



The legacy of gender-based violence and HIV/AIDS in the postgenocide era: Stories from women in Rwanda

Susan Garnett Russell, Sanaya Lim, Paul Kim & Sophie Morse

To cite this article: Susan Garnett Russell, Sanaya Lim, Paul Kim & Sophie Morse (2016) The legacy of gender-based violence and HIV/AIDS in the postgenocide era: Stories from women in Rwanda, Health Care for Women International, 37:7, 721-743, DOI: [10.1080/07399332.2015.1083026](https://doi.org/10.1080/07399332.2015.1083026)

To link to this article: <http://dx.doi.org/10.1080/07399332.2015.1083026>



Accepted author version posted online: 20 Aug 2015.
Published online: 20 Aug 2015.



Submit your article to this journal [↗](#)



Article views: 156



View related articles [↗](#)



View Crossmark data [↗](#)



Citing articles: 1 View citing articles [↗](#)

The legacy of gender-based violence and HIV/AIDS in the postgenocide era: Stories from women in Rwanda

Susan Garnett Russell^a, Sanaya Lim^b, Paul Kim^c, and Sophie Morse^d

^aTeachers College, Columbia University, New York, New York, USA; ^bCalOptima, Los Angeles, California, USA; ^cGraduate School of Education, Stanford University, Stanford, California, USA; ^dDepartment of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland, USA

ABSTRACT

Drawing on qualitative interviews with 22 Rwandan women, we describe the lived experiences of women survivors of gender-based violence (GBV) more than a decade and a half after the 1994 Genocide. We argue that the intersection between GBV and human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) has long-term implications: the majority of women interviewed continue to endure trauma, stigma, social isolation, and economic hardship in the postgenocide era and are in need of expanded economic and mental health support. Our findings have implications for the importance of providing integrated psychosocial support to survivors of GBV postconflict contexts.

ARTICLE HISTORY

Received 3 November 2014
Accepted 11 August 2015

Gender-based violence (GBV) and human immunodeficiency virus (HIV) are critical global health issues, and the intersection between these two problems is widely recognized (Campbell et al., 2008; Dunkle et al., 2004; Maman, Campbell, Sweat, & Gielen, 2000). Gender-based violence (GBV) is both a root cause and consequence of HIV because it can increase the risk of HIV transmission (United Nations Educational Scientific and Cultural Organization [UNESCO], 2013). Women make up the fastest growing group of persons who have new HIV infections across the globe, and gender-based violence and gender inequality are determinants of risk (Campbell et al., 2008; Dunkle et al., 2004). In conflict settings, there is an increased risk of sexual and other forms of violence, which consequently increases the risk for infection of HIV (Dahrendorf & Shifman, 2004; World Health Organization, 2004). Sexual violence in particular is used as a weapon of war against local populations, especially against women and girls, in countries affected by conflicts, genocides, and wars (Chun & Skjelsbæk,

2010). War and conflict also exacerbate the everyday violence that women and girls face in times of peace (Dahrendorf & Shifman, 2004).

Both GBV and HIV played devastating roles in the 1994 Rwandan Genocide. The legacy of the 1994 genocide continues to impact Rwandans more than two decades later: women were particularly affected as they were subjected to various forms of sexual violence, including sexual assaults, mutilations, torture, and HIV infection. Findings from several studies conducted by nongovernmental organizations (NGOs) on Rwanda suggest that despite progress achieved in the aftermath of the genocide, women survivors of the genocide still struggle with numerous issues. These include poverty; health issues related to HIV/AIDS; a lack of access to quality education and jobs; poor nutrition; trauma; isolation; rejection from their family and the communities; and barriers to reconciliation (African Rights, 2004; Human Rights Watch, 2004; Spencer, 2009; Claude, Kitel, & Piette, 2013).

Several health studies have documented high rates of post-traumatic stress disorder (PTSD) and depression among women survivors (Cohen, d'Adesky, & Anastos, 2005; Gard et al., 2012), but few studies provide first-hand accounts of women's lived experience of GBV, HIV/AIDS, and trauma in postgenocide contexts. The purpose of our research therefore is to describe the experiences of women survivors of violence perpetrated during the Rwandan genocide and to understand the phenomenon of experiencing and surviving GBV. The stories and experiences of 22 women survivors are told through in-depth individual interviews. In this research study, we explore the following questions: How do these women cope with the on-going trauma from GBV inflicted upon them during the Rwandan genocide? What are the challenges and needs identified by women survivors of the Rwandan genocide? The findings from our research can be used to better understand the long-term impact of HIV and GBV in Rwanda and other postconflict settings. In addition, the information gleaned on the intersection between GBV and HIV in a conflict-affected setting can also be applied to other nations in Sub-Saharan Africa facing similar challenges. These issues are being researched and addressed by scholars working across different disciplines and regional contexts; thus, our research is relevant to a broader international and interdisciplinary audience.

Rape as a weapon of war

The 1993 Declaration on the Elimination of Violence against Women defines violence against women as GBV that results in "physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (United Nations General Assembly, 1993).¹ Scholars have documented the use of sexual violence as a policy of war and as a systematic weapon to inflict trauma on the civilian population, and particularly on women, during times of conflict (Buss,

2009; Diken & Laustsen, 2005). Systematic mass rape is used during conflicts as a way for one social group to advance their social and economic position over another group, as well as to destroy families and communities (Milillo, 2006). The primary goal of rape during violent conflict is to “inflict trauma and thus to destroy family ties and group solidarity within the enemy camp” (Diken & Laustsen, 2005, p. 111). Mass rape is also utilized to further ethnic cleansing (Diken & Laustsen, 2005). In these cases, rape is used not only to terrorize individual women but also to demean a particular ethnic group or community (Logan, 2006). Instances of mass rape have been documented in the conflicts in Rwanda, the Democratic Republic of Congo (DRC), Liberia, Colombia, the former Yugoslavia, Sierra Leone, Burundi, Liberia, Uganda, and Sudan (Diken & Laustsen, 2005; Ward & Marsh, 2006; WHO, 2004). In addition to the violence that is perpetrated by actors of armed conflicts and civilians, there is evidence that women sometimes endure sexual violence at the hands of international peace keeping forces and humanitarian aid workers (Dahrendorf & Shifman, 2004).

Rape during the Rwandan Genocide

During the Rwandan Genocide, more than 800,000 Tutsi and moderate Hutu were massacred in the short period of 100 days (Prunier, 1995).² As much as 75% of the Tutsi population was killed (Des Forges, 1999).³ The widespread violence was aimed at the general Tutsi population, but the genocide impacted women in particularly salient ways. In Rwanda, rape was used as an organized weapon of war and ethnic cleansing by the Hutu militia groups. A historical myth about lascivious Tutsi women tempting away Hutu men fueled notions of sexual competition between groups and was used to justify mass rape during the genocide (Hintjens, 2001). Some Hutu women who were married to Tutsi men or protected Tutsi people were also raped (Human Rights Watch, 1996).

Members of the police, military, and army were encouraged not only to kill but also to rape Tutsi women (Hintjens, 2001). Sexual violence was used to further the political goal of the Hutu militia groups, the *Interahamwe*, to destroy the Tutsi ethnic group (Human Rights Watch, 1996). The following quote illustrates the use of mutilation as a form of gender-based violence during the genocide aimed to destroy Tutsi identity and prevent reproduction:

Mutilation was often employed to completely destroy women’s bodies—to take away their uniquely Tutsi features, such as noses or long fingers, not to mention mutilations of breasts and vaginas. Women were often raped with objects like sharpened sticks or machetes, or tortured with boiling water or acid. The mutilation served a greater purpose: to prevent women from having Tutsi children (Sai, 2012).

The aforementioned example illustrates how perpetrating acts of GBV was one important way the Tutsi population was targeted.

The rape of women was integral to the genocidal strategy: “The exhortation to kill, destroy and humiliate the Tutsi... [had] a clear implication: rape their women. Women—and girls—were the ‘spoils of genocide’” (African Rights, 1994, p. 83). While the genocide was orchestrated by the extremist “Hutu Power” group, ordinary Rwandans participated in the killing of neighbors, family members, and members of their community (Prunier, 1995). Sexual violence against women was perpetuated as a strategy not only by the Hutu militia groups and the military but also by ordinary citizens (Human Rights Watch, 1996). According to an estimate by Bijleveld, Morssinkhof, and Smeulers (2009), approximately 350,000 women were raped during the genocide; other sources estimate that as many as 500,000 women were raped (Human Rights Watch, 1996).

The prevalence of HIV/AIDS in Rwanda

Before the genocide, the adult rate of HIV infection was estimated to be as high as 27% in urban areas⁴ (Institut National de la Statistique du Rwanda [INSR] & ORC Macro, 2006); moreover, an estimated 35% of the Rwandan military was HIV positive (Human Rights Watch, 1996). The genocide exacerbated the country’s HIV/AIDS epidemic because some women contracted the virus as a consequence of rape during the genocide. According to the World Health Organization (2004), the HIV prevalence rates in rural areas of Rwanda increased from 1% before the conflict to 11% after the conflict (p. 1). In the subsequent decade and a half since the genocide, the HIV-prevalence rate has decreased to approximately 3% for the general population; nonetheless, women have a higher prevalence rate than men: 4% and 2%, respectively (National Institute of Statistics of Rwanda, Ministry of Health, & ICF International, 2012, p. 213). Furthermore, women survivors of sexual violence have higher rates of HIV/AIDS (African Rights, 2004; Amnesty International, 2004; Zraly, Rubin-Smith, & Betancourt, 2011). According to the 2010 Demographic and Health Survey, 17% of widows are HIV positive, indicating the long-lasting negative effects of the genocide on women survivors (National Institute of Statistics of Rwanda, Ministry of Health, & ICF International, 2012, p. 214).

Thus, many survivors not only suffered from psychological and physical ailments but also were infected with HIV, as sexual violence and the deliberate transmission of HIV were used as methods to torture and to annihilate women survivors (Donovan, 2002). Results from a study conducted by AVEGA, an organization for widows of the genocide, revealed that 67% of rape survivors were also HIV positive, and more than 80% suffered from psychological distress (Amnesty International, 2004, p. 3). In addition to the fact that many of the rape survivors were infected with HIV/AIDS or were afflicted by other medical ailments, many of these women were ostracized from their families and communities. Rape survivors were often rejected by their families due to the stigma

surrounding both rape and HIV/AIDS (African Rights, 2004). Fear and shame prevented survivors from seeking treatment for sexually transmitted infections (STIs) or HIV (Benjamin, 1998).

Further, once aware of their seropositive status, many rape survivors could not afford the antiretroviral (ARV) treatment or did not have access to the drugs (Hilsum, 2004; Mandelbaum-Schmid, 2004; Stearns, 2006).⁵ Many of the survivors affected by HIV/AIDS could not even afford basic health care (Amnesty International, 2004).⁶ The majority of survivors lacked education, skills, and additionally were denied inheritance rights to their husband's or father's property (Logan, 2006; Ward & Marsh, 2006). Consequently, the psychological and medical challenges were further exacerbated by the lack of economic security and employment opportunity for rape survivors.

The impact of rape on women after the genocide

The systematic use of rape during the Rwandan genocide had destructive consequences for survivors both in the physical and psychological sense. Many women who were raped did not seek medical care due to the stigma surrounding sexual violence, lack of money, or lack of availability of medical facilities (Human Rights Watch, 1996). Thus, as Human Rights Watch (1996) concluded, "The health consequences of gender-based violence against women often continue long after the abuse" (p. 45). In Rwanda, as in many other countries, rape is highly stigmatized, and so following an incident of sexual violence many survivors did not report or disclose the rape out of fear of rejection and stigmatization or for fear of being ostracized from society.

The stigma associated with rape often leads to other negative outcomes such as loss of employment and limited political, civil, and property rights (Amnesty International, 2004). Most women were raped by men in their communities and thus were afraid of the repercussions of revealing the rape (Bijleveld et al., 2009). The majority of survivors did not speak openly about their experience due to the fear of having to testify or due to the social stigma associated with rape (Logan, 2006). Thus, as a consequence of not reporting the rape, many women did not receive medical or psychological help.

In the aftermath of the genocide, many Rwandans experienced symptoms of PTSD. This disorder (PTSD) results from the exposure to traumatic events that lead to psychopathologic conditions (De Jong et al., 2001). A survey conducted in Rwanda by Pham, Weinstein, and Longman (2004) of 2,074 randomly selected respondents found that a quarter of the respondents experienced PTSD symptoms; further, women were more likely than men to experience PTSD symptoms. A qualitative study of Rwandan rape survivors conducted by Mukamana and Brysiewicz (2008) concluded that the women respondents had experienced humiliation and loss of dignity, a loss of identity, social isolation, and a loss of hope for the future. Despite the widespread exposure to trauma in the

postgenocide period, many survivors did not have access to counseling services to assist them in dealing with the psychological trauma and stress of the genocide (Kabeera & Sewpaul, 2008).

Organizations for survivors in Rwanda

Medical and psychological support for survivors is crucial in the recovery process after a violent conflict. In the aftermath of the genocide, several organizations were established in Rwanda to provide assistance to women survivors of the genocide. Women's associations are the primary providers of support and services to rape survivors and women living with HIV/AIDS (African Rights, 2004). The *Association des Veuves du Génocide* (AVEGA), or the Association of Widows of the Genocide, is a national-level organization that has more than 25,000 members throughout the country and provides support to genocide survivors for HIV testing, medical care, counseling, legal advice, and financial support for school fees (African Rights, 2004; Association of Widows of the Genocide [AVEGA], 1999; Totten, 2009). Rwanda Women Network is a national organization that provides medical services with a focus on GBV, HIV/AIDS, and mental and reproductive health (Rwanda Women Network, n.d.).

Complementing the national-level organizations, district-level organizations also offer support to genocide and rape survivors. For instance, Abasa is a district-level organization that provides trauma counseling and other emotional support to genocide rape survivors. Other local organizations support women survivors through counseling and psychosocial services, such as Benishyaka, Asoferwa (*Association de Solidarité des Femmes Rwandaises*), the Duhozanye Association, Ibuka, ICAP—International Centre for HIV Care, Icyuzuzo, Pro-Femmes Twese Hamwe, Anthanasie Kankazi Support Group, and the Rwanda Women's Community Development Network.

Additionally, there are some international organizations that provide support to women survivors of the genocide. Foundation Rwanda's goal is to offer support for women (and children) affected by the genocide through social enterprise opportunities for women and education opportunities for children born to women survivors of the genocide (Foundation Rwanda, 2012a, 2012b). USAID's Rebuilding Hope: Polyclinic of Hope Care and Treatment Project addresses the needs of women gender-based violence survivors through clinic-based health services and home-based services (USAID, AIDSTAR-One, & PEPFAR, n.d.). Zonta International Foundation in collaboration with UNICEF is working at 20 UNICEF sites to prevent mother-to-child transmission of HIV to survivors of domestic and gender-based violence of the genocide (Zonta International Foundation, 2012).

In addition to women's and international organizations, other governmental organizations provide support services to genocide survivors. For instance, the Fund for Genocide Survivors (FARG) provides funds to survivors to cover

school fees and medical care. The Rwandan government adopted a 2009–2012 plan on HIV/AIDS with the intention of making universal access to HIV prevention, treatment, care, and support a reality (Ministry of Health, 2009b).⁷ While these new plans aim to address HIV/AIDS at the national level, they do not specifically target women survivors infected during the genocide.

Sexual violence and legal redress after the genocide

In the aftermath of the Rwandan genocide, the international community established the International Criminal Tribunal for Rwanda (ICTR) in Arusha, Tanzania, to try those responsible for committing crimes against humanity. In 1998, with the case of Jean-Paul Akayesu, the ICTR defined rape and sexual violence, with the intention of destroying a particular group, as constituting an act of genocide. The tribunal also asserted that sexual violence committed during the genocide was an “integral part of the process of destruction of the Tutsi ethnic group” (Totten, 2009, p. 117). In theory, this ruling provided a legal avenue for women to seek redress against sexual violence committed during the genocide. One traditional Rwandan mechanism for justice is *Gacaca*, consisting of local community courts established in 2002 used to try people accused of crimes of genocide and crimes against humanity. *Gacaca* means “justice on the grass” in Kinyarwanda, and this model combines a traditional precolonial local dispute resolution mechanism with a modern judicial structure (Rettig, 2008).

Several barriers have prevented women from seeking justice for the crimes committed against them, however, including the limited availability of legal, psychological, and medical resources to address problems associated with psychological trauma and HIV/AIDS (Totten, 2009). The shame and stigma associated with rape and HIV has also dissuaded women from pursuing justice in the national courts or through *Gacaca*; consequently, very few perpetrators of sexual crimes have been prosecuted (African Rights, 2004). As the legal system is not necessarily accessible to or supportive of survivors, seeking justice often results in further trauma for women survivors of GBV (Mukamana & Brysiewicz, 2008). In addition to the legal challenges of bringing perpetrators to justice, Brounéus (2008) found evidence of psychological trauma experienced by some women survivors while testifying for *Gacaca*. Thus, more than a decade after the genocide many women had still not received reparations or legal redress for the crimes of sexual violence committed against them (Human Rights Watch, 2004).

Data and methodology

In our study, we aim to provide a description of the psychological trauma faced by women who have experienced the negative effects of conflict, GBV, and HIV/AIDS through a descriptive phenomenological approach. Descriptive phenomenological research describes concrete experiences of individuals with the intent to provide broader meaning to a particular context (Todres, 2005). Thus, for

this study, we draw on qualitative data from 22 interviews with women survivors who experienced GBV during the genocide in order to describe and understand women's individual experience of GBV experienced during the Rwandan genocide.⁸

Because discussing GBV and HIV/AIDS in Rwanda is very sensitive and difficult for many people, it is especially significant that the women were willing to share their stories and lived experiences. Interviews were conducted in Kinyarwanda, the local language, by a Rwandan woman, also a survivor of the genocide, as part of an NGO project for Seeds of Empowerment.⁹ As a Rwandan woman survivor of the genocide, the interviewer was not only able to conduct interviews in the local language, but she was also able to establish an intimate rapport with the interviewees based on a shared experience, thereby capturing more candid and accurate accounts from the women.

Our interviewer used snowball sampling, where participants were recruited for interviews through word of mouth and through other participants at local community health centers in Kigali, Rwanda. Snowball sampling is often used to find and recruit difficult populations that are not easily accessible to researchers, such as survivors of GBV or HIV-positive women (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). The interviewer conducted in-depth interviews with women at three community health centers in different areas of Kigali during a 3-month period from March through May 2009. Interviews were approximately 30 minutes to 1 hour long. Permission to conduct and to record the interview was obtained from the participants verbally. Interviews from the recordings were later translated and transcribed from the native language of the interviewees, Kinyarwanda, into English. The names of the participants have been changed to protect their identity.¹⁰ Although the interviewer did not provide incentive to the women who participated, many women expressed gratitude at being able to communicate their stories and have someone to listen to them.

We employed an inductive and iterative analysis process to identify important themes in the interviews (Patton, 1990). First, we conducted an initial analysis of the interviews, categorizing the "open" or conceptual themes that emerged from the respondents' descriptions of their experiences. Next, a secondary analysis was completed, further categorizing prevalent themes into broader categories. Several dominant categories emerged from the analysis of the interview transcripts and we use them in our discussion to contextualize our findings internationally and with other research.

More than half of the women in the sample openly admitted to being raped during the genocide; however, the actual numbers could be higher due to the fear and stigma surrounding genocidal rape. As documented in previous literature (for example, Amnesty International, 2004; Human Rights Watch, 1996; Mukamana & Brysiewicz, 2008), the interviews revealed the high levels of stigmatization and marginalization of survivors of sexual violence in society. In recognizing the barriers to sharing stories and lived experiences, it is noteworthy

that the women may not have fully represented their experiences with GBV during the genocide. The data from this qualitative study, therefore, should not be used to represent statistics on HIV infection, sexual or physical violence, or any other form of GBV. The myths surrounding victimization (blaming a person for the crime) may be reasons why women are reluctant to talk (Ellsberg & Heise, 2005).

Limitations of the research

Several limitations emerged due to the research design and topic of the study. Due to the small sample size and nonrandom sampling methods, the results of the study are limited to the sample of women interviewed and cannot be generalized to the broader population of women in Rwanda. Because the interviews were conducted by a Rwanda genocide survivor, an insider, there are implications for the data collected: women might have felt more comfortable speaking in their local language with someone with whom they could identify; alternatively, the interviewer's "insider status" may have also created bias in some way. Nonetheless, the findings provide important insight into the challenges faced by women survivors of the genocide in the present day. While there is ample literature on rape as a weapon of war and particularly in the case of the Rwandan genocide, few studies integrate the lived experiences and aftermath for women survivors of GBV and the intersection with HIV/AIDS.

Findings and discussion

The findings we present in this article are very specific to the lived experiences of the 22 Rwandan women interviewed, but the experiences of these women relate to broader global issues such as the consequences of GBV, the struggles some people face while living with HIV, food security, gender roles and income, and the connection among conflict, trauma, and PTSD. More than 21 years later, the lessons learned from this small East African nation are still relevant for an international audience because they illustrate difficulties in the postgenocide recovery process. Our data is unique in the Rwandan context because it was collected in 2009, 15 years after the genocide, and considers recent programs and policies; therefore, it shows a longer-term trajectory of postconflict trauma related to HIV and GBV.

All of the 22 women included in the interview sample had experienced some form of GBV during the conflict: 14 women described how they were raped during the genocide; three women described how they were physically beaten or abused. The average age of the women interviewed was 40 years old, with a range from 17 to 56 years of age. The highest level of education was 4 years of high school, although the majority of women mentioned having only a few years of primary school education. Nine of the women were genocide widows; two of the women were orphaned and took care of their siblings. The majority of the

women had between one and four children to take care of, with an average number of three children; the two young adults in their late teens and early twenties who were interviewed reported having to take care of their siblings. Of the women who had children in their care, five reported taking care of not only their own children but also other children who were orphaned during the genocide. Seven of the women mentioned that they had lost children during the genocide.

Further compounding the physical, psychological, and social consequences of sexual violence, 15 of the 22 women reported an HIV-positive status. The majority of these women contracted HIV/AIDS as a result of the genocide, in circumstances where rape was used as a weapon of war (Human Rights Watch, 1996). Some of the other women, however, did not know their status. The fear of social stigma, as well as lack of access to testing facilities and medical care has deterred many survivors from obtaining HIV testing or treatment (Human Rights Watch, 2004). Thus, these women faced a double burden, as reported in a study by Amnesty International (2004): “In addition to the stigma of having been raped, rape survivors living with HIV/AIDS are also marginalized, insulted or belittled because of their infection” (p. 25).

An analysis of the interviews resulted in the following emergent themes: experiences with gender-based violence and trauma; living with HIV/AIDS; abandonment and rejection from family and community; financial hardship and dependence; and optimism for the future. All of the themes reflect the challenges of living and surviving GBV and HIV/AIDS in the Rwandan postgenocide context.

Experiences with gender-based violence and trauma

All of the women in the sample were sexually or physically assaulted: fourteen of the women talked about their experience with sexual violence during the genocide. Four of the women described their experience being raped during the conflict at the age of 15 or younger. Other women described the physical complications and the psychological trauma of the aftermath of rape.

Immaculae, age 26, a genocide survivor, was raped during the genocide and is also HIV positive. She expressed her continuing trauma:

I was raped during the genocide when I was only 11 years old. I am the head of a household of three other orphans.... It is a miracle that I am still alive.... I really wonder if I am alive or walking dead and buried into multiple problems and sufferings.... I suffer a lot from trauma, loneliness, disease, and poverty.

Odette talked about her experience being raped during the genocide saying that she was “certainly traumatized” and did not know whether she had HIV/AIDS, because she could not afford to see a doctor or a counselor.

In addition to sexual violence, physical violence against women was also a common occurrence during the genocide. Three of the women interviewed

described the physical violence that they experienced during the conflict. Mary, who lost her husband and three children during the genocide, spoke of the violent physical abuse she endured: “I was beaten during the genocide and I lost my teeth.” Therese, a genocide survivor with five children, described her experience: “I was severely beaten during the genocide and still have big scars from the machete wounds.” Josefine, a 45-year-old widow, lost her husband and four children during the genocide. She described her experience:

I have big scars on my face, along the ears and in the back which mark the machetes used against me during the genocide.... I often have headaches from the wounds.... I was never treated well enough.... The scars from the machetes are also painful and seem to grow.... I am not fit for any demanding physical job and now live in a very dependent way thanks to the help from friends and FARG that built a little house for me.... I am emotionally and physically handicapped.

The experiences discussed by these respondents illustrate the pervasive nature of GBV during the genocide and the enduring psychological, physical, and economic consequences of sexual and physical violence. Rape victims are at higher risk not only for HIV, but also for other STIs (Ward & Marsh, 2006; WHO, 2004). As a result of the sexual and physical abuse that many women were subjected to, many of the women interviewed continued to experience trauma. In the aftermath of the conflict, these women continue to suffer from the traumatic events inflicted upon them, exhibiting higher rates of PTSD and depression (Cohen, d’Adesky, & Anastos, 2005). All of the emotional and physical trauma and resulting consequences from sexual assault and physical assault can be long lasting (UNESCO, 2013). In Rwanda, the psychological and physical consequences of GBV continue to have serious health consequences years after the genocide. The accounts of the women who participated in the interviews suggest a gap in the availability of services or survivors’ access to services that might help support them psychologically, physically, and economically. This lack of services is not uncommon because the capacity to provide health care in postconflict settings, including sexual and reproductive services, is often limited (Roberts, Guy, Sondorp, Lee-Jones, 2008, p. 57). For example, in postconflict East Timor and Kosovo and among internally displaced women in Colombia, over two-thirds of women reported that reproductive health care was difficult to access (Ward & Marsh, 2006).

Living with HIV/AIDS

In addition to experiencing GBV, the majority of the women (15 of 22) also reported an HIV-positive status. A study conducted in 2000 of 1,000 genocide widows in Rwanda revealed that 67% of rape survivors were HIV positive (Ward & Marsh, 2006, p. 10). Ten of the women in our study said that they contracted HIV/AIDS directly as a consequence of being raped during the genocide. Other women did not know their HIV status or how they had been infected.

Sandrine, a 27 year old with two children, had known about her status of HIV/AIDS for the past 5 years and was infected as a direct consequence of the genocide. She believed that she was infected during the genocide when several men raped her. Despite living with HIV/AIDS, Sandrine did not allow the fear of sickness to take over her life: “I am worried about this disease,... but now I am so busy struggling with poverty that I do not have time to think about death.” She felt motivated to get her life together and start up a business if given the opportunity and financial support.

Eugenia, who was 56 and HIV positive, described being raped by a soldier after her husband fled to another country during the genocide: “I believe that I was contaminated with the disease [HIV] when I was raped by military men after my husband fled to another country.” Jeanne, age 47 with three children, shared her experience:

I believe that I was infected [with HIV] in 1994, but I did not start the treatment until 2006.... I did not start treatment until 2006 because I was told that my immunity did not get very low before and it was not necessary to be put on treatment then. I am very grateful to have access to the medicine and I believe that my body responds well to it.

There are various reasons why people do not get tested for HIV or take anti-retroviral drugs, including fear of stigma and discrimination (AVERT, 2014a). Receiving health information regarding HIV/AIDS is essential to receiving care because misinformation delays the treatment process.

The women spoke of the importance of good nutrition and medication adherence for the medication to be effective. Without the proper nutrition, the ARV treatments reportedly caused “dizziness” and “loss of physical energy,” as one woman interviewee reported. Another woman who had known about her seropositive status since 2005 expressed her concerns: “I am worried that the treatment might not work well for me because I do not eat well enough.” Thus, having information and access to ARV and health support were mentioned as particularly important for HIV-infected survivors. For survivors of the genocide, health services provide an opportunity to screen for, and respond to, different cases of violence against women (WHO, 2004). There is a need to understand the intersection between these two issues that are often addressed separately and to provide screening when possible.

The psychological trauma of living with HIV was also a theme. Esperance, an HIV-positive widow, expressed that she was “not able to move from her past life” and had disturbing nightmares on a continual basis. The trauma can also prevent survivors from accessing care. For example, a study done by the UNESCO (2013) reports that the combination of gender discrimination, the stigma associated with living with HIV, and a fear of violence can also dissuade women from seeking information about HIV, from getting tested, from disclosing their seropositive status, or from seeking counseling and treatment.

Abandonment and rejection from family and community

In addition to dealing with the adverse health consequences of living with HIV/AIDS, several of the women spoke of the stigmatization and marginalization associated with sexual violence and HIV/AIDS. Muteteli, a genocide survivor, was raped when she was a teenager during the genocide. She contracted HIV/AIDS and “accepted to be raped in order to protect her own siblings.” She explained her situation: “When I found out I was HIV/AIDS positive, my own family rejected me because it is like a curse to carry HIV/AIDS in Africa.” Despite the sufferings she endured at the hands of her perpetrators, Muteteli said, “My most terrible wound is knowing that my own family has rejected me.” One of the forms of stigmatization is the rejection by husbands and families, as experienced by several of the women. Tracy, a mother of two, was HIV positive and was also raped during the genocide. When she informed her husband of her health status, he left her alone to take care of the children: “My husband abandoned me and did not leave any address where to be found.... I was afraid that my husband was just busy contaminating other people in a different neighborhood where he was not known.”

These survivors faced a loss of social support and social capital that often results in additional psychological trauma and economic hardship and endures long past the initial violation. Studies show that in both the United States and Sub-Saharan Africa, disclosing an HIV-positive status to partners may put a person at an increased risk for violence (Maman, Campbell, Sweat, & Gielen, 2000; Rothenberg, Paskey, Reuland, Zimmerman, & North, 1995; Temmerman, Ndinya-Achola, & Piot, 1995; Gielen, O’Campo, Faden, & Eke, 1997). In Rwanda, HIV infection remains associated with immoral sexual practices, and so even discussing the disease can be taboo (Amnesty International, 2004). These existing cultural and social practices and beliefs can cause ostracism and shame toward survivors of sexual violence, especially in cultures like Rwanda where virginity is highly valued (Colombini, 2002; United Nations Population Fund, 1999; United Nations High Commission for Refugees [UNHCR], 2001). Some women face rejection by their husband, as Ward and Marsh (2006) report: “Raped women may be abandoned by husbands who fear contracting HIV, or who simply cannot tolerate the shadow of dishonor they believe their raped wives have cast across them” (p. 9).

The examples from the stories the women shared illustrate the detriment to families and communities due to the continued stigma of rape and HIV in Rwandan society, despite the time passed since the genocide. Women in Burundi had similar experiences; researchers discovered in 2003 that survivors had been mocked and humiliated by other women in their communities because of the abuse they had suffered (Ward & Marsh, 2006).

Financial hardship and dependence

In Rwandan society, women have been traditionally dependent on their husbands for financial support. Several of the women expressed this feeling of dependency on their husbands. Elaine, a 52-year-old with three children of her own and five orphans under her care explained: “My husband abandoned me.... He used to abuse me because I depended too much on him.” Although she had endured the pain and trauma of the genocide, she felt “lost after my husband fled to the United Kingdom without taking me with him.”

Many of the women interviewed were living in poverty and were financially dependent on family or local organizations. They reported a lack of jobs and stable income. The difficulty of raising a family and finding financial resources for the cost of food, rent, and school fees were mentioned as tremendous challenges for the women in the study.

The interviewees were also vocal in describing the loss of family members. Many experienced losing their husband and children and, in some instances, their entire family to the mass violence. In many cases, the result was that women or children became the head of households and sole providers. The women interviewees described having to find jobs to support their families. In certain instances, their deteriorating health conditions and emotional trauma prevented them from searching for jobs or from performing their duties as employees.

Several women expressed the economic and physical challenges as result of their HIV-positive status. For example, Lucia explained, “If you’re a women living with HIV/AIDS, you don’t even have the physical energy to go out there and take on some physical activity that would generate some income.” Naomi and her husband were both infected by HIV/AIDS and were raising six children: “We can only afford to eat twice a day when my husband gets a contract in the construction business.... Jobs in construction are quite unpredictable and not stable.” Emma, a 36-year-old with four children, expressed her concerns: “I struggle in finding food for my whole family, as my new husband is currently jobless.... It is hard for me to cover the cost of rent, the foods, and the school fees.”

For the first time since the genocide, women acquired the role as heads of households and were responsible for providing housing, food, care, and school fees for their surviving family (Human Rights Watch, 1996). For those who mentioned that they were currently working, the availability of jobs was limited and many women found themselves taking on cleaning jobs to make ends meet. Other women sold second-hand clothing, sodas, fruits and vegetables, or charcoal to make a living. Many women and their families experienced significant challenges but were hopeful that the future would bring some financial support. To alleviate the financial hardships many of the women faced, half of the women relied on some form of financial support from organizations including FARG, AVEGA, and the UN. Several of the women mentioned that these organizations

provided funds for schools fees, medical fees, HIV/AIDS treatment, living expenses, and construction of houses. For the women survivors interviewed, the restructuring of household responsibility that came as a result of the loss of family members during the genocide has consequences that permeate all levels of life. Financial challenges and the responsibility they bring exacerbate health and psychological difficulties. For the survivors interviewed living with HIV/AIDS, the ramifications can be even greater.

Optimism for the future

In spite of the difficult circumstances that many of the women described, several also mentioned a strong will to live, hope for the future, and a positive psychological attitude. Apolline, age 41, lost her husband and one child during the genocide. She still suffers from trauma related to the genocide, and she now takes care of her three remaining children and three orphans left behind by relatives. She expressed the need to sustain her family: “I cannot afford to die because I still need to take care of my children.” Some of the women interviewees also exhibited post-traumatic growth or positive psychological change in response to past traumas (Tedeschi & Calhoun, 2004). Angelina, 54 years old and HIV positive, had three children who were also HIV positive. Despite the challenges she faced, she still had a strong will to survive: “I am still alive today because those kids depend on me and I have no extra help.”

A majority of the women spoke of the desire to own their own business in the future including having vegetables and fruit market stalls, opening up a hair salon, and running a restaurant. Thus, despite the significant challenges faced by these women including health issues, poverty, stigma, and trauma, they still harbored hopes and desires for a better future for themselves and their children.

Even the women who showed hope for the future still lived with trauma. While the will to survive and endure was a predominant theme, it should not overshadow the need for both government and nongovernment organizations to provide long-term care and support to survivors. In fact, four of the women we interviewed mentioned that counseling would help with their trauma. Having the opportunity to discuss their experiences would help relieve their trauma in order to move forward with their lives. Therese expressed her hope: “If I had [a] regular counseling coach and financial help, I would be able to sell things at the market and make a living.” Claudine, a 33-year-old genocide rape survivor with one child explained: “My most urgent priority is to get help with counseling.” In spite of past traumas and current challenges, the majority of the women demonstrated resilience and a positive outlook for the future.

Policy recommendations and implications for practice

Our article addresses the intersection of GBV and HIV/AIDS in a postconflict context and the implications for policies for psychological health and income-

generation programs. The recommendations emerge from the postgenocide experiences in one of the first countries where sexual violence was recognized as a war crime. Our study, however, is relevant to other postconflict contexts. Policymakers, researchers, NGO workers, health care workers, and local governments working in various postconflict settings to address GBV and HIV can potentially benefit from our findings when considering policies and programs supporting the recovery of GBV survivors and people living with HIV. Although not all of the survivors experienced the same type of GBV, the commonalities across all of the women's stories was the long-lasting impact and continued struggle with various problems. These include access to health care, psychosocial support, family acceptance, and financial security. The obstacles to justice (through *Gacaca*) and to health care were both salient and recurring themes, as was the need for counseling and mental health services, despite the majority of HIV-positive women having mentioned they had access to ARV drugs.

Although themes were detected and presented among women who experienced similar forms of gender-based violence, each survivor's experience is unique and does not fit into a prescribed formula. Nevertheless, certain general recommendations can be made regarding access to important services for survivors. While access to community health care services has improved in Rwanda with the implementation of the primary health care system (PHC), there is still a need for a system that provides integral mental health care to women survivors of sexual violence (Zrally, Rubin-Smith, & Betancourt, 2011).

According to the women, access to ARVs was not sufficient because they also faced psychological trauma, rejection from family, and economic problems as a consequence of their situation. Although ARVs may be available, there is a critical link between food and ARV therapy in Rwanda, and some women could not afford the food needed to take the drugs (Urdang, 2006). Taking them on an empty stomach can be extremely painful, and severe weight loss can be a side effect (AVERT, 2014b). Food insecurity in Rwanda, therefore, can have a direct impact on the well-being of a survivor living with HIV/AIDS if they do not have access to sufficient food to maintain weight, prevent pain while taking the drugs, and aid with their absorption.

A few of the women mentioned the process of *Gacaca* and the quest for justice. Donata, a 45-year-old genocide widow with three children, expressed her opinion: "*Gacaca* is very necessary but also a very painful experience." None of the women, however, discussed the role of *Gacaca* or the ICTR as having a direct influence on their situation or in addressing the crimes of GBV.

While some women had access to medical care or treatment for HIV/AIDS from the government or various organizations that work with survivors (such as AVEGA or FARG), the women revealed that there is a lack of provision of psychosocial services for survivors. Furthermore, many of the women did not have employment or adequate financial resources to provide for themselves and for their families. Thus, there is a clear need to expand basic medical and support

services to include counseling and mental health services. Taking local contexts into consideration is important in determining the type of psychological support and counseling that would be most effective and relevant.

In general, relatively few resources are dedicated to mental health services in Rwanda. In a qualitative study on Rwandan survivors of sexual violence, Zraly, Rubin-Smith, and Betancourt (2011) found that these women “faced a number of barriers in trying to access the health care system and have their mental health needs met” (p. 258). In addition to dealing with trauma, therefore, many women survivors of GBV are not able to access psychological services. There is a need to increase funding and services for mental health services. According to the WHO (2005), Rwanda only spends 1% of the health budget on mental health services (p. 395). Many of the women interviewed suffer from trauma and stigma associated with their experience of GBV and could likely benefit from counseling and psychological services.

Most postgenocide interventions have assisted Tutsi survivors, excluding many other sexual violence survivors (such as Hutus who sympathized with Tutsis and also experienced gender-based violence). In her analysis of sexual violence in Rwanda 1990–2001, Jennie Burnet (2012) concludes that there is a need for “more open frameworks for confronting instances of sexual violence during violent conflict, ones that make it possible for more victims to come forward for medical, psychological, and social support” (p. 112). There are still barriers to access for survivors in Rwanda. The reproductive health risks and problems, chronic ailments, psychological consequences, injury, and death associated with GBV need to be addressed by both policymakers and health care providers (Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008).

In a 2013 study, *Intimate Partner Violence in Rwanda: The Mental Health of Victims and Perpetrators* (Verduin, Engelhard, Rutayisire, Stronks, & Scholte), the association between intimate partner violence (IPV) and common mental health disorders (CMDs) in post-genocide Rwanda is revealed. In the aforementioned study, the authors explain that the experiences of interpartner and collective violence may have raised the risk of CMDs and that Rwandans with mental health disorders (including PTSD) may be more likely to perpetrate IPV (Verduin et al., 2013). Although the goal of our study was not to diagnose CMDs or PTSD, the lived experiences of the women did illustrate the on-going trauma and mental health implications of surviving various forms of violence. The need for diagnosis and the adequate medical response to these different forms of trauma are crucial, especially as CMDs and PTSD could lead to an increase in the perpetration of IPV.

Many of the women in our study conveyed that they were still living with trauma and were learning how to cope with the loss of support from family members. The interviewees constantly relived and verbalized past events, and experienced emotions of shame, fear, and abandonment from family and community. It is likely that many of the women interviewed continue to experience

PTSD more than 20 years after the genocide as a result. The connection between postgenocide PTSD and the perpetration of IPV merits attention in future research both in the Rwandan context and in other postgenocide countries. In addition, there is a need to recognize and conduct additional research on the elevated risk of CMDs resulting from collective violence (including GBV) in order to be able to detect and treat cases.

Regarding the stigma and shame associated with sexual violence, there is a need to understand the concrete impacts this social ostracizing could have on survivors. Findings from a case study conducted by Claude and colleagues (2013) in the Democratic Republic of Congo illustrate that the stigma and discrimination against survivors of sexual violence in conflict increases their vulnerability and promotes the spread of HIV/AIDS through the deprivation of medical care and support. Further research is warranted on how stigma and disapproval can limit both access to services and also cause the spread of STIs including HIV. These research sites could include Rwanda as well as other countries in postconflict and post-genocide periods.

Conclusion

Before, during, and after the genocide in Rwanda, rape and sexual violence became a common feature of a social landscape where many forms of GBV were already condoned (Burnet, 2012). Through our study, we bring to light the personal experiences and challenges faced by women survivors of GBV in the post-genocide period. These survivors face the challenges of societal stigma that existed before the genocide as well as the long-term impacts of the genocide mentioned throughout the article. Survivors of rape and other forms of GBV are often denied help by their communities and are actually blamed, doubted, or victimized (Campbell, Wasco, Ahrens, Sefl, & Barnes, 2001). These experiences are called “second rape,” “the second assault,” or “secondary victimizations” (Campbell et al., 2001). These community attitudes need to be addressed through sensitization and education interventions to prevent this revictimization.

The consequences of GBV are often devastating and long term and affect both the physical health and mental well-being of women and girls (Velzeboer, Ellsberg, Arcas, & García-Moreno, 2003). Previous studies on women survivors of the genocide also provide harrowing accounts of the violence inflicted on women during the genocide. The results from these interviews build on this, and attest to the enduring impact of the genocide more than 15 years later. They highlight the lack of access to comprehensive medical and psychological care, employment, and family support. The findings point to the need to increase psychological support and provide income-generating activities for women survivors of GBV.

The stories emerging from our interviews reveal that many of the women survivors of the Rwandan genocide continue to suffer from psychological trauma, medical conditions, and social stigma more than a decade and a half later. Given the long-term and pervasive nature of the trauma and impact, there is a need for ongoing studies and interventions for both survivors and their children. In addition to experiencing GBV, the majority of respondents were also infected or affected by HIV/AIDS. This intersection has a compounding effect for some survivors. Social, physiological, and psychological repercussions—known consequences of GBV—were also apparent in the stigmatization of those infected with HIV/AIDS. Through our study, we have sought to articulate the interaction of these two separate but often linked experiences and their long-term consequences.

Additionally, these women need access to more opportunities for income generation such as microcredit lending for small businesses or vocational training courses. Further research is necessary to determine policy-specific interventions that may alleviate the burden and suffering of survivors of GBV during the genocide, particularly in the provision of integrated health and counseling services.

Finally, in spite of the economic, medical, and psychological challenges that these women confronted in their day-to-days lives, many had aspirations for the future and sought to provide a better life for their children. As a report by Human Rights Watch (1996) states, “The future of Rwanda is largely in the hands of its women.” Thus, increased attention to these vulnerable women is important for the development of future policies for the provision of comprehensive health and psychosocial services, as well as economic opportunities, for survivors of GBV in Rwanda. More research should be conducted both in Rwanda and in other postconflict countries to better understand what factors support survivors’ healing processes.

Notes

1. Article 1 of the Declaration on the Elimination of Violence Against Women available at <http://www.un.org/documents/ga/res/48/a48r104.htm>.
2. For more background on the Rwanda Genocide see Prunier (1995) and Des Forges (1999).
3. In Rwanda, the Hutu, Tutsi, and Twa historically comprised approximately 84%–90%, 9%–15%, and 1% of the population, respectively (Straus, 2006, p. 19).
4. According to the Demographic and Health Survey (DHS) in 1991, the HIV prevalence rate was 27% in urban areas, 8.5% in semiurban areas, and 2.2% in rural areas.
5. Seropositive status refers to an HIV-positive status (Genet, Sebsibie, & Gulty, 2015).
6. In 2005, the Rwandan Government implemented a program in partnership with Partners in Health and a local NGO, Inshuti Mu Buzima, to provide community-based health care services in rural areas. For more information see <http://www.pih.org/pages/rwanda/>. In the same year, the Rwandan Government also initiated the *Mutuelles de Santé* (CTAMS), a community-based health insurance scheme. According to the Ministry of Health, 91% of Rwandans have health insurance (2009a).

7. Recently, the government adopted a new plan for 2013–2018 that is focused on “pursuing the same objective, with inspiration from the global targets of ‘zero new HIV infections, zero HIV-related deaths and zero stigma and discrimination due to HIV’” (Ministry of Health, 2013). This plan was not in place, however, at the time of data collection.
8. Although a total of 77 women were interviewed for the NGO project, only 22 interviews from women who experienced some form of violence during the genocide are analyzed in this article.
9. Seeds of Empowerment (SOE), a 501C3 nonprofit organization, conducted the interviews and transcribed interviews for analysis. SOE was founded by the third author.
10. The second author followed IRB procedures for the analysis of secondary data. An earlier version of the article was submitted by the second author for a master of science in health care administration.

References

- African Rights. (1994). *Rwanda: Death, despair and defiance*. London, England: Author.
- African Rights. (2004). *Rwanda: Broken bodies, torn spirits—Living with genocide, rape and HIV/AIDS*. Kigali, Rwanda: Author.
- Amnesty International. (2004). Rwanda: “Marked for death,” rape survivors living with HIV/AIDS in Rwanda. *AI Index*, 1–34 (AFR 47/007/2004). Retrieved from <http://www.amnesty.org/en/library/info/AFR47/007/2004>
- Association of Widows of the Genocide (AVEGA). (1999). *Survey on violence against women in Kigali, Rwanda*. Human Rights Watch Publication.
- AVERT. (2014a). HIV & AIDS stigma and discrimination. Retrieved from <http://www.avert.org/hiv-aids-stigma-and-discrimination.htm>
- AVERT. (2014b). HIV and nutrition. Retrieved from <http://www.avert.org/hiv-and-nutrition.htm>
- Benjamin, J. A. (1998). Issues of power and empowerment in refugee studies: Rwandan women’s adaptive behaviour at Benaco Refugee Camp. *Refugee*, 17(4), 27–32.
- Bijleveld, C., Morssinkhof, A., & Smeulders, A. (2009). Counting the countless: Rape victimization during the Rwandan genocide. *International Criminal Justice Review*, 19(2), 208–224.
- Brounéus, K. (2008). Truth-telling as talking cure? Insecurity and retraumatization in the Rwandan gacaca courts. *Security Dialogue*, 39(1), 55–76.
- Burnet, J. E. (2012). Situating sexual violence in Rwanda (1990–2001): Agency, sexual consent, and the political economy of war. *African Studies Review*, 55(2), 97–118.
- Buss, D. E. (2009). Rethinking “rape as a weapon of war.” *Journal of Feminist Legal Studies*, 17(2), 145–163.
- Campbell, J. C., Baty, M. L., Ghandour, R. M., Stockman, J. K., Francisco, L., & Wagman, J. (2008). The intersection of intimate partner violence against women and HIV/AIDS: a review. *International Journal of Injury Control and Safety Promotion*, 15(4), 221–231.
- Campbell, R., Wasco, S. M., Ahrens, C. E., Sefl, T., & Barnes, H. E. (2001). Preventing the “Second Rape”: Rape survivors’ experiences with community service providers. *Journal of Interpersonal Violence*, 16(12), 1239–1259.
- Chun, S., & Skjelsbæk, I. (2010). Sexual violence in armed conflicts. *PRIO Policy Brief*, 2010(1). Oslo: PRIO.
- Claude, O. K. J., Kittel F., & Piette, D. (2013). Stigma of victims of sexual violence’s in armed conflicts: Another factor in the spread of the HIV epidemic? *Epidemiology*, 3, 124.

- Cohen, M. H., d'Adesky, A., & Anastos, K. (2005). Women in Rwanda: Another world is possible. *Journal of the American Medical Association*, 294, 613–615.
- Colombini, M. (2002). Gender-based and sexual violence against women during armed conflict. *Journal of Health Management*, 4(2), 167–183.
- Dahrendorf, N., & Shifman, P. (2004). Sexual violence in conflict and post conflict: A need for more focused action. *Refugee Survey Quarterly*, 23(2), 7–19.
- De Jong, J.T.V.M., Komproe, I. H., Van Ommeren, M., El Lasri, M., Araya, M., Khaled, N., & Somsaundaram, D. (2001). Lifetime events and posttraumatic stress disorder in 4 post-conflict settings. *Journal of American Medical Association*, 286(5), 555–562.
- Des Forges, A. (1999). *Leave None to Tell the Story*. New York, NY: Human Rights Watch.
- Diken, B., & Laustsen, C. B. (2005). Becoming abject: Rape as a weapon of war. *Body & Society*, 11(1), 111–128.
- Donovan, P. (2002). Rape and HIV/AIDS in Rwanda. *The Lancet*, 360, 17–18.
- Dunkle, K. L., Jewkes, R. K., Brown, H. C., Gray, G. E., McIntyre, J. A., & Harlow, S. D. (2004). Gender-based violence, relationship power, and risk of HIV infection in women attending antenatal clinics in South Africa. *The Lancet*, 363(9419), 1415–1421.
- Ellsberg, M., & Heise, L. (2005). *Researching violence against women: A practical guide for researchers and activists*. Washington, DC: World Health Organization, PATH.
- Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: An observational study. *The Lancet*, 371(9619), 1165–1172.
- Foundation Rwanda. (2012a). *Education Initiative*. Retrieved from <http://www.foundationrwanda.org/ourimpact/educationinitiative.aspx>
- Foundation Rwanda. (2012b). *The Ladies of Abasangiye Cooperative*. Retrieved from <http://www.foundationrwanda.org/ourimpact/cooperative.aspx>
- Gard, T. L., Hoover, D. R., Shi, Q., Cohen, M. H., Mutimura, E., Adedimeji, A. A., & Anastos, K. (2012). The impact of HIV status, HIV disease progression, and post-traumatic stress symptoms on the health-related quality of life of Rwandan women genocide survivors. *Quality of Life Research*, 22, 2073–2084.
- Genet, M., Sebsibie, G., & Gultie, T. (2015). Disclosure of HIV seropositive status to sexual partners and its associated factors among patients attending antiretroviral treatment clinic follow up at Mekelle Hospital, Ethiopia: A cross sectional study. *BMC Research Notes*, 8, 109.
- Gielen, A. C., O'Campo, P., Faden, R. R., & Eke, A. (1997). Women's disclosure of HIV status: Experiences of mistreatment and violence in an urban setting. *Women & Health*, 25(3), 19–31.
- Hilsum, L. (2004). Rwandan genocide survivors denied AIDS treatment. *British Medical Journal*, 328, 913.
- Hintjens, H. M. (2001). When identity becomes a knife: Reflecting on the genocide in Rwanda. *Ethnicities*, 1(1), 25–55.
- Human Rights Watch. (1996). *Shattered lives: Sexual violence during the Rwandan genocide and its aftermath*. New York, NY: Author.
- Human Rights Watch. (2004). *Struggling to survive: Barriers to Justice for Rape Victims in Rwanda*, vol. 16(10). New York, NY: Author.
- Institut National de la Statistique du Rwanda (INSR) and ORC Macro. (2006). *Rwanda Demographic and Health Survey 2005*. Calverton, MD: Author.
- Kabeera, B., & Sewpaul, V. (2008). Genocide and its aftermath: The case of Rwanda. *Journal of International Social Work*, 51(3), 324–336.

- Logan, S. (2006). Remembering the women in Rwanda: When humans rely on the old concepts of war to resolve conflict. *Affilia: Journal of Women & Social Work*, 21(2), 234–239.
- Mack, N., Woodsong, C., MacQueen, K., Guest, G., & Namey, E. (2005). *Qualitative research methods: A data collector's field guide*. Research Triangle Park, NC: Family Health International.
- Maman, S., Campbell, J., Sweat, M. D., & Gielen, A. C. (2000). The intersections of HIV and violence: Directions for future research and interventions. *Social Science & Medicine*, 50(4), 459–478.
- Mandelbaum-Schmid, J. (2004). Rwandan genocide survivors in need of HIV treatment. *Bulletin of the World Health Organization*, 82(6), 472.
- Milillo, D. (2006). Rape as a tactic of war: Social and psychological perspectives. *Journal of Women and Social Work*, 21(2), 196–205.
- Ministry of Health, Republic of Rwanda. (2009a). *Ministry of Health Annual Report 2008*. Retrieved from <http://www.moh.gov.rw/fileadmin/templates/MOH-Reports/Final-MoH-annual-report-2008.pdf>
- Ministry of Health, Republic of Rwanda. (2009b). *Rwanda National Strategic Plan on HIV and AIDS 2009–2012*. Retrieved from <http://apps.who.int/medicinedocs/documents/s18409en/s18409en.pdf>
- Ministry of Health, Republic of Rwanda. (2013). *Rwanda HIV and AIDS National Strategic Plan July 2013–July 2018*. Retrieved from http://www.nationalplanningcycles.org/sites/default/files/country_docs/Rwanda/chd-strategic_plan.pdf
- Mukamana, D., & Brysiewicz, P. (2008). The lived experience of genocide rape survivors in Rwanda. *Journal of Nursing Scholarship*, 40(4), 379–384.
- National Institute of Statistics of Rwanda, Ministry of Health, & ICF International. (2012). *Rwanda demographic and health survey 2010*. Calverton, MD: Author.
- Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Newbury Park, CA: Sage.
- Pham, P. N., Weinstein, H. M., & Longman, T. (2004). Trauma and PTSD symptoms in Rwanda: Implications for attitudes towards justice and reconciliation. *Journal of American Medical Association*, 292(5), 602–612.
- Prunier, G. (1995). *The Rwanda crisis: History of a genocide*. New York, NY: Columbia University Press.
- Rettig, M. (2008). Gacaca: Truth, justice, and reconciliation in postconflict Rwanda?. *African Studies Review*, 51(03), 25–50.
- Roberts, B., Guy, S., Sondorp, E., & Lee-Jones, L. (2008). A basic package of health services for post-conflict countries: Implications for sexual and reproductive health services. *Reproductive Health Matters*, 16(31), 57–64.
- Rothenberg, K. H., Paskey, S. J., Reuland, M. M., Zimmerman, S. I., & North, R. L. (1995). Domestic violence and partner notification: Implications for treatment and counseling of women with HIV. *Journal of the American Medical Women's Association*, 50(3–4), 87–93.
- Rwanda Women Network. (n.d.). *Programs*. Retrieved from <http://www.rwandawomennetwork.org/spip.php?article3>
- Sai, N. (2012). *Rwanda. Women under siege*. Retrieved from <http://www.womenundersiegeproject.org/conflicts/profile/rwanda>
- Spencer, R. (2009). *Sexual violence. Global grassroots conscious social change for women*. Retrieved from http://www.globalgrassroots.org/sexual_violence.html
- Stearns, B. (2006). A new crime against humanity: HIV/AIDS and security after the Rwandan genocide. *Human Security Journal*, 1, 36–50.

- Straus, S. (2006). *The order of genocide: Race, power, and war in Rwanda*. Ithaca, NY: Cornell University Press.
- Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15(1), 1–18.
- Temmerman, M., Ndinya-Achola, J., & Piot, P. (1995). *The right not to know HIV-Test results*. *Lancet*, 345, 969–970.
- Todres, L. (2005). Clarifying the life-world: Descriptive phenomenology. In I. Holloway (Ed.), *Qualitative research in health care*. Buckinghamshire, England: Open University Press.
- Totten, S. (2009). *Plight and fate of women during and following genocide*. New Brunswick, Canada: Transaction Publishers.
- United Nations Educational Scientific and Cultural Organization (UNESCO). (2013). *Addressing the links between gender-based violence and HIV in the Great Lakes region*. Paris, France: UNESCO Division for Gender Equality.
- United Nations General Assembly. (1993). *Declaration on the elimination of violence against women*. Retrieved from <http://www.un.org/documents/ga/res/48/a48r104.htm>
- United Nations High Commission for Refugees (UNHCR). (2001). *How-to guide: Sexual and gender-based violence programme in Guinea*. Retrieved from <http://www.unhcr.org/3c4d6af24.pdf>
- United Nations Population Fund (UNFPA). (1999). *UNFPA report finds incidences of rape and abduction among Kosovo refugees: Women want to speak out*. UNFPA press release, 25 May. Retrieved from <http://www.unfpa.org/news/pressroom/1999/kosovo-rept.htm>
- Urdang, S. (2006). Rwandan women: AIDS therapy beyond drugs. *Africa Renewal Online*. Retrieved from <http://www.un.org/africarenewal/magazine/april-2006/rwandan-women-aids-therapy-beyond-drugs>
- USAID, AIDSTAR-One, & PEPFAR. (n.d.). *Rebuilding hope: Polyclinic of Hope Care and Treatment Project*. Retrieved from http://www.aidstar-one.com/focus_areas/gender/resources/case_study_series/rebuilding_hope_rwanda#tab_3
- Velzeboer, M., Ellsberg, M., Arcas, C., & García-Moreno, C. (2003). *Violence against women: The health sector responds*. Retrieved from <http://www.cabdirect.org/abstracts/20053000714.html>
- Verduin, F., Engelhard, E. A., Rutayisire, T., Stronks, K., & Scholte, W. F. (2013). Intimate partner violence in Rwanda: The mental health of victims and perpetrators. *Journal of Interpersonal Violence*, 28, 1839–1858.
- Ward, J., & Marsh, M. (2006, June). Sexual Violence Against Women and Girls in War and Its Aftermath: Realities, Responses and Required Resources. *Symposium on Sexual Violence in Conflict and Beyond*. International symposium conducted by the United Nations Population Fund, the European Commission, and the Government of Belgium, Brussels, Belgium. Retrieved from <http://www.gbv.ie/wp-content/uploads/2007/12/48-sexual-violence-against-women-and-girls-in-war-and-its-aftermath.pdf>
- World Health Organization (WHO). (2004). Violence Against Women and HIV/AIDS: Critical Intersections: Sexual Violence in Conflict Settings and the Risk of HIV. *The Global Coalition on Women and AIDS, Information Bulletin Series*, Number 2. Retrieved from <http://apps.who.int/gender/en/infobulletinconflict.pdf>
- World Health Organization (WHO). (2005). *Mental health atlas*. Geneva, Switzerland: Author.
- Zonta International Foundation. (2012). Prevention of mother-to-child transmission of HIV and gender-based violence in Rwanda. Retrieved from <http://www.zonta.org/Portals/0/PDFs/Rwanda.pdf>
- Zraly, M., Rubin-Smith, J., & Betancourt, T. (2011). Primary mental health care for survivors of collective sexual violence in Rwanda. *Global Public Health*, 6(3), 257–270.