☐ Kusali na wengine (3)

☐ Kuzungumuza na wandugu (4)

☐ Musaada kutoka kwenyi shirika isio ya serekali(5)

☐ Matunzo kutoka kwa muganga (6)

☐ Kusipo eleza watu juu ya shida langu (7)

☐ Huduma ndani ya jamaa langu (8)

☐ Waganga wa dawa sa kiasili (9)

☐ Ibada za kiasili kwa ajili ya uponyaji (10)

☐ Kupata kazi / kutumika(11)

☐ Kuhusika na kazi ya nyumbani (12)

☐ Kujaribu kusahau shida (13)

☐ Mengine(14) _____

49. ***Kati ya njia zifuatazo, kitu gani kitakusaidia juu ya hiyo matatizo yako ya akili na kukusaidia kwa vile uko?*** **[SOMA YOTE, CHAGUA YOTE ANAITAJA]**

☐ Kikundi husika na msaada kwa wanawake (1)

☐ Unaenda kubafumu (2)

☐ Ibada za kiasili za uponyaji (3)

☐ Mashauri ya dini/msaada (4)

☐ Ushauri kwa matatizo ya mafikiri/akili (5)

☐ Matunzo kwa muganga (6)

☐ Miradi ya kutowa faida (7)

☐ Kujifunza kazi za mikono (8)

☐ Kusoma (9)

☐ Misaada ya kibinadamu/chakula & fasi ya kulala (10)

☐ Hakuna kitu (11)

☐ Mengine (12) _____

50. ***Unqfikiri wajeuri wakiazibiwa, itazuwia hiyo shida ya ujeuri isifikie wengine watu?***

☐ Ndiyo (1) ☐ Hapana (0)

51. ***Kwa kiasi gani unaogopa kujeuriwa wewe na jamaa loko na watu wenye kubeba silaha?*** **[SOMA YOTE, CHAGUA MOJA]**

☐ Hakuna woga (1) ☐ Woga kidogo (2) ☐ Woga kabisa (3) ☐ Woga kiasi (4)

52. ***Kwa kiasi gani unaogopa kujeuriwa wewe na jamaa loko na wana memba wa jamaa lako, marafiki ao wa civil wageni?*** **[SOMA YOTE, CHAGUA MOYA]**

☐ Hakuna woga (1) ☐ Woga kidogo (2) ☐ Woga kabisa (3) ☐ Woga kiasi (4)

◀ ◀ ◀ ◀ ◀ ◀ ◀ MATUNZO YA AKILI ▶ ▶ ▶ ▶ ▶ ▶ ▶

◀ ◀ ◀ ◀ ◀ ◀ ◀ MCHUNGUZI – TAFAZALI ANGALIA TENA KUHAKIKISHA MUKO PEKE YENU▶ ▶ ▶ ▶ ▶ ▶

Kwa kila ulizo, mwezi unaopita, mara ngapi ulijisikia kama ifuatavyo :

Shida	Hapana	Kidogo	Ya kutosha	Saana
53. Kukosa nguvu, nasikia uregevu	0	1	2	3
54. Kuji ukumu / kujilaumu	0	1	2	3
55. Kulilia upesi	0	1	2	3
56. Kupoteza tama ya tendo la ndoa	0	1	2	3
57. kukosewa na hamu ya kula	0	1	2	3
58. Kukosa usingizi ao kulala kiasi	0	1	2	3
59. Kupoteza matumaini	0	1	2	3
60. Kuuzika	0	1	2	3
61. Kujisikia upeke	0	1	2	3
62. Kutaka kujiuwa	0	1	2	3

Problems	hapana	Kidoga	Ya kutosha	Saana
63. Kujisikia kama umetegwa ama utashikwa	0	1	2	3
64. Kuishi ndani ya Wasi wasi	0	1	2	3
65. Kukata tamaa kwa kila kitu	0	1	2	3
66. Kusikia kila kitu ni nguvu	0	1	2	3
67. Kijisikia sistahili, sina mafaa	0	1	2	3
68. Kushitukia bure	0	1	2	3
69. Kuishi na woga wa rafula bila sababu	0	1	2	3
70. Kizunguzungu, uzaifu, kupoteza fikiri kwa muda	0	1	2	3
71. Kisirani	0	1	2	3
72. Roho kupiga sana	0	1	2	3
73. Kutetemeka	0	1	2	3
74. Husikia mafikiri uwaka moto	0	1	2	3
75. Kichwa kuuma	0	1	2	3
76. Woga ya sana	0	1	2	3
77. Ukosefu wa utulivu	0	1	2	3

Shida	Hapana	Kidogo	Ya kutosha	Sana
78. Kukumbuka saaa zote shida zilizo kuumiza zaidi	0	1	2	3
79. Kujisikia sawa ngisi uko unaishi tena ule ujeuri	0	1	2	3
80. kulota ule ujeuri	0	1	2	3
81. kujisikia ubagulia na wengine	0	1	2	3
82. Kujisikia hauguswe tena na kitu ama tama	0	1	2	3
83. Kushitukia bure	0	1	2	3
84. Kushindwa nakutenda kazi ngisi ipasavyo	0	1	2	3
85. Kubaki makini	0	1	2	3
86. Kusirika sirika ao kupata kisirani ya nguvu sana	0	1	2	3
87. Kuepuka kila kitu kinaweza kukukumbusha ule ujeuri	0	1	2	3
88. Kushindwa kukumbuka sehemu moja ao ujeuri wote uliofika	0	1	2	3

Shida	Hapana	kidogo	Ya kutosha	sana
89. Kujisikia hauna tena mwelekeo wa maisha	0	1	2	3
90. Kuepuka mawazo yote inayoambatana na vidonda vya ndani ama ujeuri ulio pitia	0	1	2	3
91. Kushikwa kwa rafula na mawazo ama kutenda vibaya wakati unakumbushwa ujeuri ulio pitia.	0	1	2	3
92. Kuji ukumu	0	1	2	3

93. ***Mu maisha yako, ulishaka jaribu kujiuwa?***

☐ Ndiyo (1) ☐ Hapana (2) **[ENDA SAWALI 95]**

94. Unafikiri kama vita ndiyo ilitumaka unataka/unajaribu kujiuwa? **[CHAGUA MOYA]**

☐ Si waki wote (1) ☐ Kuna wakati (2) ☐ Mara kwa mara (3) ☐ Mara mingi (4)

95. ***Kuko mutu ndani ya nyumba yako alishaka jaribu kujiuwa?***

☐ Ndiyo (1) ☐ Hapana (2)

96. ***Kuko mutu ndani ya nyumba yako alishaka kujiuwa?***

☐ Ndiyo (1) ☐ Hapana (2)

◄◄ ◄◄◄◄◄UJEURI►►►►►►►

◄◄ ◄◄◄◄◄MUCHUNGUZI – TAFAZALI ANGALIYA TENA UHAKIKISHE KAMA MUKO PEKE ►►►►►►►

Mwaka unaopita, kuko siku wewe ao mutoto wako aliishurutishwa kufanya mambo yafuatayo:	Hapana	Ndiyo	NR	Nani? S=Mimi C=Mutoto	Umri
97. Kukazwa kutumika kwenyi bar/nganda/soko?					
98. Kukazwa kutumika ndani ya nyumba za ukahaba/ mbaraga?					
99. Kukazwa kutumika ku nyumba ya mtu Fulani ?					
100. ***Kakazwa kutumika fasi ya kuchimba madini ?***					
101. Kukazwa kutumika mu shamba ya mtu mwengine?					
102. Kukazwa kubeba mizigo ya madini ndani ya miji zingine?					
103. Kukazwa kulipa tena deni yenyi nilikua nilisha lipa?					
104. Kukazwa kulipa codi ao amande zisizofaa?					
105. Kukazwa kuolewa na mtu (rebele/Ndugu/Muchimba madini/mwanameber wa jamii)? Nani ?.....					
106. Kukazwa kutumika kama mbaraga na mtu unayekutisha?					
107. Kukazwa kubaki kama mutumwa wa ngono na mutu bila kuolewa?					
108. Kuna wakati ulishikwa na kupeleka mahali haujuwe bila itaji ? Wapi?					
109. Kuku shurtisha tendo la ndowa ili upate chakula, dawa, pesa ao kitu kingine unaitajji?					

[KAMA JIBU KU SWALI 97 MPAKA 109 NI HAPANA ENDA SWALI 113]

110. ***Mbinu gani walitumia kwa kukuorozesha ao kukuingiza ndani ya kazi hiyo?*** **[USISOME, CHAGUA YOTE ATAKAYOITAJA]**

☐ Mimi peke nilijiorozesha (1) ☐ Jamaa langu ilitishwa kwa ukali (4) ☐ Niliogopa juu ya usalama wangu (5)
☐ Waliniteka nyara/walinipeleka Kwa makazo (2) ☐ niliitaji kazi, usalama, mahali pa kuishi, chakula (6)
☐ Jamaa langu ilinitowa kwao (3) ☐ vishawishi/ kusukumwa na marafiki (7) ☐ Walinihaidia pesa, walinipa dawa za kulevya, walinivuta kwa maneno (8) ☐ mengine (9)_____
☐ Mwanamuke alinitowa kwao (10)

111. ***Sababu gani ulibaki kule?*** **[USISOME. CHAGUA MOYA]**

☐ Niliogopa kutoroka (1) ☐ Marafiki pia walikuwa pale (5) ☐ Sikuelewa mahali nilipo/ Ningepoteya (9)
☐ Jamaa yangu ilitishwa (2) ☐ Jamaa yangu ilikuwa pia pale (6) ☐ Nilimaliza pale chini ya wiki mbili (10)
☐ Nilikumbwa na njaa nanilikuwa naitaji chakula (3) ☐ Walinihaidiya pesa/ drogue/zawadi. (7)
☐ Nilikosa makao na fasi yakuishi kwa usalama(4) ☐ Niliogopa kubaguliwa nikirudiya nyumbani(8) ☐ Mengine(11)
☐ Nilikuwa na deni mingi (12) ☐ " malikia" hakukubali niondoke (13)

112. ***Zawadi gani walikupatiya kusudi usitoke? [CHAGUA ZOTE ZENYI KUSITAILI]***

☐ Chakula (1) ☐ Pesa (4) ☐ usalama wangu (7) ☐ Hakuna (10)
☐ Makao (fasi ya kulala)(2) ☐ usalama ya marafiki (5) ☐ usalama wa mutoto wangu (8)
☐ Dawa za kulevya (3) ☐ usalama ya jamaa langu (6) ☐ Nilitaka tu kubakiya (9) ☐ Ingine (11)

TAFAZALI UONYESHE KAMA UNAKUBALI AO HAUKUBALI DECLARATION HIZI [COCHER KILA MOJA KWA MUSTARI YAKE]	NAKUBALI	SIKUBALI	HAKUNA JIBU	SIJUI
113. ***Mwanamuke mwema anatii bwana yake hata kama hakubali***				
114. ***Jamii yangu inakubali wanawake mwenyi walibakwa warudie nyumbani***				
115. ***Mwanamuka anapashwa fanya tendo la ndoa na bwana yake hata kama hataki***				
116. ***Mwanaume ana haki ya kupiga bibi yake kama hakutii***				
117. ***Wanawake na mabinti wanaitaji mafundisho kuhusu haki zao za kukataa tendo la ndoa***				
118. **Sheria inapashwa linda haki za wanawake na mabinti**				
119. ***Jamii inapashwa jikaza kuepusha wanawake na mabinti tendo la ndoa kama hawakubali***				
120. ***Kila mwenye kubaka anapashwa azibiwa na jamii, hapana na mahakama/ tribinali.***				
121. ***Kila mwenye kubaka anapashwa azibiwa na makama/ tribinali. Hapana na jamii.***				
122. ***Kwa uongozi wa sasa, sheria ni kwa wote wote***				
123. ***Kwa uongozi wa sasa, sheria ya leta iko kwa wenyi pesa***				
124. ***Mpango wa matunzo ya Kichwa/ya kimafikiri inaotolewa mjini kwetu inatosha kwa kukujibu maitaji ndani ya jamii yetu***				
125. ***Najisikiya slama e kuishi hapa ndani ya jamii yangu***				
126. ***Ninapiga watoto wangu kwa kuwaadibisha***				
127. ***Mila zenyi kuumiza ao kutesa mutoto zinapashwa endelea juu ni mila zetu***				
128. ***Binti hapashwe enda ku masomo juu inakubaliwa na mila zetu***				

ULIZO	Nakubali	sikubali	Jibu Hakuna	Sijui
129. Mara mingi mwanamuke anabakwa juu aliistahili .				
130.Hata mwanamuke akisema hapana kwa tendo la ndoa maramingi anaitaka				
131. Ubakaji mingi ni juu wanawake wanachokoza wanaume.				
132. Mwanamuke mwenyi hataki kubakwa hanapashwa piganisha mubakaji				
133. Wasodaa tu njo wanabaka				
134. Mwnamuke anpashwa fanya tendo la ndowa na mume wake hata hawe katika yali gani				
135. Mwanamuke anaweza furahi tendo la ndoa hata kama anakazwa				
136. Mara mingi mwanamuke mwenye kubakwa ni muhanga mwenyi hana kosa.				
137. Mara mingi wanawake wanasema ubaji juu ya kukinga sifa/mafaa yake				
138. Binti Wazuri awabakiwe sana kama binti wabaya				
139. Mwanamuke mwenye aliejuwa mume hapashwi hapashwe lia juu alibakwa				
140. Wanawake wanaweza jiletea kubakwa kwa hali ao tabia zao				
141.Wanaume tu njo wanabaka . Hapana wanawake.				
142. Mwanamuke akivala nguo fupi wala zenyi kubana mwili ahastahili kubakwa.				
143. Binti akibusu sana mchumba wake ni kosa lake kama ule mchumba anamukazia tendo la ndoa				

144. *Nimekuuliza swali mingi sana. Uko na ya kuongeza?*

KWA WACHUNGUZI:

[KUULIZA SWALI HIZI KWA MUTU MWENYE KUSIRIKA SANA AO MWENYE KUGONJWA KICHWA AO MWENYE UNAOGOPEA SANA:]
Naona unateseka juu ya ujeuri walio kutendea. Pole sana. Nataka upate msaada. Nitapana jina yako ku ONG ya matunzo na mashauri inatumika hapa mjini. **[MUABIYE JINA YA ONG IKO KU LISTE YAKO]** . ***Unakubali niwapatiye jina yako kusudi wakutembeleye?***

[SOMA HII KWA KILA PARTICIPANT MWENGINE (MWENYE HANA HASIRA YA SANA AO MAGONJWA YA KICHWA:]
Kuko ONG hapa mjini wanapana msaada Fulani kusaidiya wanawake matunzo na vingine. Wa rele kominotere wa hapa wanaweza kukuongoza ukitaka kuwaona.

Hata kama hauitaji msaada sasa, unaweza kutana na mutu mwenye kuiitaji ao weye peke unaweza itaji msaada badaye. Nataka tu ujuwe kama iko hapa mjini.

[KUMALIZA: KWA KILA PARTICIPANT]

Aksanti kwa wakati ulikamata kwa kuongeya na mimi. ***Ginsi nilisema mbele, Hii uchunguzi itabaki siri na tunafanya ughunguzi huu kwa kujua vizuri namna gani kukinga afia na haki za wanawake.***

Wakati Tuko na tembeya kuuliza hizi swali tuko naambiya watu kama hii ni uchinguzi tu. Lakini hatuwaambiye nani tulisha uliza.
Tunajua kamma watu watataka kujua tuko wanani na tunafanya nini hapa.Tunaomba usiwaambiye kwa ndani nini tuliongeya. Uwaambiye tu kama ni uchunguzi juu ya afia.

Aksanti tena kwa wakati wako.

Saha uchunguzi uliisha:_____

MUCHUNGUZI, TAFAZALI, ANDIKA HAPA MENGINE UNATAKA ONGEZA:

_____

_____

_____

_____

_____

_____

_____

_____

UKIMALIZA WATU WOTE MU HII NYUMBA,

- **MBELE UTOKE: Hakikisha umeandika jibu zote na kama uliuliza swali zote na uchunguzi umeisha.**
- **Lagana utoke pale.**
- **Andika referanse gani wanaitaji.**
- **Weka kestionere vizuri.**

Annex V: Semi-Directed Qualitative Instrument

USHINDI Qualitative Key Informant Interview

Notes for the Interviewer:

- At all times you must remain non-judgmental
- Do not offer any of your own opinions
- Do not agree or disagree with statements in the discussion
- There are no right or wrong answers
- Do not put words in participants' mouths
- No names should be used
- When speaking to the respondent, we are talking about his or her experiences and opinions and what they believe is the prevailing community opinion
- Be sure to write everything down just as the person says it. Do not edit or interpret what they are saying

Introduction:

Hello and thank you very much for talking with me. We are interested in learning more about how women and men who suffered sexual violence have been able to find services in your community. In addition, we are interested in barriers that might make this care difficult. We hope that your answers to these questions will inform and help improve the programmatic interventions for survivors. You will not receive any money for being here and your participation will in no way affect your position or affect the services anyone receives in the community. We will also ask questions about what you personally thinks puts people at risk for sexual violence and what may be the reasons sexual violence happens in your community.

Everything you say here is completely confidential. We will not use your name or tell anyone you talked with us. You are free to leave at any time or skip questions. You will not be asked to share your personal information or history. Instead, we are interested in your opinions, experiences and views about the services for women who have survived sexual violence. We will be interviewing others; please do not discuss what was said here once you leave. This discussion should take about 30 minutes. Thank you again for your time. You are free not to participate or withdraw at any time during the survey without fear of any repercussions.

1. Consent to Interview: Yes No
2. Date: (MM/DD/YY)
3. Data collector name:
4. Health Zone:
5. Health Area:
6. Village:
7. Age of respondent: Years
8. Sex:
9. Education (highest level finished):
10. Ethnic Group:
11. Why do you think sexual violence happens? (Probe: rape myths, "inappropriate dress", alcohol, drugs etc…)
12. What do you think are the best ways to prevent sexual violence in your community?
13. In your opinion, who is a most risk for sexual violence?
14. Do you think the rates have increased, decreased or remained the same?
15. Are there traditional practices that you think may put people at risk for SGBV? (Probe circumcision, AIDS myths, rape myths etc…)

16. Do you think the balance of power among men and women plays a role so that women are more or less at risk (Probe: same for men). Please give examples of these imbalances
17. For young girls/boys, what are the greatest risks?
18. What do you think should happen to those who commit sexual violence?
19. How do you think traditional leaders/healers should address the problem of SGBV?
20. What do you think I should know about SGBV in your community?
21. Do you personally think that SGBV is a problem in your community?

Annex VI: List of Key Informant Interviews

Key Informant	Location
Katana Health Zone	
1. Chief, Maroc-Muhala Norbert Muhingo	Chirunga HA Maroc-Muhala Village
2. Traditional Birth Attendant	Chirunga HA Maroc-Muhala Village
3. Chief, Chishoke I	Birvava HA, Chishoke I village
4. 23 year old female community member	Birvava HA, Chishoke I village
5. 56 year old female community member; Chief's wife	Birvava HA, Chishoke I village
6. Chief Chishoke II	Birvava HA, Chishoke II village
7. Territorial Chief of Mabingu	Mabingu HA
8. 67 year old community female	Mabingu HA, Kangoko village
9. 17 year old community female	Mabingu HA, Kangoko village
10. 25 year community female	Mabingu HA, Kangoko village
11. 28 year old community male	Ihimbi HA, Kasongolere village
12.17 year old community female	Ihimbi HA, Kasongolere village
13. Sister Enjeanie	Chirunga HA, Katana Center Parish
14. Witch Doctor (female)	Kabushwa HA
Walikale Health Zone	
15. Chief, Mabanda	Sacre Coeur HA, Mabanda village
16. Chief, Boboro	Bilobilo HA, Boboro village
17. 18 year old community female	Bilobilo HA, Boboro village
18. 50 year old community female	Bilobilo HA, Boboro village
19. 21 year old community female	Bilobilo HA, Boboro village
20. Community men (12) ages 30-57 years old	Bilobilo HA, Indjiki village
21. 18 year old community male	Bilobilo HA, Indjiki village
22. 105 year old community male	Bilobilo HA, Indjiki village
23. Chief, Mubi II	Bilobilo HA, Mubi II village
25. Community men (7) ages 27-61 years old	Bilobilo HA, Mubi Kopa village
26. Chief, Osakari	Elbia HA, Osakari village
27. Community men (6) ages 35-66 years old	Elbia HA, Osakari village
28. 29 year old community woman (survivor)	Elbia HA, Osakari village
29. 72 year old community couple	Elbia HA, Osakari village
30. 28 year old community female	Elbia HA, Wenga II village
31. Chief, Shemakongolo	Elbia HA, Shemakongolo village
32. Chief, Kasima Centre (female)	Sacre Coeur HA, Kasima Centre village
Karisimbi Health Zone	
33. 18 year old community female	Murara HA, Mukosasenge Ave
34. Avenue Chief	Murara HA, Tshela Ave
35. Avenue Chief	Kasika HA, Bahizi Ave
36. 17 year old community female	Kasika HA, Bahizi Ave
37. Avenue Chief	Kasika HA, Mikundi Ave

Annex VII: Complete Data Tables[118]

Table 1. Weighted population characteristics for 578 women respondents and 322 men respondents

	Female		Male		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[d] (95% CI)**	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[d] (95% CI)**	**p-value, adjusted Wald test of association**
Mean age in years	574	35.3 (31.99 - 38.6)	322	41.5 (39.1 - 44.0)	**0.0208**
Mean time residing in current location in years	562	15.7 (13.1 - 18.3)	309	19.9 (13.5 - 26.4)	**0.0354**
Mean household size	576	7.3 (6.3 - 8.3)	322	7.2 (6.5 - 7.9)	0.2859
Mean no. of household members under 18	574	3.7 (3.0 - 4.4)	317	3.5 (2.5 - 4.6)	0.3039
Marital Status					
Married	395/576	70.3 (62.0 - 78.5)	252/319	81.1 (71.3 - 90.9)	**0.0464**
Never married	62/576	8.0 (5.6 - 10.4)	46/319	16.1 (5.0 - 27.3)	0.1083
Widowed	47/576	10.5 (3.1 - 17.8)	4/319	0.1 (0.0 - 0.1)	**<0.0001**
Divorced or separated	27/576	6.9 (0.0 - 14.6)	6/319	0.7 (0.0 - 1.7)	**0.0163**
Living with partner/unmarried	29/576	3.0 (0.0 - 6.2)	4/319	1.7 (0.0 - 4.8)	0.5517
Spouse missing	14/576	0.4 (0.0 - 0.7)	5/319	0.2 (0.0 - 0.4)	0.3005
Other	4/576	0.9 (0.0 - 2.5)	2/319	0.1 (0.0 - 0.2)	**0.0191**
Ethnic group					
Batwa	210/574	23.6 (7.0 - 40.1)	206/322	20.9 (7.2 - 34.6)	0.6325
Nande	66/574	23.5 (3.2 - 43.9)	32/322	19.5 (1.3 - 37.7)	0.2941
Lega	45/574	10.8 (4.3 - 17.4)	23/322	5.7 (2.1 - 9.3)	**0.0083**
Holoholo	89/574	10.5 (0.0 - 23.1)	66/322	21.5 (6.9 - 36.0)	0.1554
Kongo	55/574	7.9 (2.6 - 13.2)	27/322	5.8 (3.5 - 11.3)	0.6024
Balega	19/574	4.5 (0.0 - 9.9)	14/322	3.8 (0.3 - 7.2)	0.8465
Hutu	13/574	3.4 (0.3 - 6.5)	9/322	8.0 (0.0 - 19.6)	0.4197
Other[a]	77/574	15.7 (10.3 - 21.2)	45/322	14.8 (4.8 - 24.9)	0.9000
Religion					
Christian	526/564	97.3 (95.4 - 99.3)	291/316	92.1 (81.8 - 100.0)	0.0882
Muslim	27/564	2.0 (0.5 - 3.5)	17/316	4.8 (0.0 - 10.8)	0.1018
Other[b]	14/564	0.7 (0.0 - 1.4)	8/316	3.1 (0.0 - 7.7)	0.0779
Household owns land	390/572	71.0 (66.4 - 75.7)	249/317	68.2 (58.9 - 77.4)	0.4882
Occupation					
Farmer/Herder	235/576	20.5 (6.0 - 35.0)	143/317	31.5 (10.7 - 52.2)	0.1519
Housewife	57/576	16.1 (11.1 - 21.2)	11/317	2.7 (0.0 - 6.2)	**0.0152**
Small Business	125/576	28.3 (22.6 - 34.0)	21/317	5.2 (1.7 - 8.7)	**<0.0001**
Not working	81/576	18.9 (13.1 - 24.7)	27/317	10.1 (5.5 - 14.7)	0.0553
Student	15/576	2.2 (0.6 - 3.8)	16/317	8.4 (0.0 - 19.7)	**0.0180**
Other[c]	63/576	14.0 (10.0 - 18.0)	99/317	42.1 (27.4 - 56.9)	**<0.0001**
Literacy[d]	349/576	69.0 (59.1 – 78.8)	271/319	88.9 (80.7 – 97.1)	0.0969
Can add/subtract numbers	528/576	95.9 (91.7 – 100.0)	308/319	98.2 (96.2 – 100.0)	**0.0485**
Highest level of education					
Primary	190/575	25.8 (15.3 - 36.3)	80/319	20.3 (7.2 - 33.3)	0.1547
Secondary	192/575	45.6 (30.4 - 60.7)	156/319	49.7 (40.0 - 59.3)	0.6910
University	38/575	7.3 (2.4 - 12.2)	48/319	21.3 (8.1 - 34.6)	**0.0099**

[118] Data logs and the complete database are available through IMA.

None	155/575	21.4 (13.6 - 29.1)	35/319	8.8 (1.1 - 16.5)	0.1099
Received job training/completed certificate program	144/565	30.9 (26.7 – 35.1)	124/317	44.2 (33.9 – 54.6)	**0.0083**
Found training useful	90/131	69.7 (53.2 – 86.1)	86/118	88.4 (77.5 – 99.2)	0.1392

Survey results are representative of the population defined in Table 1, in July 2016. aBreakdown of "Other" ethnicity responses: Baluba (6), Luba (6), Tutsi (3), Mongo (2), Mangbetu (1), 104 respondents were of different or mixed Bantu tribes. bBreakdown of "Other" religion responses: Animist/local beliefs (4), 18 respondents indicated a different religion. cBreakdown of "Other" occupation responses: Driver (15), Professional (13), Government worker (12), Clerical (12), Security Officer (6), Retired (4), Military (1), 99 respondents performed miscellaneous work. [d]Literacy is defined as self-reported reading and writing with some or no difficulty. All statistics are weighted percentages unless otherwise noted. Denominators are the sum of the survey weights for the respondents with the characteristic; number of respondents is given in the first column (as n=XX).

Table 2. Weighted population characteristics for 216 women respondents and 104 men respondents in Karismbi Health Zone

	Female		**Male**		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[d] (95% CI)**	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[d] (95% CI)**	**p-value, adjusted Wald test of association**
Mean age in years	216	31.8 (30.2 - 33.5)	104	40.6 (38.7 - 42.5)	0.0858
Mean time residing in current location in years	213	16.2 (13.2 - 19.1)	103	22.1 (17.7 - 26.5)	0.1002
Mean household size	216	6.6 (5.9 - 7.2)	104	6.8 (5.9 - 7.6)	0.1618
Mean no. of household members under 18	216	3.3 (2.8 - 3.7)	104	2.8 (1.5 - 4.1)	0.3415
Marital Status					
Married	163/216	71.5 (52.7 - 80.4)	73/104	75.9 (60.4 - 91.4)	0.4105
Divorced or separated	7/216	9.2 (0.0 - 19.1)	3/104	0.3 (0.0 - 0.8)	**0.0070**
Never married	23/216	7.9 (5.0 - 10.8)	25/104	23.5 (7.3 - 4.0)	0.0606
Widowed	17/216	7.8 (4.6 - 10.9)	1/104	0.0 (0.0 - 0.2)	**0.0002**
Living with partner/unmarried	5/216	3.5 (0.0 - 8.3)	2/104	0.4 (0.0 - 1.1)	**0.0016**
Spouse missing	1/216	0.1 (0.0 - 4.6)	0/104	-	-
Ethnic group					
Nande	63/215	34.9 (11.8 - 58.0)	30/104	38.4 (17.2 - 59.8)	0.5456
Batwa	36/215	12.0 (0.0 - 27.1)	14/104	5.9 (0.0 - 12.1)	0.1839
Kongo	15/215	9.9 (2.9 - 16.9)	4/104	2.9 (0.0 - 7.0)	0.1047
Lega	16/215	9.6 (6.6 - 12.6)	12/104	6.8 (2.8 - 10.8)	0.3528
Balega	17/215	6.5 (0.0 - 15.0)	10/104	7.1 (0.0 - 14.8)	0.9266
Hutu	12/215	5.0 (0.1 - 9.9)	8/104	15.9 (0.0 - 32.6)	0.2646
Holoholo	5/215	0.6 (0.0 - 1.3)	6/104	11.2 (0.0 - 26.1)	**0.0003**
Other[a]	51/215	21.4 (14.1 - 28.8)	20/104	11.8 (1.3 - 22.3)	0.3121
Religion					
Christian	198/212	97.7 (95.7 -100.0)	87/101	86.6 (65.1 - 100.0)	**0.0454**
Muslim	13/212	1.9 (0.0 - 4.0)	12/101	9.1 (0.0 - 22.1)	**0.0220**
Other[b]	2/212	0.4 (0.0 - 1.1)	2/101	4.3 (0.0 - 13.4)	0.0890
Household owns land	129/214	67.5 (61.3 - 73.7)	73/104	66.4 (57.8 - 75.1)	0.7789
Occupation					
Small Business	71/216	34.6 (30.2 - 38.9)	12/104	8.6 (1.9 - 15.4)	**0.0082**
Not working	55/216	24.9 (21.2 - 28.6)	17/104	11.4 (4.9 - 17.9)	**0.0320**
Housewife	32/216	19.5 (15.1 - 23.8)	3/104	0.5 (0.0 - 1.6)	**0.0019**
Student	8/216	2.9 (0.7 - 5.0)	13/104	16.2 (0.6 - 31.7)	**0.0082**
Farmer/Herder	5/216	0.6 (0.0 - 1.9)	5/104	8.8 (0.0 - 21.6)	**0.0301**
Other[c]	45/216	17.5 (14.2 - 20.9)	54/104	54.5 (42.6 - 66.4)	**0.0003**
Highest level of education					
Primary	55/216	21.4 (10.6 - 32.1)	15/104	14.2 (0.0 - 32.2)	0.3652
Secondary	107/216	58.3 (46.7 - 69.8)	52/104	44.1 (38.1 - 50.0)	**0.0278**
University	30/216	8.8 (1.8 - 15.8)	34/104	31.1 (24.9 - 37.3)	**0.0121**
None	24/216	11.6 (6.7 - 16.4)	3/104	10.6 (0.5 - 20.7)	0.8740

Survey results are representative of the population defined in Table 1, in July 2016. [a]Breakdown of "Other" ethnicity responses: Baluba (6), Luba (6), Tutsi (3), Mongo (1), Mangbetu (1), 54 respondents were of different or mixed Bantu tribes. [b]Breakdown of "Other" religion responses: Animist/local beliefs (2), 2 respondents indicated a different religion. [c]Breakdown of "Other" occupation responses: Professional (9), Driver (9), Government worker (6), Security Officer (3), Military (1),

Retired (4), 57 respondents performed miscellaneous work. [d]All statistics are weighted percentages unless otherwise noted. Denominators are the sum of the survey weights for the respondents with the characteristic; number of respondents is given in the first column (as n=XX).

Table 3. Weighted population characteristics for 186 women respondents and 92 men respondents in Katana Health Zone

	Female		Male		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[e] (95% CI)**	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[e] (95% CI)**	**p-value, adjusted Wald test of association**
Mean age in years	*183*	*33.0 (31.7 - 34.2)*	*92*	*40.8 (31.0 - 50.7)*	*0.2090*
Mean time residing in current location in years	*179*	*19.5 (17.0 - 22.0)*	*86*	*36.2 (26.6 - 45.9)*	*0.1197*
Mean household size	*184*	*7.7 (7.5 - 7.9)*	*92*	*6.9 (6.1 - 7.6)*	*0.2873*
Mean no. of household members under 18	*182*	*3.9 (3.8 - 4.1)*	*87*	*3.6 (3.3 - 3.9)*	*0.0629*
Marital Status					
Married	*132/186*	*73.4 (66.4 - 80.4)*	*79/91*	*94.6 (90.1 - 99.1)*	***0.0202***
Never married	*19/186*	*11.8 (7.1 - 16.4)*	*5/91*	*1.3 (0.0 - 2.6)*	***0.0020***
Widowed	*12/186*	*6.0 (0.8 - 11.3)*	*2/91*	*0.1 (0.0 - 0.3)*	***0.0007***
Divorced or separated	*12/186*	*2.2 (0.5 - 4.0)*	*1/91*	*2.9 (0.0 - 8.1)*	*0.7761*
Other[a]	*11/186*	*6.5 (0.0 - 15.1)*	*4/91*	*1.1 (0.0 - 3.1)*	*0.1612*
Ethnic group					
Batwa	*170/184*	*92.8 (86.8 - 98.7)*	*84/92*	*88.9 (70.9 - 100.0)*	*0.3906*
Lega	*5/184*	*1.4 (0.0 - 3.5)*	*3/92*	*2.0 (0.0 - 4.4)*	*0.5367*
Other[b]	*9/184*	*5.8 (1.8 - 9.9)*	*5/92*	*9.1 (0.0 25.1)*	*0.4923*
Religion					
Christian	*176/185*	*96.0 (93.7 - 98.3)*	*87/91*	*95.1 (88.1 - 100.0)*	*0.7747*
Other[c]	*10/185*	*4.0 (1.7 - 6.4)*	*4/91*	*4.9 (0.0 - 11.9)*	*0.7786*
Household owns land	*130/186*	*81.3 (69.2 - 93.4)*	*75/92*	*83.9 (79.9 - 87.9)*	*0.7403*
Occupation					
Farmer/Herder	*105/185*	*48.0 (31.9 - 64.1)*	*50/89*	*44.9 (34.8 - 55.1)*	*0.6775*
Small Business	*35/185*	*24.6 (17.0 - 32.3)*	*5/89*	*4.0 (0.0 - 9.9)*	***0.0424***
Not working	*14/185*	*10.1 (2.3 - 17.9)*	*6/89*	*4.7 (0.0 - 12.4)*	*0.5455*
Housewife	*15/185*	*4.8 (0.0 - 9.7)*	*5/89*	*4.7 (0.0 - 11.1)*	*0.9675*
Other[d]	*16/185*	*12.4 (0.0 - 28.9)*	*23/89*	*41.7 (22.5 - 60.9)*	*0.0065*
Highest level of education					
Primary	*56/184*	*26.8 (9.7 - 44.0)*	*30/90*	*29.7 (23.4 - 36.0)*	*0.7063*
Secondary	*27/184*	*25.3 (2.5 - 48.1)*	*31/90*	*47.2 (13.8 - 80.6)*	*0.1420*
University	*5/184*	*1.6 (0.0 - 4.2)*	*3/90*	*3.2 (0.0 - 8.5)*	*0.6069*
None	*96/184*	*46.3 (39.7 - 52.9)*	*26/90*	*29.9 (0.0 - 44.3)*	*0.1526*

Survey results are representative of the population defined in Table 1, in June 2016. [a]Breakdown of "Other" marital status responses: Husband missing (5), Wife missing (1), Living with partner (3), 6 with miscellaneous classifications of marital status [b]Breakdown of "Other" ethnicity responses: Holoholo (1), Nande (1) and 12 respondents were of different or mixed Bantu tribes [c]Breakdown of "Other" religion responses: Muslim (2), Animist/local beliefs (1), 11 belonging to various other religions [d]Breakdown of "Other" occupation responses: Student (5), Driver (4), Government worker (1), Security Officer (1), 28 respondents performed miscellaneous work. [e]All statistics are weighted percentages unless otherwise noted. Denominators are the sum of the survey weights for the respondents with the characteristic; number of respondents is given in the first column (as n=XX).

Table 4. Weighted population characteristics for 176 women respondents and 126 men respondents in Walikale Health Zone

	Female		Male		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[d] (95% CI)**	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[d] (95% CI)**	**p-value, adjusted Wald test of association**
Mean age in years	175	41.9 (33.2 - 50.6)	126	41.0 (36.6 - 45.5)	0.1210
Mean time residing in current location in years	170	8.9 (2.4 - 15.5)	120	9.5 (6.0 - 12.9)	**0.0124**
Mean household size	176	10.0 (7.9 - 12.1)	126	7.9 (7.1 - 8.7)	**0.0400**
Mean no. of household members under 18	176	5.4 (3.1 - 7.6)	126	4.5 (3.8 - 5.3)	0.2660
Marital Status					
Married	100/176	61.8 (26.2 - 97.3)	100/124	82.4 (81.3 - 83.6)	0.2176
Widowed	18/176	26.5 (0.0 - 63.6)	1/124	0.0 (0.0 - 0.1)	**<0.0001**
Never married	20/176	4.5 (0.1 - 9.0)	16/124	12.4 (3.0 - 21.9)	**0.0111**
Living with partner/unmarried	21/176	3.7 (0.1 - 7.4)	2/124	4.6 (0.0 - 14.1)	0.8369
Divorced or separated	8/176	2.5 (0.3 - 4.6)	2/124	0.3 (0.0 - 9.5)	**0.0472**
Spouse missing	9/176	1.1 (0.0 - 2.2)	3/124	0.2 (0.1 - 0.4)	0.0963
Ethnic group					
Holoholo	83/175	61.0 (19.7 - 100.0)	60/126	47.2 (22.3 - 72.1)	0.6979
Lega	24/175	25.8 (0.0 - 6.2)	8/126	5.9 (0.0 - 14.7)	**0.0001**
Kongo	40/175	7.6 (0.0 - 21.1)	23/126	13.0 (3.7 - 22.2)	0.5343
Batwa	4/175	0.6 (0.0 - 1.8)	8/126	10.8 (5.4 - 16.3)	**0.0287**
Other[a]	24/175	4.7 (1.8 - 7.6)	27/126	23.4 (6.8 - 40.1)	**0.0470**
Religion					
Christian	152/167	97.4 (94.2 - 100.0)	117/124	98.9 (96.6 - 100.0)	0.1236
Muslim	12/167	2.3 (0.0 - 5.4)	5/124	0.8 (0.0 - 2.7)	0.1599
Other[b]	4/167	0.2 (0.0 - 0.7)	2/124	0.3 (0.0 - 1.0)	0.7909
Household owns land	131/172	75.2 (66.5 - 84.0)	101/121	63.1 (44.2 - 82.0)	0.0577
Occupation					
Farmer/Herder	125/175	75.4 (59.3 - 91.6)	88/124	60.5 (43.9 - 77.0)	0.4604
Housewife	10/175	13.9 (0.0 - 30.7)	3/124	5.1 (0.0 - 15.7)	0.5579
Small Business	19/175	6.1 (0.0 - 14.5)	4/124	0.4 (0.0 - 0.9)	**<0.0001**
Not working	12/175	2.5 (0.0 - 5.1)	4/124	10.7 (1.9 - 19.6)	0.0868
Other[c]	9/175	2.1 (1.5 - 2.7)	25/124	23.4 (8.9 - 37.9)	**0.0010**
Highest level of education					
Primary	79/175	43.2 (17.8 - 68.6)	35/125	25.1 (8.7 - 41.5)	**0.0019**
Secondary	58/175	13.3 (1.2 - 25.5)	73/125	59.0 (44.4 - 73.6)	**0.0216**
University	3/175	6.6 (0.0 - 14.8)	11/125	14.8 (0.0 - 43.7)	0.1479
None	35/175	36.9 (22.1 - 52.7)	6/125	1.1 (0.0 - 3.0)	**0.0002**

Survey results are representative of the population defined in Table 1, in July 2016. [a]Breakdown of "Other" ethnicity responses: Balega (6), Hutu (2), Mongo (1), Nande (4), 38 respondents were of different or mixed Bantu tribes. [b]Breakdown of "Other" religion responses: Bahai (3), Animist/local beliefs (1), 2 respondents indicated a different religion. [c]Breakdown of "Other" occupation responses: Government worker (5), Student (5), Professional (4), Driver (2), Security Officer (2), Clerical (2), 14 respondents performed miscellaneous work. [d]All statistics are weighted percentages unless otherwise noted. Denominators are the sum of the survey weights for the respondents with the characteristic; number of respondents is given in the first column (as n=XX).

Table 5. Weighted SGBV Means and Rates, by Gender, for 900 Respondents.

	Female		Male		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[a] (95% CI)**	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[a] (95% CI)**	**p-value, adjusted Wald test of association**
Total respondents	n= 578		n=322		
Reported SGBV[b]	242/578	31.6 (23.3 – 39.8)	123/322	32.9 (17.7 – 48.2)	0.8841
Reported IPV[c]					
Reported Lifetime Physical IPV	171/574	22.6 (17.3 – 27.9)	80/321	25.0 (8.8 – 41.3)	0.8115
Reported IPV in the Last Year	*93/573*	12.0 (3.3 – 20.8)	*38/322*	12.9 (5.4 – 20.4)	0.8810
Reported Sexual IPV	35/89	58.1 (36.9 – 79.2)	5/28	18.9 (0.0 – 52.1)	0.1316
Reported SV[d]					
Reported Lifetime SV	87/569	11.8 (7.4 – 16.2)	27/313	3.1 (0.0 – 6.3)	**0.0323**
Reported SV in the Last Year	*52/569*	5.3 (1.9 – 8.8)	*18/313*	6.1 (0.0 – 12.2)	0.8155
Reported Conflict-Related SV	28/89	12.7 (2.6 – 22.9)	18/28	68.1 (31.3 – 100.0)	**0.0087**
Perpetrated by men only	24/27	91.9 (78.8 – 100.0)	15/16	97.5 (90.9 – 100.0)	0.4722
Perpetrated by women only	3/27	8.1 (0.0 – 21.2)	0/16	-	-
Perpetrated by mixed gender group	0/27	-	1/16	2.5 (0.0 – 9.1)	-
Reported Community-based SV	62/89	87.4 (77.2 – 97.5)	10/28	31.9 (0.0 – 68.7)	**0.0086**
Perpetrated by men only[e]	58/61	94.6 (87.5 – 100.0)	5/9	81.9 (48.2 – 100.0)	0.2000
Perpetrated by women only	3/61	5.4 (0.0 – 12.4)	5/9	79.7 (37.6 – 100.0)	**0.0002**
Reported SV Type					
Rape (vaginal, object, unspecified)	52/89	48.9 (25.9 – 71.9)	4/28	1.3 (0.0 – 3.8)	**<0.0001**
Forced to Undress	21/89	25.7 (3.5 – 47.9)	9/28	64.1 (22.6 – 100.0)	0.1649
Forced Marriage	6/89	5.9 (0.0 – 12.1)	0/28	-	-
Molestation	5/89	4.2 (0.0 – 12.1)	2/28	8.6 (0.0 – 24.1)	0.5333
Forced prostitution	5/89	3.9 (0.0 – 9.8)	2/28	17.2 (0.0 – 50.5)	0.2788
Abduction	3/89	0.4 (0.0 – 1.0)	5/28	18.7 (0.0 – 51.5)	**0.0002**
Other [f]	17/89	28.4 (6.3 – 50.4)	7/28	7.3 (0.0 – 18.2)	0.1207
Characteristics of male SV perpetrators		n = 81		n = 21	
Immediate family member	35/77	64.9 (46.7 – 83.2)	3/18	26.4 (0.0 – 66.7)	0.1483
Extended family member/ community member	12/77	13.8 (0.7 – 27.0)	0/18	-	-
Non-combatant stranger	8/77	9.4 (0.0 – 19.9)	1/18	0.4 (0.0 – 1.3)	**0.0058**
Combatant	22/77	11.9 (0.7 – 23.2)	14/18	73.2 (32.6 – 100.0)	**0.0147**
Most frequent perpetrators:					
Mai-Mai	9/22	37.0 (8.7 – 65.3)	7/14	92.1 (73.9 – 100.0)	**0.0133**
Interahamwe	5/22	28.5 (0.0 – 78.9)	4/14	6.5 (0.0 – 22.8)	0.1122
FDLR[f]	2/22	15.4 (0.0 – 31.6)	2/14	0.9 (0.0 – 3.3)	**0.0387**
Characteristics of female SV perpetrators		n = 6		n = 6	
Immediate family member	1/6	1.1 (0.0 – 6.3)	4/6	77.4 (32.1 – 100.0)	**0.0003**
Extended family member/ community member	1/6	29.5 (0.0 – 89.9)	1/6	16.0 (0.0 – 54.2)	0.5491
Non-combatant stranger	1/6	50.9 (0.0 – 100.0)	0/6	-	-
Combatant	3/6	17.9 (0.0 – 40.1)	1/6	6.6 (0.0 – 23.3)	0.4887
Most frequent male perpetrators:					
FDLR	2/3	61.1 (0.0 – 100.0)	0/1	-	-
Interahamwe	0/3	-	1/1	-	-
Reported Consequences of SV					
Bleeding	32/89	27.1 (10.0 – 44.2)	2/28	3.6 (0.2 – 6.9)	0.0007
Pregnancy	18/89	16.6 (5.5 – 27.8)	1/28	4.1 (0.0 – 13.4)	0.2760
Anxiety	11/89	10.1 (1.9 – 18.4)	7/28	11.9 (0.0 – 28.5)	0.8280
Reproductive Complications	9/89	8.8 (1.4 – 16.2)	2/28	23.6 (0.0 – 60.1)	0.3445
Beaten	20/89	7.7 (1.9 – 13.5)	6/28	5.5 (0.0 – 13.1)	0.6324

Torn	8/89	5.5 (0.0 – 11.1)	0/28	-	-
Miscarriage	6/89	5.4 (0.0 – 12.0)	0/28	-	-
Bruised	11/89	4.0 (1.4 – 6.6)	8/28	54.2 (2.2 – 100.0)	**0.0050**
Others	9/89	20.0 (0.0 – 42.8)	4/28	4.7 (2.1 – 7.2)	**0.0378**

Source: Study Database. Survey results are representative of the July 2016 adult household-based population in Eastern DRC as defined in Auxiliary Table 1. [a]All statistics are weighted percentages unless otherwise noted. Denominators are the sum of the survey weights for the respondents in the subpopulation. Note that because denominators refer to the number of respondents that reported having experienced the abuse type, not the number of abuses, percentages in the table may sum to greater than 100 percent. [b]GBV=Gender Based Violence=physical IPV, sexual IPV, and conflict-related and community-based sexual violence. Conflict-related sexual violence is defined as sexual violence perpetrated by a combatant as identified by the victim. [c]IPV=Intimate Personal Violence=any violence that is physical, psychological, and/or sexual committed by a spouse/partner. [d]SV=Sexual Gender-Based Violence=the sexual violence described for GBV. [e]Of the 9 males who reported an incident of community-based sexual violence, one man reported two separate incidents – one of which was perpetuated by a male and the other by a female. . [e]Breakdown of "Other" sexual violence types: Forced to perform act with another civilian (3), Sexual slavery (1), 20 other miscellaneous acts. [f]FDLR=Democratic Forces for the Liberation of Rwanda. . [6]Breakdown of "Other" reported consequences of sexual violence: Fear of STI/AIDS (4), STD (3), Physical disability not reproductive (2), Depression (1) and 4 other acts.

Table 6. Weighted SGBV and mental health means and rates by health zone

	Karisimbi		**Katana**		**Walikale**		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[a]** (95% CI)	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[a]** (95% CI)	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[a]** (95% CI)	**p-value, adjusted Wald test of association**
Total respondents	n= 320		n=278		n=302		
Respondent violence							
SGBV (adult, All Zones)			***365/900***	**32.1 (24.7 – 39.4)**			
SGBV (adult)	*103/320*	28.7 (18.9 – 38.4)	120/278	39.1 (31.3 – 46.9)	142/302	36.1 (32.8 – 39.5)	0.1621
SGBV (child, All Zones)			***605/900***	**61.0 (51.1 – 71.0)**			
SGBV (child)	*232/320*	69.3 (56.1 – 82.6)	185/278	51.9 (26.1 – 77.8)	188/302	45.4 (31.2 – 59.7)	0.1036
Sexual Violence							
Lifetime	*26/315*	8.3 (7.5 – 9.0)	*33/265*	*8.5 (0.8 – 16.2)*	*55/302*	*9.2 (0.0 – 21.0)*	*0.9625*
Last year	*14/315*	3.7 (0.0 – 7.3)	*20/265*	*5.5 (0.6 – 10.4)*	*36/302*	*10.9 (9.1 – 12.7)*	*0.0702*
All reported SV	*49/320*	14.0 (8.2 – 19.8)	*47/278*	*14.7 (9.1 – 20.3)*	*77/302*	*19.1 (8.3 – 30.0)*	*0.5435*
Child Sexual violence	*22/320*	7.7 (4.7 – 10.7)	*35/278*	*10.5 (3.8 – 17.2)*	*46/302*	*20.5 (18.0 – 23.0)*	***0.0013***
Fear sexual violence from armed groups	*301/319*	92.9 (87.8 – 98.1)	*259/277*	*88.3 (80.2 – 96.4)*	*302/302*	*100.0 (100.0 – 100.0)*	*0.1971*
Fear sexual violence from community members	*207/320*	56.2 (23.9 – 88.6)	*241/277*	*73.8 (65.8 – 81.7)*	*277/302*	*98.3 (95.8 – 100.0)*	***0.0056***
Interpersonal Violence							
Lifetime	*64/319*	19.3 (15.6 – 22.9)	*88/277*	*30.4 (26.6 – 34.2)*	*99/299*	*29.9 (22.9 – 37.0)*	***0.0029***
Last year	*33/319*	9.8 (0.9 – 18.7)	*50/275*	*18.1 (10.6 – 25.6)*	*48/298*	*15.0 (11.4 – 18.6)*	*0.3092*
All reported IPV	*75/320*	22.9 (16.7 – 29.0)	*98/278*	*32.6 (26.5 – 38.7)*	*110/302*	*30.7 (23.1 – 38.3)*	*0.0826*
Household reported Self Trafficking (All Zones)			***128/900***	***11.9 (8.0 – 15.7)***			
Household reported Self Trafficking	*36/320*	11.1 (6.5 – 15.8)	*44/278*	*13.0 (9.0 – 16.9)*	*48/302*	*16.2 (8.9 – 23.5)*	*0.4518*
Forced to work in bar/bistro	*9/36*	50.1 (19.4 – 80.9)	*4/44*	*16.5 (0.0 – 36.7)*	*2/47*	*0.4 (0.0 – 1.3)*	***0.0038***
Forced indebtedness	*16/36*	30.7 (10.3 – 51.1)	*14/44*	*38.1 (9.0 – 67.3)*	*28/48*	*53.2 (31.5 – 75.0)*	*0.2809*
Forced domestic help	*10/36*	19.6 (3.9 – 35.3)	*7/44*	*35.3 (0.0 – 71.7)*	*0/48*	-	-
Forced marriage	*7/36*	18.8 (0.0 – 40.3)	*4/44*	*12.5 (0.0 – 27.6)*	*6/47*	*14.6 (1.5 – 27.7)*	*0.8149*
Forced pimping	*3/36*	14.7 (0.0 – 41.5)	*2/44*	*2.1 (0.0 – 5.5)*	*1/48*	*0.5 (0.0 – 1.5)*	*0.1181*
Held against will	*5/36*	10.9 (0.0 – 22.7)	*19/44*	*48.3 (22.4 – 74.1)*	*9/46*	*25.4 (6.3 – 44.6)*	***0.0051***
Forced to work in a field	*4/36*	7.9 (1.9 – 14.0)	*8/44*	*8.9 (0.4 – 17.4)*	*4/47*	*5.3 (0.0 – 12.2)*	*0.6199*
Survival sex	*7/36*		*6/44*	*4.6 (0.0 – 11.5)*	*4/47*	*1.4 (0.0 – 3.4)*	*0.1134*
Forced to work in a mine	*0/36*	-	*1/44*	*8.2 (0.0 – 21.8)*	*8/47*	*23.2 (0.0 – 52.4)*	*0.3386*

Forced to carry goods from mine	*0/36*	-	*7/44*	*44.1 (19.6 – 68.7)*	*9/47*	*23.7 (13.7 – 33.7)*	*0.0675*
Forced to be sexual servant	*4/36*	15.6 (0.0 – 34.0)	*4/44*	*8.4 (0.0 – 1.7)*	*0/48*	-	-
Forced to work in sex business	*4/36*	6.3 (1.5 – 11.2)	*0/44*	-	*2/47*	*3.4 (0.0 – 8.9)*	*0.1786*
Household reported Child Trafficking (All Zones)			***47/900***	***5.2 (3.6 – 6.7)***			
Household reported Child Trafficking	*23/320*	5.8 (3.7 – 7.8)	*15/278*	*2.8 (1.0 – 4.7)*	*9/302*	*5.2 (2.0 – 8.3)*	*0.1210*
All reported Trafficking							
Forced to work in bar/bistro	*11/23*	48.9 (13.7 – 84.2)	*1/15*	*3.4 (0.0 – 9.7)*	*1/9*	*0.1 (0.0 – 0.1)*	***0.0001***
Forced domestic help	*12/23*	33.8 (26.0 – 41.6)	*4/15*	*65.2 (33.0 – 97.4)*	*0/9*	-	**-**
Forced pimping	*5/23*	12.2 (0.0 – 30.1)	*1/15*	*5.5 (0.0 – 15.6)*	*1/9*	*1.7 (0.0 – 4.9)*	***0.0245***
Held against will	*1/23*	11.3 (0.0 – 28.2)	*7/15*	*31.5 (0.0 – 78.0)*	*3/9*	*43.7 (2.9 – 84.5)*	***0.0089***
Forced to work in a field	*2/23*	8.2 (0.0 – 18.6)	*3/15*	*18.3 (0.0 – 39.9)*	*0/9*	-	**-**
Forced indebtedness	*3/23*	4.3 (0.0 – 12.4)	*3/15*	*24.9 (0.0 – 60.4)*	*4/9*	*54.4 (0.0 – 100.0)*	*0.5861*
Forced marriage	*2/23*	1.7 (0.0 – 4.6)	*2/15*	*8.6 (0.0 – 20.8)*	*0/9*	-	**-**
Forced to be sexual servant	*1/23*	0.1 (0.0 – 0.5)	*3/15*	*9.7 (0.0 – 21.6)*	*0/9*	-	-
Forced to work in a mine	*0/23*	-	*1/14*	*33.0 (0.0 – 85.6)*	*2/9*	*27.1 (0.0 – 79.1)*	**-**
Forced to carry goods from mine	*0/23*	-	*2/15*	*16.2 (0.0 – 47.6)*	*3/9*	*4.1 (0.0 – 8.9)*	**-**
Forced to work in sex business	*0/23*	-	*1/15*	*5.5 (0.0 – 15.6)*	*2/9*	*41.6 (0.0 – 100.0)*	-
Survival sex	*0/23*	-	*3/15*	*1.9 (0.0 – 4.8)*	*1/9*	*1.7 (0.0 – 4.9)*	-
Respondent Mental Health							
Depression/Anxiety	*35/320*	17.8 (9.5 – 26.1)	*72/278*	*15.9 (7.5 – 24.3)*	*119/302*	*58.6 (36.1 – 81.1)*	***0.0009***
PTSD	*40/320*	14.1 (6.4 – 21.9)	*67/278*	*16.1 (9.6 – 22.7)*	*108/302*	*49.9 (28.4 – 71.4)*	***0.0015***
Suicidal Ideation	73/319	23.9 (6.5 – 41.2)	*68/274*	*21.6 (13.6 – 29.5)*	*108/295*	*40.7 (35.6 – 45.8)*	*0.1661*
Suicide attempt	*37/313*	17.4 (10.9 – 23.9)	*62/276*	*23.9 (14.1 – 33.7)*	*48/300*	*11.7 (4.7 – 18.7)*	*0.2503*
Household Suicide attempt	*11/312*	1.6 (1.1 – 2.0)	*17/253*	*4.8 (0.1 – 9.4)*	*27/299*	*1.8 (0.0 – 4.0)*	*0.1323*
Substance abuse	*98/320*	33.2 (29.3 – 37.0)	*78/277*	*23.1 (11.6 – 34.5)*	*66/302*	*16.9 (8.8 – 25.0)*	***0.0201***

Survey results are representative of the population defined in Table 1, in July 2016.[a]All statistics are weighted percentages unless otherwise noted. Denominators are the sum of the survey weights for the respondents with the characteristic; number of respondents is given in the first column (as n=XX).

Table 7. Weighted trafficking means and rates, by gender, for 900 respondents.

	Female		**Male**		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[a]** (95% CI)	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted %[a]** (95% CI)	**p-value, adjusted Wald test of association**
Total respondents	n=578		n=322		
Self-Reported Trafficking[a]	86/578	12.9 (10.0 – 15.9)	42/322	7.2 (1.2 – 13.2)	0.1411
Reported Types					
Forced to work in bar/bistro	12/85	46.3 (19.2 – 73.3)	3/42	21.3 (0.0 – 46.0)	0.2197
Forced indebtedness	*44/86*	41.9 (17.5 – 66.2)	*17/42*	22.3 (6.5 – 38.0)	0.2017
Survival sex	*15/86*	15.5 (7.8 – 23.2)	*1/41*	6.3 (0.0 – 17.0)	0.3211
Forced marriage	*16/85*	14.9 (0.0 – 34.9)	*1/42*	9.1 (0.0 -24.4)	0.6576
Forced to be sexual servant	*7/86*	13.7 (0.0 – 30.2)	*3/42*	13.6 (2.3 – 24.9)	0.9868
Forced domestic help	*9/86*	12.9 (0.0 – 27.8)	*4/42*	21.7 (4.3 – 39.1)	0.4683
Forced pimping	*5/86*	8.4 (0.0 – 23.4)	*1/42*	6.0 (0.0 – 18.6)	0.4576
Forced to work in a field	*11/85*	5.8 (0.5 – 11.1)	*3/42*	10.2 (0.0 – 21.0)	0.4393
Forced to work in sex business	*5/85*	4.6 (0.6 – 8.6)	*2/42*	6.8 (0.0 – 17.3)	0.6869
Held against will	*13/85*	3.3 (0.0 – 7.0)	*17/42*	44.0 (27.8 – 60.2)	**0.0002**
Rebel Groups	*2/6*	34.8 (5.1 – 64.4)	*2/4*	80.9 (36.7 – 100.0)	0.2481
Other	*4/6*	65.2 (35.6 – 94.9)	*2/4*	19.1 (0.0 – 63.3)	0.2481
Forced to carry goods from mine	*6/85*	2.9 (0.0 – 5.9)	*8/42*	28.6 (6.1 – 51.0)	**0.0007**
Forced to work in a mine	*4/85*	0.5 (0.0 – 1.0)	*4/42*	14.4 (0.0 – 30.3)	**<0.0001**

Recruitment Technique Used					
Personal security threatened	21/65	20.4 (0.0 – 42.9)	15/33	38.1 (16.3 – 60.0)	0.3245
Wanted to enlist	10/65	17.7 (8.8 – 26.5)	3/33	18.7 (0.0 – 44.5)	0.9448
Family gave me to them	9/65	17.3 (7.9 – 26.7)	2/33	3.5 (0.0 – 9.9)	0.0752
Abducted kidnapped	15/65	15.6 (0.0 – 33.6)	13/33	41.3 (21.9 – 60.6)	0.1315
Promised money/drugs/incentive	10/65	13.8 (0.5 – 27.1)	2/33	8.1 (0.0 – 20.2)	0.5842
Family threatened with violence	11/65	11.9 (0.0 – 29.3)	2/33	2.0 (0.0 – 5.1)	0.0818
Needed work/safety/shelter/food	6/65	8.4 (0.0 – 17.6)	2/33	2.2 (0.0 – 3.4)	**0.0349**
Friends pressured	3/65	3.3 (0.0 – 8.2)	1/33	7.5 (0.0 – 23.4)	0.5696
A woman in the village suggested it	2/65	0.4 (0.0 – 0.9)	2/33	8.5 (0.0 – 2.6)	**0.0003**
Other	11/65	28.4 (2.3 – 54.5)	2/33	8.2 (0.0 – 22.2)	0.1967
Main reason for staying					
Personally threatened	13/52	36.9 (14.0 – 59.8)	9/29	36.7 (6.3 -67.4)	0.4055
Starving and needed food	7/52	18.0 (7.9 – 28.0)	1/29	9.0 (0.0 – 24.6)	0.4494
Homeless and needed shelter	3/52	7.6 (0.0 – 22.0)	0/29	-	-
I had too much debt	2/52	6.4 (0.2 – 12.7)	1/29	3.1 (0.0 – 9.8)	0.5256
Promised money/drugs/incentives	4/52	5.5 (0.0 – 14.1)	2/29	15.3 (0.0 – 32.2)	0.3002
Family threatened	3/52	4.1 (0.0 – 11.9)	1/29	0.7 (0.0 – 2.2)	0.2340
In unfamiliar environment	3/52	3.0 (0.0 – 8.7)	5/29	14.1 (0.5 – 27.6)	0.1262
Family were there	3/52	0.3 (0.0 – 0.6)	1/29	1.7 (0.0 – 5.3)	0.1242
Stayed less than 2 weeks	1/52	0.3 (0.0 – 0.8)	1/29	1.0 (0.0 – 3.0)	0.3446
Friends were there	2/52	0.2 (0.0 – 0.5)	1/29	0.6 (0.0 – 1.8)	0.5042
The "queen" insisted/forced	0/52	-	1/29	3.7 (0.0 – 10.8)	0.1414
Other	11/52	17.7 (0.8 – 34.6)	6/29	14.1 (0.0 – 29.3)	0.7478
Incentives offered to stay					
Money	24/65	42.0 (29.2 – 54.8)	8/32	48.8 (10.6 – 86.9)	0.7362
Food	16/65	37.4 (21.4 – 53.4)	4/32	19.6 (0.0 – 45.2)	0.2395
Personal safety	16/65	15.7 (0.0 – 32.1)	23/32	26.8 (7.4 – 46.3)	0.3866
Shelter	5/65	7.8 (0.0 – 18.3)	2/32	8.1 (0.0 – 20.1)	0.9822
Drugs	5/65	7.6 (0.0 – 19.1)	1/32	7.5 (0.0 – 23.5)	0.9930
Family/Safety of	4/65	6.3 (0.0 – 17.7)	2/32	1.1 (0.0 – 3.4)	0.2325
Safety for my baby	3/65	4.3 (0.0 – 9.9)	0/32	-	-
Friends/Safety of	0/65	-	1/32	6.2 (0.0 – 1.9)	0.1745
I wanted to stay	0/65	-	0/32	-	-
None	20/65	27.2 (4.2 – 50.2)	11/32	23.5 (1.1 – 45.8)	0.8393
Other	5/65	8.1 (2.6 – 13.6)	1/32	2.6 (0.0 – 8.0)	0.2663
Household Reported Child Trafficking	33/578	4.5 (3.4 – 5.5)	14/322	5.7 (0.0 – 12.1)	0.7108
Reported Types					
Forced domestic help	*10/33*	41.3 (22.2 – 60.4)	*5/14*	22.9 (2.1 – 43.7)	0.3380
Forced to work in bar/bistro	8/33	25.8 (0.0 – 54.1)	4/14	71.7 (43.0 – 100.0)	0.0960
Held against will	*5/33*	20.7 (0.0 – 43.6)	*2/14*	2.0 (0.0 – 4.9)	**0.0149**
Rebel Groups	*1/1*	-	*1/1*	-	**-**
Forced to work in a field	*4/33*	8.3 (0.0 – 20.5)	*0/14*	-	-
Forced to work in sex business	*2/33*	5.3 (0.0 – 16.0)	*0/14*	-	-
Forced indebtedness	*2/33*	3.9 (0.0 – 10.5)	*1/14*	0.6 (0.0 – 1.9)	0.1772
Forced to work in a mine	*2/33*	3.5 (0.0 – 10.5)	*0/14*	-	-
Forced marriage	*2/33*	2.4 (0.0 – 6.0)	*2/14*	7.0 (0.0 – 21.8)	0.4563
Forced to carry goods from mine	*3/33*	0.4 (0.0 – 1.0)	*1/14*	0.5 (0.0 – 1.6)	0.9170
Survival sex	*3/33*	0.4 (0.0 – 0.9)	*0/14*	-	-
Forced to be sexual servant	*1/33*	0.2 (0.0 – 0.7)	*2/14*	1.3 (0.0 – 3.5)	0.1510
Recruitment Technique Used					
Wanted to enlist	6/27	31.5 (12.0 – 51.1)	1/11	4.6 (0.5 – 8.7)	**0.0065**
Needed work/safety/shelter/food	3/27	25.0 (3.5 – 46.6)	0/11	-	-
Promised money/drugs/incentive	7/27	21.1 (0.0 – 44.5)	0/11	-	-

Abducted kidnapped	9/27	15.0 (0.0 – 32.1)	3/11	55.7 (12.6 – 98.8)	0.0267
Family gave me to them	1/27	1.1 (0.0 – 3.3)	3/11	24.0 (0.0 – 60.2)	**00076**
Family threatened with violence	5/27	11.4 (0.0 – 25.1)	2/11	23.6 (0.0 – 82.5)	0.6403
Friends pressured	4/27	9.3 (0.0 – 27.2)	0/11	-	-
Personal security threatened	3/27	8.4 (0.0 – 20.8)	4/11	15.8 (4.8 – 26.8)	0.4755
Other	3/27	22.6 (0.0 – 47.2)	0/11	-	-
Main reason for staying					
Family were there	3/23	26.9 (1.9 – 51.8)	1/11	16.8 (0.0 – 58.8)	0.5637
Stayed less than 2 weeks	1/23	20.1 (0.0 – 47.5)	0/11	-	-
Family threatened	3/23	15.3 (0.0 – 42.6)	1/11	7.8 (0.8 – 14.7)	0.4872
I had too much debt	2/23	14.1 (0.0 – 36.4)	1/11	51.7 (5.3 – 98.1)	**0.0009**
Personally threatened	3/23	5.0 (0.0 – 13.3)	3/11	10.1 (0.0 – 30.6)	0.6070
Friends were there	1/23	4.8 (0.0 – 15.1)	0/11	-	-
In unfamiliar environment	2/23	3.9 (0.0 – 11.0)	1/11	1.1 (0.0 – 3.6)	0.3869
Starving and needed food	3/23	3.6 (0.0 – 8.7)	0/11	-	-
Promised money/drugs/incentives	4/23	2.2 (0.0 – 5.4)	1/11	4.6 (0.5 – 8.7)	0.3234
Afraid of stigma after going home	0/23	-	1/11	6.8 (0.7 – 12.9)	-
Other	1/23	4.3 (0.0 – 13.2)	2/11	1.2 (0.0 – 2.7)	0.4052
Incentives offered to stay					
Money	14/27	51.2 (7.2 – 95.2)	7/10	91.9 (75.5 – 100.0)	**0.0076**
I wanted to stay	2/27	21.0 (0.0 – 43.4)	0/10	-	-
Drugs	2/27	10.7 (0.0 – 25.0)	0/10	-	-
Shelter	2/27	10.6 (0.0 – 25.8)	0/10	-	-
Food	3/27	10.3 (0.0 – 28.6)	2/10	19.9 (0.0 – 60.5)	0.6676
Personal safety	4/27	6.4 (0.1 – 12.6)	2/10	23.8 (0.0 – 77.3)	0.3901
Safety for my baby	3/27	6.3 (0.0 – 14.9)	0/10	-	-
Family/Safety of	2/27	1.7 (0.0 – 5.0)	1/10	6.8 (0.0 – 22.2)	0.3927
Friends/Safety of	1/27	0.2 (0.0 – 0.7)	0/10	-	-
None	8/27	27.3 (3.9 – 50.7)	2/10	1.3 (0.0 – 3.9)	**0.0015**
Other	1/27	0.1 (0.0 – 0.3)	0/10	-	**-**

[a]Could list more than one

Table 8. Weighted Mental Health Prevalences for 900 Respondents.

Characteristic (n=respondents with characteristic)	**Respondents with characteristic in first column**	**Weighted % substance abuse** (95% CI)	**Weighted % MDD** (95% CI)	**Weighted % PTSD** (95% CI)	**Weighted % suicide ideation** (95% CI)	**Weighted % suicide attempt** (95% CI)
Total response		n=242	n= 226	n= 215	n= 249	n= 147
Adults	900	27.8 (21.4 – 34.2)	26.8 (14.3 – 39.2)	22.6 (10.3 – 34.9)	27.4 (15.2 – 39.5)	15.2 (9.5 – 20.9)
Female	578	21.1 (16.3 – 26.1)	31.0 (19.7 – 42.3)	26.6 (13.7 – 39.6)	29.3 (16.3 – 42.3)	19.6 (12.9 – 26.3)
Male	322	38.9 (25.8 – 51.9)	19.7 (0.0 – 39.9)	15.9 (7.2 – 31.2)	24.1 (8.4 – 39.7)	7.9 (2.2 – 13.7)
p-value, adjusted Wald test of association		**0.0003**	0.2662	0.1237	0.4859	**0.0205**
SGBV Reported	365	29.0 (19.1 – 38.8)	42.6 (29.8 – 55.4)	40.7 (30.5 – 50.8)	49.6 (33.6 – 65.5)	39.4 (21.4 – 57.3)
No SGBV Reported	535	27.3 (20.6 – 33.9)	19.3 (5.0 – 33.6)	14.1(0.0 – 30.6)	17.0 (8.6 – 25.3)	3.8 (0.3 – 7.3)
p-value, adjusted Wald test of association		0.7225	**0.0167**	0.0710	**<0.0001**	**0.0002**
SV Reported	173	33.8 (19.4 – 48.1)	62.3 (45.3 – 79.4)	65.2 (52.0 – 78.5)	66.3 (54.4 – 78.3)	45.8 (25.3 – 66.3)
No SV Reported	727	26.7 (20.8 – 32.6)	20.4 (6.5 – 34.2)	14.9 (1.3 – 28.6)	20.3 (8.6 – 31.9)	9.6 (6.2 – 13.1)
p-value, adjusted Wald test of association		0.2355	**0.0010**	**0.0006**	**<0.0001**	**<0.0001**
IPV Reported	283	26.2 (13.9 – 38.4)	43.8 (32.1 – 55.5)	42.7 (33.2 – 52.3)	49.9 (35.5 – 64.2)	38.6 (19.6 – 57.6)
No IPV Reported	617	28.4 (21.7 – 35.1)	20.7 (7.6 – 33.8)	15.4 (0.0 – 31.1)	19.4 (9.2 – 29.6)	6.9 (1.8 – 12.0)
p-value, adjusted Wald test of association		0.7505	**0.0025**	0.0520	**<0.0001**	**0.0013**
Trafficking Reported	219	29.8 (14.8 – 44.8)	27.6 (13.99 –41.3)	30.4 (17.8 – 43.0)	35.2 (14.0 – 56.5)	31.7 (13.9 – 49.4)
No trafficking Reported	681	27.3 (17.4 – 37.3)	26.6 (12.0 – 41.1)	20.7 (6.8 – 34.7)	25.5 (14.4 – 36.6)	11.2 (5.9 – 16.5)
p-value, adjusted Wald test of association		0.8365	0.9131	0.2422	0.2215	**0.0272**

Source: Study Database. Survey results are representative of the adult household-based population in the health zones of Karisimbi, Walikale and Katan as defined in methods, in June – July 2016. Denominators are the sum of the survey weights for the respondents with the characteristic. Number of respondents is given in the first column (as n=XX).

Table 9. Weighted health means and rates for 900 respondents.

	Female		**Male**		
Characteristic	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted % (95% CI)**	**Respondents With Characteristic/ Total Respondents to Question**	**Weighted % (95% CI)**	**p-value, adjusted Wald test of association**
Total respondents	n=578		n=322		
Respondent Health					
Substance use					
Never used drugs or alcohol	*374/559*	66.0 (59.4 – 72.5)	161/319	52.8 (36.0 – 69.6)	0.0656
Current substance abuser	116/577	21.2 (16.3 – 26.1)	126/322	38.9 (25.8 – 51.9)	**0.0003**
Intake increased in the last year	13/559	1.0 (0.1 – 1.8)	13/319	2.7 (0.0 – 5.4)	0.2106
Intake stable in the last year	49/559	11.0 (8.0 – 14.1)	44/319	17.7 (10.3 – 25.1)	**0.0078**
Intake decreased in the last year	59/559	10.5 (6.7 – 14.2)	71/319	17.0 (9.4 – 24.7)	**0.0427**
Mental Health (Self-reported)					
Mental health counseling received	78/539	11.7 (7.4 – 15.9)	51/313	11.9 (6.0 – 17.8)	0.9582
Feeling ashamed	*87/578*	10.5 (1.7 – 19.3)	*42/322*	9.6 (4.0 – 15.2)	0.8053
Concerns about confidentiality	*49/578*	7.6 (0.0 – 15.2)	*28/322*	6.1 (1.3 – 11.0)	0.5685
Do not believe this would help	*47/578*	4.4 (0.6 – 8.3)	*36/322*	5.8 (0.3 – 11.4)	0.4668
Fear of stigma	*31/578*	2.3 (0.1 – 4.4)	*12/322*	1.0 (0.1 – 1.9)	0.1464
Access to a program or facility	*8/578*	1.9 (0.0 – 4.4)	*7/322*	3.9 (0.0 – 9.4)	0.4807
Interfere with responsibilities at home	*17/578*	0.5 (0.1 – 1.0)	*12/322*	0.5 (0.0 – 1.0)	0.7594
Fear of family non-acceptance	*10/578*	0.4 (0.0 – 0.9)	*6/322*	0.1 (0.0 – 0.3)	0.2277
Nothing	*296/578*	59.8 (50.4 – 69.2)	*160/322*	50.1 (30.8 – 69.3)	0.4713
Other	*158/578*	25.6 (20.0 – 31.3)	*91/322*	33.8 (8.4 – 59.2)	0.4549
Reported Household Suicide	15/563	2.3 (0.0 – 4.5)	9/312	1.8 (0.2 – 3.3)	0.7502
Reported Household Suicide Attempt	33/557	1.5 (0.2 – 2.8)	22/307	3.0 (0.9 – 5.1)	0.2660

Reproductive Health					
Mean # of pregnancies	519	4.8 (3.6 – 6.0)	NA	NA	NA
Mean # of miscarriages	511	0.8 (0.6 – 0.9)	NA	NA	NA
Mean # of live births	524	3.9 (2.8 – 5.0)	NA	NA	NA
Mean # pregnancies resulting from violence[a]	518	0.01 (0.01– 0.02)	NA	NA	NA
Mean # miscarriages resulting from violence[b]	522	0.1 (0.0 – 0.2)			
Self-reported medical services used					
Clinic	417/578	68.5 (58.6 – 78.5)	231/322	72.0 (54.4 – 89.5)	0.7178
Pharmacy	162/578	36.6 (27.3 – 45.8)	106/322	38.6 (15.2 – 62.1)	0.8282
Hospital	182/578	35.2 (28.2 – 42.1)	90/322	27.2 (18.2 – 36.1)	**0.0363**
Traditional healer/witch doctor	113/578	14.4 (9.8 – 9.0)	74/322	21.8 (5.8 – 37.8)	0.2686
Midwives	7/578	0.2 (0.0 – 0.6)	1/322	0.1 (0.0 – 0.3)	0.5293
Feeding Center	2/578	0.2 (0.0 – 0.7)	1/322	0.0 (0.0 – 0.1)	**0.0286**
Community health worker	3/578	0.0 (0.0 – 0.1)	2/322	0.1 (0.0 – 0.4)	0.0576
None	22/578	5.1 (1.8 – 8.4)	14/322	1.9 (0.5 – 3.4)	**0.0332**
Other	11/578	1.2 (0.4 – 1.9)	12/322	2.4 (0.0 – 5.6)	0.4382
Main reason services were not used					
No money to pay for services	512/565	90.8 (86.5 – 95.0)	274/311	86.2 (80.8 – 91.6)	0.2347
Did not know to get services	5/565	0.6 (0.0 – 1.6)	6/311	4.0 (0.0 – 10.3)	0.0697
No transportation	7/565	0.5 (0.0 – 1.1)	2/311	0.4 (0.0 – 1.2)	0.9153
Too far away	2/565	0.0 (0.0 – 0.1)	4/311	0.3 (0.0 – 0.9)	**0.0064**
Not available	5/565	2.7 (0.4 – 2.9)	1/311	0.1 (0.0 – 0.2)	**0.0010**
Other	34/565	6.4 (1.1 – 11.7)	24/311	8.9 (1.8 - 16.1)	0.6814
How far of a walk to nearest medical services					
Less than 1 hour	386/573	71.6 (60.9 – 82.3)	224/321	75.0 (66.2 – 83.8)	0.6327
1 – 2 hours	144/573	21.5 (8.0 – 35.0)	73/321	16.9 (5.8 – 28.0)	0.4726
2 – 4 hours	17/573	0.8 (0.0 – 1.6)	13/321	1.1 (0.0 – 2.2)	0.2355
More than 4 hours	4/573	0.2 (0.0 – 0.4)	1/321	0.0 (0.0 – 0.1)	**0.0289**
Don't know	22/573	5.9 (1.0 – 10.9)	10/321	6.9 (0.0 – 14.1)	0.6422
Access to transportation for medical services					
Yes	158/575	21.6 (14.7 – 28.5)	95/321	20.3 (10.9 – 29.9)	0.7891
Yes but can't afford it	105/575	18.2 (10.8 – 25.5)	83/321	25.4 (14.9 – 35.9)	0.2388
No	306/575	59.9 (54.2 – 65.7)	136/321	48.2 (35.9 – 60.5)	**0.0327**
Don't know	6/575	0.3 (0.0 – 0.7)	7/321	6.0 (0.0 – 13.5)	**0.0027**
Self-reported most needed services					
Education (Primary/Secondary	264/578	54.0 (49.1 – 58.9)	146/322	43.7 (32.8 – 54.5)	0.1106
Medical Care	340/578	53.8 (47.8 – 59.7)	195/322	68.0 (54.4 – 81.6)	0.0642
Rehabilitation Centers	325/578	49.3 (40.2 – 58.3)	182/322	64.6 (49.2 – 80.0)	**0.0100**
Support Groups	211/578	38.0 (31.4 – 44.6)	123/322	24.8 (17.1 – 32.4)	**0.0444**
Vocational/Skills Training	244/578	30.6 (23.5 – 37.8)	149/322	43.8 (35.8 – 51.7)	**0.0283**
Mental Health Counseling	152/578	19.2 (8.0 – 30.4)	75/322	17.6 (9.0 – 26.2)	0.7030
Religious counseling/support	133/578	17.7 (11.4 – 23.9)	64/322	11.5 (2.8 – 20.2)	0.3179
Income generation projects	56/578	9.8 (4.0 – 15.6)	33/322	7.4 (1.6 – 13.3)	*0.6248*
Nothing would be helpful	7/578	0.5 (0.0 – 1.0)	4/322	0.2 (0.0 – 0.7)	0.3959

Source: Study Database. Survey results are representative of the adult household-based population in Eastern DRC, defined in Auxiliary Table 1, in July 2016. [a]Represents number of miscarriages resulting from violence for the total population, not just survivors of sexual violence. [b]Represents number of pregnancies resulting from violence for the total population, not just sexual violence survivors. Denominators are the sum of the survey weights for the respondents in the subpopulation.

Table 10. Percentages for Agreement on Rights, Gender Roles, Justice and Cultural Practices for 900 Respondents			
	Female	**Male**	
Statement	**Weighted %**	**Weighted %**	**p-value, adjusted Wald test of association**
	n = 578	n = 322	
Traditional practices that may hurt or harm a child must continue because it is our way	11.7	10.1	0.8193
It is OK NOT to send girls to school since that is tradition in our village	15.8	9.5	0.1704
Anyone who sexually abuses another should be punished by the community not the courts	25.1	27.1	0.6956
The mental health programs offered in my area are sufficient to meet the needs of my community	30.9	38	0.2579
A man has the right to beat his wife if she disobeys him	36.5	28.7	0.0158
It's a wife's obligation to have sex with her husband even if she doesn't want to	43.5	31.4	0.0018
Under the current system, justice is attainable.	46.8	51.3	0.5531
I use beatings as a form of discipline for my children	61.6	49.8	0.2531
The current justice system only helps those who have money to pay for justice	64.9	59.7	0.2905
A good wife obeys her husband even if she disagrees	68.1	57.9	0.1690
More should be done to protect women and girls from having sex when they don't want to	68.8	60.9	0.3101
My community will accept survivors of sexual violence back into the community	70.3	81.2	0.0032
I feel safe living in my community	76.6	85.3	0.1206
Women and girls need more education about their rights to refuse sex	78	72.2	0.2361
Anyone who sexually abuses another should be punished by the courts not the community	80.1	82.1	0.7464
There should be legal protections for women and girls	93	86.9	0.1592

Table 11. Weighted Percentages on Agreement with Rape Myths for 900 Respondents			
	Female	**Male**	
Statement	**Weighted %**	**Weighted %**	**p-value, adjusted Wald test of association**
	n = 578	n = 322	
Only soldiers can rape	3.7	8.6	0.1442
In most cases when a woman is raped, she deserved it	6.1	6.6	0.8648
A woman can enjoy sex even when it is forced upon her	17.1	24.2	0.2183
A spouse owes the other partner sex no matter what the circumstance	20.7	18.7	0.8150
Most rapes happen because women entice men	25.3	40.9	0.1335
Women who have had prior sexual relationships should not complain about rape	26.3	29.6	0.5335
Men, not women, are responsible for rape	29.7	15.9	0.1040
Women often claim rape to protect their reputations	35.1	37.9	0.5162
Women who say no to sexual intercourse often mean yes	37.3	35.3	0.7559
"Good" girls are less likely to be raped as "bad" girls	46.9	29.4	0.0028
A raped woman is usually an innocent victim	53.9	51	0.5953
Women can provoke rape by their appearance or behavior	62.2	73.7	0.1268
Women who wear short skirts or tight shirts are inviting rape	68.3	61.7	0.2002
If a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her	72.2	70.2	0.5264
If a woman really didn't want to be raped she could fight off the attacker	79.1	74	0.3972

Table 12. Percentages for Agreement on Rights, Gender Roles, Justice and Cultural Practices by Health Zones

	Karisimbi	Walikale	Katana	
Statement	Weighted %	Weighted %	Weighted %	p-value, adjusted Wald test of association
	n = 322	n = 302	n = 278	
Traditional practices that may hurt or harm a child must continue because it is our way	12.2	5.4	15	0.2175
The mental health programs offered in my area are sufficient to meet the needs of my community	34.2	40.4	21.2	0.3821
It is OK NOT to send girls to school since that is tradition in our village	14.1	3.5	25.1	0.0375
Anyone who sexually abuses another should be punished by the community not the courts	28.2	16	30.4	0.0163
A man has the right to beat his wife if she disobeys him	27	42.9	44.8	0.2467
Under the current system, justice is attainable.	46.8	55.5	44.8	0.5198
I use beatings as a form of discipline for my children	69.1	29.6	51.2	0.0211
It's a wife's obligation to have sex with her husband even if she doesn't want to	43.1	15.8	55.8	<0.0001
A good wife obeys her husband even if she disagrees	61.4	64.4	75	0.2697
My community will accept survivors of sexual violence back into the community	69.9	85.6	75.4	0.3199
The current justice system only helps those who have money to pay for justice	60.7	58.1	77.7	0.2399
I feel safe living in my community	76.2	90.9	77.9	0.1251
Anyone who sexually abuses another should be punished by the courts not the community	77.1	91.6	79.9	0.0014
Women and girls need more education about their rights to refuse sex	77.2	69	80.4	0.1525
More should be done to protect women and girls from having sex when they don't want to	70.4	40.8	83.5	0.0092
There should be legal protections for women and girls	91.1	83.8	98.7	0.1390

Table 13. Weighted Percentages on Agreement with Rape Myths by Health Zone

	Karisimbi	Walikale	Katana	
Statement	**Weighted %**	**Weighted %**	**Weighted %**	**p-value, adjusted Wald test of association**
	n = 322	n = 302	n = 278	
Only soldiers can rape	4.5	1.3	14.8	0.0307
Men, not women, are responsible for rape	28.4	19.4	17.7	0.3252
In most cases when a woman is raped, she deserved it	4.7	2.4	17.9	0.0325
Women who have had prior sexual relationships should not complain about rape	24	28.8	39	0.1334
A spouse owes the other partner sex no matter what the circumstance	17.4	10.3	42.6	0.0261
Most rapes happen because women entice men	22.9	45.1	42.7	0.0691
A woman can enjoy sex even when it is forced upon her	16	11.1	45.2	0.0066
"Good" girls are less likely to be raped as "bad" girls	38.6	31.7	57.9	0.0005
Women who say no to sexual intercourse often mean yes	29.3	39.5	60.2	0.0331
Women who wear short skirts or tight shirts are inviting rape	61.3	80.7	62.1	<0.0001
Women often claim rape to protect their reputations	32.4	23.9	68	0.0007
A raped woman is usually an innocent victim	44.4	64.3	68.5	<0.0001
Women can provoke rape by their appearance or behavior	62.6	70.6	75.2	0.2104
If a woman really didn't want to be raped she could fight off the attacker	74.8	79.6	82.8	0.1172
If a girl engages in kissing a boyfriend and she lets it go too far, it is her own fault if her partner forces sex on her	67	74.4	83.8	0.0278