Long-Term Effects of Wartime Sexual Violence on Women and Families

The Case of Northern Uganda

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This document was submitted as a dissertation in July 2018 in partial fulfillment of the requirements of the doctoral degree in public policy analysis at the Pardee RAND Graduate School. The faculty committee that supervised and approved the dissertation consisted of Glenn Wagner (Chair), Jeanne Ringel, and Ragnhild Nordás (University of Michigan).

This work was funded by dissertation awards from the Jim Lovelace Foundation and the Pardee Global Human Progress Initiative.
Abstract

Wartime sexual violence is one of the most devastating forms of violence committed against women and girls during armed conflicts. It is used as a tool of war to systematically target vulnerable groups, incite displacement, inflict suffering, and sever community cohesion. Research has shown that it has catastrophic effects on the health and well-being of survivors. However, there is a dearth of evidence on its long-term effects on survivors and their personal networks. In northern Uganda—a region that was marred by protracted conflict for 20 years—about 30 percent of women report having experienced at least one form of conflict-related sexual violence, including forced marriage, rape, and forced pregnancy. The objectives of this dissertation were to study the enduring effects of wartime sexual violence on Ugandan women and explore its ripple effects on families.

In-depth interviews were conducted to: (a) assess survivors’ perception of the persisting effects of wartime sexual violence on their health, relationships, and care seeking behaviors; and (b) explore how the indirect exposure to wartime sexual violence affected parents, siblings, and intimate partners. The relationship between women’s exposure to conflict events and their experience of intimate partner violence was explored using data from a nationally representative survey.

Findings show that women survivors continue to suffer from unresolved and untreated trauma, lack access to mental health care, and face economic hardships due to community stigma and customary laws that prevent women from owning land. Family members were susceptible to secondary traumatic stress, and both survivors and family members used coping mechanisms, such as memory repression and faith. Relationships were often disrupted after survivors disclosed their experiences or if they had children born of wartime rape. Intimate partner violence was found to be generally high among Ugandan women, but significant differences in prevalence rates were not observed for women living in war-affected regions versus those in unaffected areas.

Recommendations for policy and practice include providing trauma-informed care within existing community support mechanisms; working with religious leaders to address inequities around land inheritance; and supporting survivor-led initiatives, including reintegration of children born of wartime rape through family reunions.
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Executive Summary

Research Objectives

Wartime sexual violence, also referred to as conflict-related sexual violence (CRSV),¹ is one of the most devastating forms of violence waged against civilian populations during an armed conflict. It is often used as a tool of war to systemically target vulnerable groups, inflict psychological trauma, incite displacement, deter opposition movements, and sever community cohesion. In addition to instilling fear and dividing communities, wartime sexual violence can have catastrophic effects on the health and well-being of survivors, their families, and communities at large. In Africa’s conflict zones, where systems of justice and security are further weakened by armed conflict, at least one in four women experience conflict-related sexual violence (Spangaro et al., 2013). High levels of sexual violence have been a feature of past and recent African conflicts and their aftermath. For instance, between 250,000 to 500,000 women are estimated to have been raped during the 1994 Rwandan genocide (Nowrojee, 1996), and more than 1.5 million Congolese women reported having been raped in their lifetime (Peterman, Palermo, & Bredenkamp, 2011). Globally, sexual violence continues to be used as a weapon of war and its systematic use has been verified in current armed conflicts including in Syria, Iraq, Nigeria and Central African Republic (UNSC, 2018).

¹ The definition of conflict-related sexual violence used in this dissertation is the one provided by the United Nations Security Council that defines it as “rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization linked, directly and other forms of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is or indirectly (temporally, geographically or causally) to a conflict. This link may be evident in the profile of the perpetrator; the profile of the victim; and in a climate of impunity or state collapse; in the cross-border dimensions; and/or in violations of the terms of a ceasefire agreement.” (Ki-Moon, 2015).
Empirical research on the long-term effects of wartime sexual violence on survivors, families, and communities is very limited (Koos, 2017; Rowley, Garcia-Moreno, & Dartnal, 2012). However, a deeper understanding of the long-term consequences of wartime sexual violence on survivors, families, and others indirectly affected by this crime is crucial for informing policies and designing effective programs that address the needs of conflict-affected communities. This dissertation focuses on northern Uganda, where close to 30 percent of women experienced at least one form of conflict-related sexual violence during the protracted conflict that lasted for 20 years (Kinyanda et al., 2010). My aim was to study the enduring effects of conflict-related sexual violence on women survivors, and explore the ripple effects it has on families who care(d) for them.

Research Questions and Approach

To assess the long-term effects of conflict-related sexual violence on survivors, I focused on understanding the impact of this experience on female survivors. Although men and boys can also be victims of wartime violence, women and girls are disproportionately targeted and constitute the majority of all survivors (UNSG, 2002). As such, my aim was to: (b) explore the effects of wartime sexual violence on women’s health, relationships, and care seeking behavior, and (b) provide a descriptive overview of intimate partner violence among women living in areas affected by conflict. To address the first aim, 30 women survivors who had experienced abduction, forced marriage or sexual violence were interviewed from three conflict-affected districts in northern Uganda: Gulu, Lira, and Pader. Using semi-structured interview guides, participants were asked about how their experiences continue to affect their health, relationships,

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2 The term survivor is used to describe an individual victim of any form of sexual violence who survived a sexual violence incident.
3 The types of conflict-related sexual violence experienced by Ugandan women who were abducted by the Lord’s Resistance Army (LRA) between 1986–2006 included forced marriage, forced pregnancy, rape, and gang rape.
and care seeking behavior. To address the second aim, I used secondary data on measures for intimate partner violence from the Ugandan Demographic Health Survey and data on conflict-events committed by armed groups known to use sexual violence during the Ugandan conflict from the GEO-SVAC dataset.⁴

To explore the ripple effects of conflict-related sexual violence on families of survivors, 22 family members of women survivors were interviewed. Participants included parents, siblings, and intimate partners living in the three districts from where survivors were recruited. Using semi-structured interview guides, participants were asked about how they perceived their indirect exposure to wartime sexual violence had affected their health, relationship with the survivor, and other family members. In addition, they were asked about the support systems they sought (if any) and which ones they found to be the most useful.

The interviews with survivors and family members were conducted with the support of local organizations including the Justice Reconciliation Project (JRP)⁵ and the Women’s Advocacy Network (WAN)⁶. In addition, ethical approval was obtained from RAND’s Human Subject Protection Committee (HSPC), and the Ugandan National Council for Science and Technology (UNCST).

Findings

**Women survivors continue to suffer from unresolved and untreated trauma**

⁴ The GEO-SVAC dataset offers geolocation of conflict events involving actors reported to have perpetrated sexual violence (Karim, Nordás, & Ostby, 2016). As of July 29, 2018, more information on the dataset can be found at https://files.prio.org/ReplicationData/GEO-SVACpercent20Codebook.pdf.

⁵ JRP is a Ugandan non-governmental organization based in Gulu, northern Uganda, whose mission is to empower conflict-affected communities through their active involvement in research, advocacy, as well as the process of justice, healing, and reconciliation.

⁶ The WAN is a semi-autonomous group within JRP that was founded by conflict-affected women in 2011.
A decade after the war ended, women survivors continue to face multiple challenges related to their abduction and experience of wartime sexual violence. Persisting psychological problems such as anxiety and depression were often triggered by a range of stressors, including stigma and economic hardships. For most women, these issues remained unresolved. Survivors relationships with family members and intimate partners were also negatively affected because of their CRSV experience. This, in turn, had a negative impact on their care seeking behavior. Participants in this study also faced economic hardships because of challenges with accessing land and their inability to support themselves due to various barriers including community rejection. Survivors also had a great desire (but found it difficult) to support the education of children born in captivity, who faced similar difficulties with accessing land rights. This is because according to some Acholi traditions, children inherit land from fathers or through their paternal lineage. In addition, survivors encountered stigma from some family and community members due to being labeled as a “former rebel” and the stigma that came with that label as well as having children born as a result of abduction by LRA rebels. Finally, although most participants didn’t seek formal care due to personal and structural barriers including fear of stigma, cost of services, and lack of information. However, survivor-led support groups were a source of strength for most women.

In terms of intimate partner violence (IPV), I found that it was generally high in Uganda, including in conflict-affected regions, with over 65 percent of women saying they experienced at least one form of IPV, including emotional, physical, or sexual violence by their partners. The most common type of violence experienced in conflict-affected areas was physical violence, followed by emotional and sexual violence. However, this was not reflected in the qualitative interviews where most women didn’t report experiencing violence from their intimate partners. In the few cases where women did mention experiencing violence, it was mostly emotional
abuse. In terms of attitudes, I found that more men living in non-conflict affected regions found wife beating acceptable compared to men living in conflict-affected regions. This is an interesting finding that requires further investigation.

**Family members are susceptible to secondary trauma, and often bear the responsibility of caring for children born in captivity**

In terms of the indirect impact of wartime violence on families, I found that all family members in the study experienced symptoms of secondary traumatic stress, similar to symptoms described in the vicarious trauma literature, including anger, anxiety, sadness, and withdrawal. None of the participants in the study sought formal care for their symptoms, but rather encouraged the survivor and themselves to forget the past, since they believed that repressing memories associated with their abduction and sexual abuse was the best way to deal with their trauma. In addition, they relied on their faith and focused on their relationship with God to make what they were experiencing bearable. Unlike the survivors interviewed in this study, family members did not report having a support system where they could discuss what they were feeling and experiencing. However, they shared that they would have benefited from counseling services and other types of social support tailored to their needs.

Most family members said their relationship with the survivor became complicated as a result of the survivor’s disclosure of sexual abuse. In most cases, family members knew about what the survivor experienced but did not encourage further conversation. Mothers of survivors reported that the responsibility of caring for children born in captivity mainly rested on them, which at times negatively impacted their own relationship with their spouses and other family members.
Policy recommendations

The challenges faced by survivors of conflict-related sexual violence and their families can only be addressed through the collaboration of multiple stakeholders working with conflict-affected communities. These include local governments, non-governmental organizations, faith leaders, traditional elders, care providers, community workers, researchers, as well as survivors and families themselves. With this in mind, and drawing on the findings from this study, I present a set of key recommendations that could feasibly be implemented by the aforementioned stakeholders.

1. **Integrate mental health services into general health provision and existing community support mechanisms.** It is important that mental health services for survivors of sexual violence and family members are integrated into existing services and community support mechanisms, since specific targeting of survivors for specialized care can make them susceptible to stigma and discrimination. Therefore, interventions and support related to mental health services should be implemented based on participatory principles and with the feedback and support of communities.

2. **Invest in improving the capacity of community workers so they can provide effective psychosocial care to survivors in their communities.** There are not adequate providers or community health workers who can provide mental health services in Uganda in general, and especially in conflict-affected communities. Given that leaders of self-started survivor-led groups are providing informal care to survivors, donors and program implementers should consider improving the capacity of these women and men through training in case management and psychosocial support.
3. **Reduce the stigma towards survivors of sexual violence and children born of war by working with faith leaders, and traditional elders.** Community leaders including faith leaders and traditional elders have leverage in the community that allows them to dispel stigma and shame projected towards survivors of sexual violence and children born in captivity. Program implementers should work with these leaders, in addition to survivors, for successful implementation of interventions in these communities.

4. **Consider implementing interventions that use evidence-based psychotherapy techniques that have proven effective in similar settings.** Group psychotherapy techniques such as cognitive behavior therapy (CBT) that facilitate cognitive and emotional processing of trauma with other individuals who shared similar experiences have been found to be effective and cost-efficient in low income and conflict-affected settings. Local organizations and researchers working with communities in northern Uganda should consider implementing similar interventions among survivors and families in northern Uganda.

5. **Use validated psychometric measures to assess the prevalence of secondary trauma among family members.** A concerted effort by researchers and local organizations is needed to develop studies that can assess the full impact of indirect exposure to conflict-related sexual violence on families and others who care for primary survivors. The evidence from these studies can then be used to improve existing care or implement new services for this population.

6. **Encourage community dialogues around how war, abductions, and sexual violence can alter relationships.** The experience of wartime sexual violence has the power to damage relationships between family members, intimate partners, friends, and others in the community. Family members and friends of survivors can take better care of
survivors, as well as themselves if they know what to expect during and after caring for traumatized women and men affected by wartime sexual violence. Risk-reduction strategies such as strong social connections and counseling can protect individuals who care for survivors from secondary trauma.

7. **Provide access to land rights for women survivors and children born of war.** Land is an important resource for Ugandan women, since most Ugandans depend on agriculture for income and sustenance. Land is especially invaluable for survivors who might find it difficult to be employed in other sectors because of stigma and factors related to their history. In addition, land is traditionally passed on to children through their paternal lineage which makes it difficult for children born of war to inherit land. Activists and survivors should work with traditional elders and community leaders to challenge these customs and lead reconciliation efforts that can reunite children with their paternal families.

8. **Support survivor-led grassroots organizations.** Survivor-led groups such as the Women’s Advocacy Network, have made efforts to destigmatize what it means to be a survivor of wartime sexual violence or a former abductee of the Lord’s Resistance Army. In addition, they have played a huge role in reuniting children born of war with their paternal families. These are promising grassroot efforts that should be supported both financially as well as through enhanced resources and training.

9. **Provide educational support for children born in captivity.** Children born in captivity are often mistreated and don’t have equal opportunities for education. This is often exacerbated by their mothers’ lack of resources, stigma they face in the community, and other structural barriers. Local governments should consider funding the education of these children, most of whom don’t have formal support systems.
10. Increase women survivor’s access to economic opportunities. One of the major barriers that survivors face is related to access to economic opportunities because either they can’t own land or don’t have the right skills that could make them competitive in other sectors. Funders and program implementers should consider ways to provider adult education as well as training in a range of vocational skills so that survivors can diversity their skill sets and get the resources they need to be self-sufficient.

Conclusion

The use of sexual violence during war continues to be one of the most calamitous repercussions of modern day armed conflicts. Scholars have provided a better understanding of why it happens, and possible prevention strategies. The purpose of this dissertation was to provide a better understanding of its long-term consequences on individuals, their families, and society at large. Understanding the full effects of this crime on the health and well-being of those affected is critical to rebuilding conflict-affected communities and achieving sustainable peace.
Acknowledgments

I am grateful for my dissertation committee—Glenn Wagner, Jeanne Ringel, and Ragnhild Nordås—for providing substantial supervision, constructive criticism, and moral support throughout this process. I would not have been able to do this research without their guidance, and any shortcomings that might appear are my own. I am also indebted to Rhoda Wanyenze for her support with helping me navigate the Institutional Review Board process in Uganda. I thank Gery Ryan for always being available to brainstorm ideas and encouraging me to think deeply about the policy impact of my work. I greatly appreciated ideas, comments, and suggestions given on qualitative and quantitative methods at different stages of my dissertation work by Gery Ryan, Sarah MacCarthy, Scott Ashwood, Deborah Mindry, and Italo Gutierrez. I also greatly appreciated the thoughtful and insightful feedback provided by Emmet Keller, Daniel Egel, Martin Shapiro, and members of RAND’s Behavioral Interest Group during the initial stages of proposal writing.

This dissertation would not have been possible without my partner organizations in Uganda: The Justice Reconciliation Project (JRP) and the Women’s Advocacy Network (WAN). A particular note of gratitude goes to the staff at JRP including Isaac Okwir, Oryem Nyeko, Nancy Apiyo, Patrick Odong, and Grace Acan, as well as WAN leaders in different districts who helped us recruit participants to the study. I thank Grace Acan and Pauline Anena for incredible research assistance on the field and Mercy Lynn Agasha for accompanying me to Gulu on my first trip to northern Uganda. A special thanks to Janet Abaneka who meticulously translated all the interviews from different Acholi dialects to English. I thank the people in northern Uganda—
particularly those I met in Kitgum, Gulu, and Arusha—for welcoming me with kindness and generosity and teaching me invaluable lessons about resilience.

I express my heartfelt thanks to the scientific committee and staff at the Brocher Foundation in Switzerland for the invitation to spend four glorious months on the shores of Lac Léman and the opportunity to meet scholars from all over the world. I am grateful for my colleagues and friends at the Pardee RAND Graduate School for their persistent support and informal conversations that added to the richness of this work. Thank you to the entire Pardee RAND administration and community, and especially Gulrez Azhar (for helping me mine DHS data) as well as James Syme and Lisa Kraus for their assistance with ArcGIS.

I am grateful for the financial support I received to implement this project from the JL Foundation and the Pardee Initiative for Global Human Progress. I also want to thank trainers at BoxnBurn Santa Monica who helped me discover my love for boxing and for their patience and investment in teaching me proper techniques. Working with them was instrumental to my mental health and progress during the last few months of writing. Finally, I would like to thank my family, without whom my desire to pursue higher education would have been impossible. I am humbled by their unconditional love, support, and generosity.

I was able to write this dissertation only because the courageous women and men in northern Uganda chose to share their stories and experiences with me. This dissertation is dedicated to them, other survivors of sexual violence, as well as families and communities around the world who may be indirectly affected by this crime.
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<tr>
<th>Abbreviation</th>
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<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>CRSV</td>
<td>Conflict-related Sexual Violence</td>
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<tr>
<td>DHS</td>
<td>Demographic Health Survey</td>
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<tr>
<td>DSP</td>
<td>Data Safeguarding Plan</td>
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<tr>
<td>GEO-SVAC</td>
<td>Geocoded Sexual Violence in Armed Conflict Dataset</td>
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<tr>
<td>GWED-G</td>
<td>Gulu Women’s Economic Development and Globalization</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IRB</td>
<td>Institutional Review Board</td>
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<td>ICTR</td>
<td>International Criminal Tribunals for Rwanda</td>
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<td>ICTY</td>
<td>International Criminal Tribunals for the former Yugoslavia</td>
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<td>IPV</td>
<td>Intimate Partner Violence</td>
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<td>JRP</td>
<td>Justice Reconciliation Project</td>
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<td>LRA</td>
<td>Lord’s Resistance Army</td>
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<td>NRM</td>
<td>National Resistant Movement</td>
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<tr>
<td>PTSD</td>
<td>Post-traumatic Stress Disorder</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>UCDP</td>
<td>Uppsala Conflict Data Program</td>
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<td>UDHS</td>
<td>Ugandan Demographic Health Survey</td>
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<td>UN</td>
<td>United Nations</td>
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<td>UN Action</td>
<td>UN Action against Sexual Violence in Conflict</td>
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<td>UNSCR</td>
<td>United Nations Security Council Resolution</td>
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<td>WAN</td>
<td>Women’s Advocacy Network</td>
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<td>WPS</td>
<td>Women, Peace, and Security</td>
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<td>WHO</td>
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1. Introduction

Global Overview of Sexual Violence in Conflict

Sexual violence has been a feature of many civil wars and conflicts around the world, including in Bosnia and Herzegovina (1992–1995), the Democratic Republic of Congo (1996–present), Liberia (1989–1996; 1999–2003), Sierra Leone (1991–2002), Rwanda (1994) and northern Uganda (1986–2006) (Palermo & Peterman, 2011). Although wartime sexual violence goes back to even before World War II, it only began to gain international attention in the 1990s when investigative journalists started to document and report the use of systematic sexual violence during the civil conflicts in Rwanda and Bosnia-Herzegovina (Skjelsbæk, 2010). Consequently, the International Criminal Tribunals for the former Yugoslavia (ICTY) and Rwanda (ICTR) declared the systematic use of rape and other forms of sexual violence during armed conflict a war crime and a crime against humanity (Haffajee, 2006). However, this did not help deter new incidents of sexual violence in subsequent armed conflicts.

In 2013, Maple Croft, a British global risk analysis firm, assessed the impact of sexual violence between 1998 and 2013. The group used two main indicators—the use of systematic sexual violence as a weapon of war, and the involvement of child soldiers either as victims or perpetrators of sexual violence during conflict—to identify the countries that were at the highest risk of experiencing sexual violence during times of conflict. Figure 1.1 shows the risk score for sexual violence against civilians during war for all countries around the world. It is worth noting

7 Small and Singer (1982, 210) defined civil war as “any armed conflict that involves: (a) military action internal to the metropole, (b) the active participation of the national government, and (c) effective resistance by both sides.” The main distinction they made between civil (internal or intrastate) war and interstate or extra state (colonial and imperial) war was the internality of the war to the territory of a sovereign state and the participation of the government as a combatant. Civil war was differentiated from other forms of internal armed conflict by the specification that state violence should be sustained and reciprocated. In addition, there must be at least 1,000 deaths as a direct result of the war (Small & Singer, 1982).
that seven of the 10 countries identified as posing the most risk are in sub-Saharan Africa and include nations currently in conflict (e.g. Central African Republic) and post-conflict settings (e.g. northern Uganda). Most recently, the United Nations (U.N.) also reported disturbing accounts of sexual violence including rape, sexual slavery, and forced marriages in 19 conflict and post-conflict settings just between January and December 2017 (UNSC, 2018). Ten of the 19 countries listed were in sub-Saharan Africa and included Mali, Central African Republic, and Nigeria.8

Figure 1.1. Countries at Extreme Risk of CRSV between 1998–2013


Scope and Magnitude of Conflict-Related Sexual Violence (CRSV)

The definition of wartime violence, which I will also refer to as conflict-related sexual violence (CRSV) in this dissertation, accords with the most recent definition provided by the United Nations Security Council that defines it as “rape, sexual slavery, forced prostitution, 

8 Other countries listed include Afghanistan, Bosnia and Herzegovina, Burundi, Colombia, Côte d’Ivoire, Democratic Republic of Congo (DRC), Iraq, Libya, Mali, Myanmar, Nepal, Nigeria, Sri Lanka, Somalia, South Sudan, Sudan (Darfur), Syrian Arab Republic, and Yemen.
forced pregnancy, enforced sterilization, and other forms of sexual violence of comparable gravity perpetrated against women, men, girls, or boys that is linked directly or indirectly (temporally, geographically or causally) to a conflict. This link may be evident in the profile of the perpetrator; the profile of the victim; in a climate of impunity or state collapse; in the cross-border dimensions; and/or in violations of the terms of a ceasefire agreement” (Ki-Moon, 2015). Perpetrators can be state actors including military, police, or paramilitary organizations under the direct command of other state actors as well as non-state actors including rebel and militia organizations (Wood, 2014).

High levels of CRSV have been a feature of past and recent conflicts and their aftermath in numerous African countries. For instance, between 250,000 to 500,000 women are estimated to have been raped during the 1994 Rwandan genocide (Nowrojee, 1996), and more than 1.5 million Congolese women reported having been raped in their lifetime (Peterman et al., 2011). In northern Uganda—Africa’s longest protracted conflict—over 25 percent of women report having suffered at least one form of CRSV (Kinyanda et al., 2010).

Global Effort and Gaps

Over the past decade, the international community has bolstered efforts to protect women and children from CRSV through various landmark U.N. Security Council Resolutions (UNSCR) that placed gender concerns at the center of the international peace and security agenda. UNSCR 1325, adopted in 2000, provided the foundation for the international Women, Peace, and Security (WPS) agenda that was reinforced by the passage of subsequent Security Council resolutions (see UNSCR 1820, UNSCR 1888, and UNSCR 1960). The Security Council has pushed for continued data collection, monitoring, analysis, and reporting on sexual violence in armed conflict, and post-conflict settings (UNSC, 2012). In addition, through these resolutions,
the Security Council underscored the gendered impacts of conflict on women and their families and identified four priority areas pertinent to matters of international peace and security: political participation, prevention, protection, and relief and recovery (Aroussi, 2011). Although some strides have been made in addressing the first three priorities, focus on the relief and recovery aspect of CRSV has been lacking.

Furthermore, several campaigns have been launched at the local and international levels to raise more awareness about CRSV, mitigate its impact, and bring perpetrators to justice. For instance, the UN Action against Sexual Violence in Conflict (UN Action) advocates for improved coordination and accountability among governments and sectors in order to prevent sexual violence, respond to the needs of survivors, and effectively prosecute perpetrators. Similarly, the United Kingdom has assumed a de facto global leadership role on the issue of CRSV, through the launch of the Preventing Sexual Violence in Conflict Initiative, and mobilizing activists and policy makers to address specific objectives geared towards ending CRSV.⁹ Even though the efforts by the international community and scholars studying the problem have provided a better understanding of the causes of CRSV, there are still significant gaps between international discussions about the problem and concrete changes at national and local levels, especially when it comes to meeting the needs of individuals affected by CRSV (Kirby, 2015; Koos, 2017).

Why does CRSV Happen?

The longstanding assumption that sexual violence, especially rape, is an inevitable aspect of modern day conflict has been challenged. Recent scholarship has shown variations in both form

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and severity across countries and conflicts, as well as across armed groups within the same conflict (Cohen, 2013; Cohen & Nordås, 2014; Leiby, 2009; Wood, 2010). A large number of studies argue that CRSV is used to control, displace, terrorize, and sever communities by attacking female members (Boesten, 2014; Leatherman, 2007; Pocar, Pedrazzi, & Fruli, 2013) and can be used to achieve the systematic destruction of families, and communities (Sharlach, 2000). Other scholars argue that group dynamics within armed groups can play a significant role in explaining the variation of wartime rape (Cohen, 2013; Wood, 2006). For example, Cohen (2013) argues that collective rape can be used to increase cohesion between members of armed groups recruited through involuntary techniques (Cohen, 2013).

Although men and boys are also affected, women and girls are disproportionately targeted and constitute the majority of all victims of CRSV (UNSC, 2002). The insecurity that results from an armed conflict exacerbates their vulnerability and can lead to a more extreme, widespread, and fatal form of sexual violence (Bastick, 2007). Even long after a conflict ends, sexual violence may continue in homes and communities at equal or higher rates than observed during conflict settings (Bastick, 2007). For instance, a study conducted in northern Uganda found that women who returned after being abducted by the Lord’s Resistance Army (LRA) continued to experience violence at home due to a range of factors, including family conflict upon return (Annan & Brier, 2010). Furthermore, because of cultural taboos around being a survivor of sexual violence, most victims remain silent, and how their experience affects their health and well-being continues to evade analysts (Skjelsbæk, 2010). Skjelsbæk (2010) argues that it is precisely these feelings of shame, fear, and guilt that makes sexual violence an effective tool for perpetrators (Skjelsbæk, 2010).
Consequences of CRSV

Despite the different explanations for the reasons behind why CRSV might occur, there is no ambiguity with regards to its severe consequences for survivors, families, and societies at large. In addition to violating the basic human rights of individuals, CRSV can have complex and long-lasting health as well as social and economic consequences for survivors (Amowitz et al., 2002; Johnson et al., 2008; Kim, Torbay, & Lawry, 2007). Firstly, CRSV is a serious public health problem with devastating impacts on the health of survivors. Some of the deleterious physical health consequences of CRSV include reproductive health problems such as traumatic genital inflammatory disease, infertility, and HIV/AIDS (Liebling-Kalifani et al., 2008; Longombe, Claude, & Ruminjo, 2008; Ward & Marsh, 2006). Moreover, high levels of behavioral health problems including anxiety disorders, suicidality, alcohol and substance abuse, and post-traumatic stress disorder (PTSD) have been reported among this population (Joachim, 2005; Liebling-Kalifani et al., 2008; Lunde & Ortmann, 1998).

Secondly, CRSV has long-term social ramifications. In African conflicts, CRSV survivors and their children are often stigmatized and rejected by family members (Jefferson, 2004), which often leads to lack of access to economic opportunities and insufficient resources to sustain themselves and their children. Studies from Uganda show that women who had children as a result of CRSV faced overwhelming challenges including community stigma, and inability to own property, access education, or earn a living (Apio, 2007). In contexts where family honor and marriage provide security to women, women CRSV survivors experience higher rates of divorce and difficulty engaging in the labor market. Quantifiable economic costs borne by the survivor include health care expenses, decreased productivity, and lower earnings (Fearon & Hoeffler, 2014).
CRSV can have ripple effects that extend from the survivor to their family and community (UN Women, 2010). It can also be used as an efficient tool to break down social infrastructures, disintegrate families, and sever communities (Arieff, 2011). Beyond exposing survivors to stigmatization, experiencing CRSV can affect how they are perceived within their families and communities (Josse, 2010). Women can be rejected by their spouses, prevented from marrying, working or attending school. Parents might not be willing to accept a young unmarried daughter who has been raped and may not allow her to remain in the household; rape survivors might be unable to continue caring for their children either for physical or psychological reasons; and the community might reject survivors and children born from an incident of rape, and these children could face stigma and discrimination (Jina & Thomas, 2013).

Studies have shown that CRSV can result in deeply traumatized populations (Cohen, Green, & Wood, 2013) and have lifelong impacts across multiple generations, such as exposure to transgenerational trauma defined as “historical, and sometimes continuing, traumatic experiences that affect more than one generation” (Dass-Brailsford, 2007). However, there is a dearth of research on the effect of CRSV survivors’ experiences on members of their families. The few studies that are available are focused on intimate partners (Smith, 2005), and find that individuals who have an intimate partner who is a rape survivor suffer various forms of vicarious trauma including anxiety, sadness, and depression (Kelly, VanRooyen, Kabanga, Maclin, & Mullin, 2011). Additional work from the Democratic Republic of Congo by Christian et al. (2011) has shown that the mental health recovery of male survivors was highly contingent upon how those closest to them reacted to the experience and treated them afterwards (Christian, Safari, Ramazani, Burnham, & Glass, 2011). Another study from Central and West Africa (Tol et al., 2013) found that family members and intimate partners were interested in learning how to
better support rape survivors in their household. In northern Uganda, researchers have found that many people in conflict-affected communities displayed significant physical and psychological war-related trauma including post-traumatic stress disorder (PTSD), depression, anxiety, somatization disorder, and substance abuse (Musisi, Kinyanda, Leibling, & Mayengo, 2000).

Armed-conflicts are known to have long-term consequences across multiple areas of society (Cohen et al., 2013, Buss et al., 2014). One negative impact that has not been fully explored is its potential linkage to the incidence of higher violence against women, such as domestic violence during war and in post-conflict settings. Gutierrez & Gallegos (2016) found that exposure to civil violent events during early teenage years increased Peruvian women’s risk of being victims of domestic violence. Another study from Colombia found that the higher incidence of combat within a district significantly increased the likelihood of women in this district becoming victims of domestic violence (Noe et al., 2012). There are currently no studies that have used nationally representative data to explore the prevalence of intimate partner violence in conflict-affected regions of Uganda.

The Case of Northern Uganda

Jan Egeland, the former United Nations Undersecretary General for Humanitarian Affairs, and current Secretary General of the Norwegian Refugee Council, cited the northern Uganda crisis as one of the world’s worst forgotten humanitarian crisis marked by horrific human rights abuses, including sexual violence against women and girls, abductions, and the use of child soldiers (France-Presse, 2003). Uganda’s conflict, mainly concentrated in the northern region (Figure 1.2) was primarily a result of a widespread uprising against the National Resistant Movement (NRM). The NRM was led by President Museveni, who took office in 1989 after ousting Idi Amin (Pham & Vinck, 2007). Before the emergence of the Lord’s Resistance Army
(LRA) led by Joseph Kony, Alice Lakwena’s Holy Spirit Movement was prominent in the mid-1980s and had more popular support than its successor. After Lakwena escaped to a refugee camp in Kenya, the LRA gained strength and became the most prominent rebel group against the government (Pham & Vinck, 2007). In the early stages of the LRA’s history, Kony was mainly rejected by Acholi leaders, resulting in the failure of the first LRA operation.

Between 1986 and 2006, the LRA engaged in large-scale human rights abuses including killings, mutilations, abduction of children, and systematic sexual violence (Vinck & Pham, 2008). CRSV was widespread during the 20-year conflict and affected communities, especially women and children, who suffered from rape and abduction (Kinyanda et al., 2010; Vinck & Pham, 2008). Over 1.6 million people—90 percent of the affected population in Acholi land—were forced to flee their homes, and live in temporary camps for internally displaced persons with extremely dire conditions (Latigo, 2008). High levels of sexual and gender-based violence against women and girls in camps were also reported (Latigo, 2008). A 2003 survey revealed that at least 1000 children died weekly in the camps (Dorsey & Opeitum, 2002).
These experiences had a lasting impact on survivors and communities including chronic reproductive health problems (Kinyanda et al., 2010), as well as social marginalization and insecurity for female households (Buss, Lebert, Rutherford, Sharkey, & Aginam, 2014). For example, a qualitative study among post-conflict communities in Kitgum found that women who had been abducted during the conflict found it difficult to integrate back into their community due to stigma. In addition, they found that women were constantly trying to navigate strained family relations that were disrupted by the conflict and subsequent displacement from their home and communities (Tiessen & Thomas, 2014). Moreover, female returnees served by a local women’s peace organization in Kitgum exhibited signs of recurring traumatic events through intrusive thoughts and nightmares, as well as generalized loss of interest and emotional withdrawal (Annan & Brier, 2010; Tiessen & Thomas, 2014). Due to the absence of adequate
health programming and psychological support and counselling, community rehabilitation has been a major challenge among conflict-affected communities in northern Uganda (Buss et al., 2014).

Objectives
In 2012, citing the dearth of research on this topic, the World Health Organization (WHO) collaborated with the Sexual Violence Research Initiative (SVRI) to develop a research agenda on CRSV in conflict- and post-conflict settings (Rowley et al., 2012). The research agenda included ten priority areas within CRSV that require further research. This dissertation focuses on two of those areas: the long-term impact of CRSV on individuals and the indirect effect of CRSV on families. I explore these areas through three aims and their corresponding research questions:

AIM 1: Provide a descriptive overview of intimate partner violence (IPV) among women living in districts that experienced conflict between 2002 and 2006.
   a) Which parts of Uganda experienced the highest level of conflict-events by actors known to use sexual violence?
   b) What is the prevalence of IPV among women living in conflict-affected districts between 2002 and 2006?
   c) What is the association between women’s (and men’s) attitudes towards wife beating and living in conflict-affected areas?

AIM 2: Explore the personal experiences of women CRSV survivors in northern Uganda.
   a) How has the experience of CRSV affected the physical, psychological, and social well-being of women survivors?
b) How do women survivors think their CRSV experience has affected their relationship with different family members?

c) What kind of support, including personal relationships and social services do women survivors seek or/and find the most helpful?

AIM 3: Gain a better understanding of how CRSV affects families of survivors.

a) How do family members of CRSV survivors perceive the experience to have affected them, and their relationship with the survivor?

b) How did the indirect exposure to the survivor’s CRSV experience affect the health and well-being of family members?

c) What kind of support or services related to the experience of war did family members of survivors seek (if any) or found the most helpful?

The rest of this manuscript is organized as follows: in Chapter 2, I present the conceptual framework and methods used to answer the research questions. Chapter 3 contains a descriptive overview of the Ugandan conflict, and prevalence of different forms of intimate partner violence among Ugandan women who lived in conflict-affected areas between 2002 and 2006. In Chapter 4, I describe the persisting challenges women survivors in Uganda are facing as a direct result of CRSV. Chapter 5 focuses on the secondary impact of CRSV, specifically on family members of women survivors. I present conclusions and policy implications in Chapter 6.
2. Methods

Conceptual Framework

To explore the long-term effects of wartime sexual violence on women and families, I used a conceptual framework adapted from Remer and Ferguson (1995), in which they outlined a model of “trauma processing” that could be used to understand the effects of rape on primary female survivors and secondary survivors\textsuperscript{10} (Remer & Ferguson, 1995). Following this framework with some modifications, Figure 2.1. shows the process flow and possible interconnections between the experiences of the primary survivor and secondary survivor, and the possible pathways the issues and responses of the secondary survivor might mirror that of the primary survivor’s. In both processes, Remer and Ferguson (1995) portrayed the survivor’s healing process in six stages. The first two stages of \textit{pre-CRSV} and \textit{CRSV event} happen in a linear fashion, while the final four stages (shaded in grey) consisting of \textit{crisis and disorientation}, \textit{outward adjustment}, \textit{reliving}, \textit{integration and reintegration} overlap and recycle. The authors posit that the healing of the primary survivor is dependent on the resources and support available in the social system (including the secondary survivor), and the healing of the secondary survivor is dependent on the healing of the primary survivor. In chapters four and five, I used this framework to explore the long-term effects of wartime sexual violence on women survivors and families in northern Uganda.

\textsuperscript{10} The focus of Remer and Ferguson’s paper was on male partners and counselors who worked with rape survivors.
Methods for Chapter 3

The purpose of this chapter was to provide: (a) an overview of conflict-events by actors known to use sexual violence in Uganda and (b) a descriptive summary of intimate partner violence (IPV) among women living in districts that experienced conflict between 2002 and 2006. The research questions are as follows:

d) Which parts of Uganda experienced the highest level of conflict-events by actors known to use sexual violence?

e) What is the prevalence of IPV among women living in conflict-affected districts between 2002 and 2006?

f) What is the association between women’s (and men’s) attitudes towards wife beating and living in conflict-affected areas?
To answer these questions, I used: (a) geo-coded data on the time and location of war-related conflict events in Uganda from the GEO-SVAC dataset, and (b) individual level data on self-reports of intimate partner violence from the 2006 Ugandan Demographic Health Survey (UDHS). In the following sections, I provide a detailed description of these two datasets, the rationale behind why each was chosen, and how these two datasets were merged for further analysis.

Data on Conflict

The GEO-SVAC dataset offers geolocation of conflict events involving actors reported to have perpetrated sexual violence (Karim et al., 2016). It is a geocoded event-based dataset where the information about sexual violence is based on the Sexual Violence in Armed Conflict (SVAC) Dataset\(^{11}\) covering the years 1989–2009 at the level of conflict-actor-year (Cohen & Nordås, 2014). GEO-SVAC, focuses on state-based conflicts, and uses the Uppsala Conflict Data Program Georeferenced Event Dataset (UCDP GED) (Sundberg & Melander, 2013)\(^{12}\) as its starting point, and extends it by providing additional variables on the use of sexual violence by the actors involved from the SVAC dataset. It provides spatial patterns of armed actors reported to be using sexual violence. GEO-SVAC does not provide information on whether each individual event involved the use of sexual violence. However, since there is no data that provides information on specific events that involved the use of sexual violence during the

\(^{11}\) The Sexual Violence in Armed Conflict (SVAC) Dataset includes reports of conflict-related sexual violence committed by government/state military, pro-government militias, and rebel/insurgent forces. The SVAC Dataset covers all conflicts active in the years 1989–2009, as defined by the UCDP/PRIO Armed Conflict Database. Data were collected for all years of active conflict (defined by 25 battle deaths or more per year) and for five years post-conflict. The SVAC dataset only provides data at the country level (Cohen & Nordås, 2014).

\(^{12}\) The UCDP GED dataset is a global dataset that covers the entirety of Asia, Africa, and the Middle East (excluding Syria) between 1989 and 2014 and the entirety of Americas and Europe between 2005 and 2014. The basic unit of analysis for the UCDP GED dataset is the “event”, an individual incident (phenomenon) of lethal violence occurring at a given time and place. More specifically, an event is defined as “An incident where armed force was by an organized actor against another organized actor, or against civilians resulting in at least 1 direct death or at a specific location and a specific date” (Sundberg & Melander, 2013).
Ugandan conflict, I used GEO-SVAC as a proxy for the general use of sexual violence for conflict-events that were recorded in various Ugandan districts for one or more of the actors involved in the events in the same year.\textsuperscript{13}

The unit of observation in the GEO-SVAC dataset is the conflict-event, with the highest temporal precision on the day-level and the highest spatial precision on the city or town-level. Due to limitation with the SVAC dataset, GEO-SVAC represents only a subset of the UCDP GED data, and contains only state-based conflicts, and the years 1989 to 2007 for Uganda. In the GEO-SVAC, sexual violence is defined as rape, sexual slavery, forced prostitutions, forced pregnancy, forced sterilization, or abortion as well as sexual mutilation and sexual torture. This definition is analogous to the definition I use for conflict-related sexual violence (CRSV) in this dissertation.

\textit{Data on Intimate Partner Violence (IPV)}

The 2006 Ugandan DHS was the fourth in the series of surveys that began in 1988. It was the first survey in this series that covered all districts in Uganda. The previous series did not cover the whole country because of insecurity in some areas and excluded areas making up the current districts of Amuru, Bundibugyo, Gulu, Kasese, Kitgum, and Pader, which are some of the districts that were highly impacted by the 20-year conflict (ACCS, 2013). According to the 2002 census, these areas comprise around seven percent of the population of Uganda (Uganda Bureau of Statistics & Macro, 2007). The 2006 UDHS was also the first survey that used a domestic violence module that included measures that focused on violence committed by intimate partners, including acts of physical, sexual and emotional violence. Previous versions only

\textsuperscript{13} If an armed actor has been reported to be involved in the use of sexual violence in a given year and conflict, all violent events connected to the same actor, year and conflict were given the same code for sexual violence.
included items on attitudes towards domestic violence in general, and did not measure violence by spouses and by other household members.

The 2006 UDHS was conducted within a six-month period between May 2006 and October 2006 and obtained information from a random sub-sample\(^{14}\) of ever-married women and men on violence by spouses and by others, and from never-married women and men on violence by anyone, including boyfriends and girlfriends. The survey collected detailed information on physical, sexual, and emotional violence perpetrated by intimate partners, including current and former husbands or partners. Respondents were asked about seven specific acts of physical violence, two acts of sexual violence, and three acts of emotional violence.\(^{15}\) The sample chosen for the domestic violence module was also asked about their attitudes towards wife beating. Although the UDHS also asked men identical questions about violence perpetrated by their current or most recent partners, this chapter is solely focused on intimate partner violence committed by men towards their female partners.

I chose the 2006 DHS because in addition to being the first survey that included questions on intimate partner violence, it was also the only survey that overlapped with currently available armed conflict data and conflict-related events perpetrated by actors known to use sexual violence for Uganda between 1989 and 2007 (Karim et al., 2016).\(^{16}\)

**Analysis**

Since the Ugandan DHS only provides data identifiers at the regional level, I used ArcGIS, a geographic information system mapping tool, to identify the districts for each of the

\(^{14}\) The age, marital status, residential, regional, educational, and wealth index distributions of the sub-sample of respondents selected for the violence module was identical to the entire Ugandan DHS sample (Uganda Bureau of Statistics & Macro, 2007).

\(^{15}\) A full list of the questions can be found in the 2006 Ugandan DHS, under Appendix F (pages 462–463). As of July 29, 2018, the DHS report can be accessed at https://www.dhsprogram.com/pubs/pdf/FR194/FR194.pdf.

\(^{16}\) Although the final 2006 DHS report provides prevalence rates for intimate partner violence (as well as other domestic violence indicators) for the major regions, it does not provide disaggregated prevalence at the district level.
368 clusters that were selected for the 2006 UDHS based on Global Positioning System (GPS) coordinates, namely longitudes and latitudes. Then, the sub-sample of women respondents for the domestic violence module were assigned a district based on their cluster number. A total of 2087 women were eligible for the violence module for the 2006 UDHS. The age, marital status, residential, regional, educational, and wealth index distributions of the sub-sample of women respondents selected for the violence module were identical to the entire UDHS sample of respondents (Uganda Bureau of Statistics & Macro, 2007). Out of this sample, 186 observations had missing latitude and longitude information, and were dropped from the analysis since districts for these observations couldn’t be identified. In addition, 531 observations were dropped for women who indicated they were either visitors, or reported that had just moved to the district where they were interviewed.

This resulted in a final sample size of 1370 women in the UDHS sample of women who responded to the domestic violence module and reported living continuously in the village, town, or city where they were interviewed since at least 2002. The three measure of intimate partner violence I used are: (a) physical violence, (b) sexual violence, and (c) emotional violence. For each of the three measures, I created a dichotomous variable, where “1” was recorded if the respondent said yes to at least one of the questions under each category. A final IPV variable was also created, where “1” was recorded if the respondent said yes to reporting at least one of the three types of intimate partner violence (sexual, physical, or emotional). To measure both women’s and men’s attitudes towards wife beating, I used the five questions used to measure

17 The groupings of households that participated in the survey (clusters) were geo referenced.
18 There were seven questions that assessed physical abuse, two questions that assessed sexual abuse, and three questions that assessed emotional abuse by an intimate partner.
women’s perception of their status. To combine the two datasets (the date on conflict-events and intimate partner violence measures), I created a dichotomous variable where “1” was recorded if respondent lived in any of the districts for which any conflict-event was recorded between 2002 and 2006 (which were the years for which the highest number of conflict-events were reported in Uganda). I then merged the measure of conflict exposure at the district level with information on women’s place of residence in the 2006 UDHS survey. In addition to the descriptive analysis of both datasets (individual and merged), I conducted bivariate analyses to determine the relationships between living in conflict affected districts and experiencing any form of intimate partner violence by key demographic characteristics including age, marital status, education and wealth index. In addition, I also tested associations between living in conflict-affected areas and women’s (and men’s) attitudes towards wife beating.

Methods for Chapters 4 and 5

Research Design

The qualitative research design used in Chapter four and Chapter five was a reflective and iterative process where the activities of developing and modifying theory, elaborating or refocusing the research questions, collecting and analyzing data, as well as identifying and addressing validity threats were interactive, and each component influenced the others as shown in Figure 2.2 (Maxwell, 2012). The research questions were at the center of the design, and were the components that connected most directly to all the other components, including the goals of the study, the theoretical underpinning for the topic’s relevance, the methods used to answer the research questions, and validity threats that needed to be taken into consideration. Moreover, the

19 A full list of the questions can be found in the 2006 Ugandan DHS, under Appendix F (page 454 for women’s attitude, and page 420 for men’s attitude). As of July 29, 2018, the DHS report can be accessed at https://www.dhsprogram.com/pubs/pdf/FR194/FR194.pdf.
research questions and the connections among the different components of the model were not fixed at the start of the study. They were modified and expanded as a result of what was learned on the field during the study’s implementation, including the pilot phase.

Figure 2.2. An Interactive Model of the Research Design


I chose a qualitative approach to study the enduring consequences of CRSV on survivors as well as the indirect impact of CRSV on families for various compelling reasons. In general, qualitative research methods are appropriate for understanding how people assign meaning to the events they experience (Denzin & Lincoln, 2011), while allowing the researcher to explore how people’s perceptions of, and response to, these events influences their behavior (Maxwell, 2012). In this regard, my goal was to explore how participants’ reality and circumstances were shaped either by their own personal CRSV experience or through their interactions with a CRSV family member, as well as the meaning they gave to these experiences.
Second, a qualitative study allows the researcher to explore phenomena, such as feelings and thought processes, that are difficult to extract or identify through quantitative research methods (Strauss & Corbin, 1998). Qualitative research questions often began with *how* or *what*, so that the researcher can gain in-depth understanding of what is going on relative to the topic (Patton, 2005). For example, I explored participants’ experiences with caring for women survivors of conflict-related sexual violence by asking a wide range of *how* and *what* questions, such as: *How did learning about the survivor’s experience of (abduction, rape etc.) affect you? How did your relationship with the survivor change after she came back from abduction? What would you like to share with families of other CRSV survivors based on your experience?*

Interviews were semi-structured. This was the best method to illicit information in this context because the flexibility of this approach, particularly compared to structured interviews, allows for the discovery or elaboration of information that is important to participants, but may not have previously been thought of as relevant by the research team (Gill, Stewart, Treasure, & Chadwick, 2008). The full list of questions used in the interview guides for both survivors and family members is show in Appendix A and Appendix B, respectively.

Third, qualitative research methods are the best approach when trying to understand social processes in context (Esterberg, 2002). This study focused on the experiences of women survivors and family members who were navigating problems faced during war, and in the post-conflict period. Some of the challenges they faced included successfully re-integrating into their former families (for survivors) and caring for women who were abducted and raped, as well as the children they returned with (for family members). Finally, qualitative methods emphasize the researcher’s role as a participant in the study, i.e. researcher’s positionality. This is described in detail under the section *Researcher Positionality.*
Research Site

The study was implemented in partnership with the Justice Reconciliation Project (JRP), and the Women’s Advocacy Network (WAN) at JRP. JRP is a Ugandan non-governmental organization based in Gulu, northern Uganda, whose mission is to empower conflict-affected communities through their active involvement in research, advocacy, as well as the process of justice, healing, and reconciliation. Since 2005, JRP has played a significant role in northern Ugandan through their work in transitional justice, which ensures that local policies and programs are informed by the experiences and needs of conflict-affected populations in Uganda and the Great Lakes region. The WAN is a semi-autonomous group within JRP that was founded by conflict-affected women in 2011. The WAN is comprised of sixteen grassroots women’s groups within Acholi sub-region and has widened its scope to include voices of conflict-affected women from Teso, West Nile and Lango sub-regions (see Figure 1.2). It currently has over 900 members, comprised of Ugandan women affected by war-related sexual and gender-based violence. The group advocates for gender justice, acknowledgment and accountability for the violations they experienced during the northern Ugandan conflict, and serves conflict-affected communities in various ways. This includes, conducting capacity building training in conflict resolution, engaging with various stakeholders and other survivor groups on women’s justice needs, and raising awareness on the plight of sexual violence survivors. For instance, in 2014, the WAN petitioned the Parliament of Uganda for redress for conflict-related and gender-based violations in northern Uganda. The parliament passed a resolution that addressed the requests made by the group through various action points.
Research Team

I was the primary investigator for this project and worked alongside a team composed of two research assistants from JRP, two WAN members who helped us recruit participants in the three districts, and two psychologists from Gulu Women’s Economic Development and Globalization (GWED-G). The psychologists accompanied the team to the field to provide psychosocial care in cases of unintended psychological distress that participants’ might experience during the interviews. GWED-G is one of the main grassroots organizations in the region providing psychosocial support to war victims. JRP had experience working closely with psychologists from GWED-G to provide psychosocial care (when needed) during participatory research projects with war-affected communities. The two research assistants from JRP were both from northern Uganda, had extensive experience working with conflict-affected communities, and conducting interviews with survivors of sexual and gender-based violence. One of the research assistants was also a program officer and a member of WAN.

Before the formal recruitment process began, the research team conducted a small pilot in September 2016 to assess the likely success of proposed recruitment approaches, identify logistical problems that might occur while using the proposed methods, give the research team an opportunity to field test the interview-guides, assess whether the questions prepared were adequate to solicit the types of responses required, and collect preliminary data that could be used to improve the research instruments before full implementation. I used the same criteria for the selection of participants as would be used in the main study. The pilot included interviews with women survivors who were abducted by the Lord’s Resistance Army. Based on our interaction with the participants in the pilot, and the feedback they gave about the questions asked, we updated the interview guides that were used for the main study. Some of the changes made included adding questions regarding whether the family member witnessed the abduction,
and questions about challenges faced around raising children who were born as a result of the abduction and/or forced marriages. Prior to recruitment of participants and data collection, I conducted a short training for the research team on the basics of qualitative methods, including interviewing and data management techniques, as well as sensitivity issues and confidentiality. The Ugandan research team was fluent in English, and different languages (dialects) spoken in the northern region, including Acholi and Lango.

**Recruitment of Participants**

The study was approved by the Human Subjects Protection Committee (HSPC) at the RAND Corporation (July 2016), the Institutional Review Board (IRB) at the Makerere University School of Public Health (July 2016), and the Ugandan National Council for Science and Technology (October 2016). Following ethical approval, participants were recruited through WAN’s network in three of the most war-affected districts in northern Uganda. Two of the districts, Gulu and Pader, were from the Acholi sub-region, while the third district, Lira, was from the Lango sub-region. The research team visited the key WAN leaders in the three different districts and used the introductory scripts (Appendix C and D) to explain the objectives of the research project, and how the outcomes would be used. The leaders were then asked if they would be willing to help the team recruit participants into the study.

To identify eligible participants, I used purposive sampling, in which participants were selected according to predetermined criteria relevant to the research objectives (Guest, Bunce, & Johnson, 2006), so that they could provide information that would be particularly relevant to the setting and research questions (Palys, 2008). Due to the sensitivity of the issues discussed and the difficulty of accessing this population, I worked closely with the teams at JRP and WAN to
make sure that all ethical procedures would be closely followed in order to ensure the safety and rights of participants were fully protected.

Individuals were eligible to participate in the study if: (a) they were over eighteen years old and had experienced at least one form of conflict-related sexual violence or (b) they were over eighteen years old and had at least one female family member (defined as daughter, granddaughter, sister, mother, sister-in-law, niece, partner or wife) who had experienced at least one form of conflict-related sexual violence and with whom they had lived for at least twelve months before and after the incident occurred. Ensuring the recruitment of family members who had lived with survivors upon their return was important because one of the study objectives was to assess how living with (being in close contact) with a CRSV survivor might have affected those closest around them. To protect participants’ confidentiality, I had originally decided to make sure that none of the recruited participants were from the same family. This was also required by the ethical boards unless survivors themselves, after learning about the study’s goals, suggested I approach their family members. This happened in four cases, where survivors who were interviewed at the first phase of the study suggested that the team also approach their mothers for an interview. All four mothers agreed to be interviewed.

I recruited a diverse group of family members with the understanding that different family members (e.g. partners vs. siblings vs. parents) and the gender of the family member (male vs. female) might influence how they responded to the survivors’ experience and the circumstances that followed. This allowed for different viewpoints to be represented in the final data (Robinson, 2014), while also providing flexibility with regards to the final composition of the sample, which was ultimately shaped by our access to participants in the region, and their willingness to participate in the study.
**Interview Setting & Procedure**

Individual face-to-face interviews were conducted over a period of seven months between September 2016 and March 2017. Prior to the start of the interviews, participants were provided with informed consent information in the language of their choice, i.e. English or Acholi (see Appendix E for the English version) that included information about the purpose of the study, risks, benefits, and compensation. The research assistants from JRP also took the time to explain the purpose of the study, information on the informed consent sheet, and answer any questions the participants had. It was emphasized to participants that their participation was fully voluntary, and that the research team would respect their rights to refuse to participate or discontinue participating once the interview started. The participants were also reassured that their refusal to participate would not affect any services or support they were receiving from JRP and WAN. None of the individuals approached refused to participate. Respondents were also informed that there were psychologists from GWED-G that accompanied the research team and were available to talk to them if they wanted to. Seven participants asked to talk to one of the psychologists from the GWED-G team, who provided counseling and encouraged respondents to seek counseling at GWED-G, in instances the psychologist felt the respondent would benefit from additional counseling. All participants gave informed consent before the start of an interview.

To ensure confidentiality, the interviews were conducted in a private place chosen by participants or a setting where participants felt the most comfortable. These included their homes, as well as public spaces that provided privacy. All participants received transportation reimbursement of 10,000 Ugandan Shillings ($3), as is standard in Gulu and surrounding areas. In a few cases, the transportation reimbursement was increased if the participant traveled from a faraway village and incurred additional transportation costs.
In their systematic review of various studies on the recommended sample size for purposive sampling, Guest et al. (2006) conclude that for the most part, data saturation occurs by the twelfth interview (Guest et al., 2006). In addition, Francis et al. (2010) define data saturation when there are three consecutive interviews without additional themes emerging (Francis et al., 2010). To account for attrition and other unknown factors, I planned to recruit approximately 20 survivors and 20 family members of survivors to be interviewed. In addition, setting the minimum sample size to twenty gave me some flexibility and confidence that I would be able to capture most themes relating to the questions asked in a transparent and reliable manner. I reached data saturation by the 19th interview (family members) and 27th interview (women survivors), but decided to conduct three more interviews in both cases to make sure there were no new themes that emerged. In total, 22 family members of survivors and 30 women survivors were interviewed.

I conducted the interviews with assistance from the two JRP research assistants. Two interviews were conducted in English while the rest were conducted in either Acholi or Lango, dialects largely spoken in northern Uganda. During the interviews that were conducted in Acholi or Lango, the second research assistant who was not leading the interview took notes in English. This allowed me to review the notes during the de-briefing session and get a sense of participants responses and emerging themes. Interviews lasted between 60–90 minutes.

After eliciting basic demographic and background related information (Appendix F), questions explored topics around the participant’s experience with CRSV, relationship with the survivor; the participant’s and family’s experience around the survivor’s abduction; interaction with the survivor after her return from the bush,\(^\text{20}\) perceived impacts of these interactions on the

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\(^{20}\) Term used by participants to describe the place abducted women were taken to by rebels from the Lord’s Resistance Army (LRA).
participant, and support or services the participant sought because of these experiences, and other
issues the participant might have faced as a result of having a CRSV survivor in the family.
Interviews started with overarching questions, and follow-up or probe questions were used to
explore topics and elicit detailed narratives about participants’ experiences. This allowed
respondents to discuss issues that were important to them. Questions and topics were informed
by previous research in the region, literature in the field, and developed overtime through
iterations with JRP and WAN.

Data Management & Protection
Following informed consent and participants’ permission, interviews were recorded using the
Olympus DS-3500 Professional Dictation Digital Voice Recorders, which are equipped with
password protection and file encryption options. All participants agreed to be recorded. Each
recording was encrypted immediately after the interview was complete. At the end of each day or
within 24 hours after interviewing (average number of interviews per day was three), the
recordings were uploaded to the interviewer’s laptop and saved under an encrypted folder. The
two JRP research assistances created a verbatim transcript of all recordings within seven days
after each interview was conducted. After all transcripts were translated to English, and verified
by an outside translator, the recordings were deleted. Audio and transcript files did not contain
any identifying information and interviewee’s details were kept confidential and firewalled
through a simple numbering system outlined under the Data Safeguarding Plan (DSP) see
Appendix G.

After comparing 5 randomly selected transcripts that were translated both by the two
research assistants (separately) as well as an outside professional translator who had experience
translating interviews from similar contexts, I decided that the rest of the transcripts should be
translated by the professional translator whose translation provided much more clarity. In addition, the formal translator better captured the essence of what participants were saying because of her mastery of the English language as well as Acholi, and Lango. The final English transcripts were stored on a separate and encrypted file on my RAND computer.

**Researcher Positionality**

Researcher bias is one of the threats to the validity of the conclusions in qualitative research. To address this potential bias, it was important for me to reflect on how my role as the lead researcher as well as being an outsider to the context (northern Uganda) might influence the research process. Positionality is defined as the position the researcher might choose to take within a given research project and can be identified by placing the researcher in relation to three areas: the subject, the participants, and the research context and process (Savin-Baden & Major, 2013). Although some aspects of positionality such as race, gender, and nationality are fixed, others like experience and personal history can be contextual and subjective (Chiseri-Strater, 1996).

To maintain the integrity of the research, positionality required that I identified and recognized my beliefs, values and views towards the research process and anticipated outcomes. Reflexivity, the idea that researchers should acknowledge and disclose their own selves in the research, seeking to understand their part in it or influence on the research, informs positionality (Bradbury Jones, 2007). This was particularly important in this case because the research team and participants in northern Uganda were interested to know why I cared about studying conflict-related sexual violence, and why I wanted to talk to survivors and family members. This required that I took the time to explain my interest in the topic, why I wanted to conduct this study, and what I hoped to change in terms of addressing the salient issues faced by survivors and family
members of CRSV in northern Uganda and other countries. Having these discussion with the
JRP team, the women at WAN who helped as recruit participants as well as the participants I
interviewed helped them understand my intentions, while also allowing me to establish rapport
and gain trust from my research partners and the community. In addition, it was important for me
to recognize that I would be emotionally affected by listening to the traumatic experiences of the
survivors and family members we interviewed (Campbell, 2013). As such, I followed the
suggestions made by Campbell (2013) on how to be an “emotionally engaged researcher”, in
which she makes suggestions on how to “balance methodological rigor with human caring”
while working on difficult topics. This involved allowing myself to feel, while also using self-
care strategies (including seeking professional help to process my emotions) so I could be
objective in my work.

Moreover, although it was impossible to eliminate my potential influence as the researcher, it
was important for me to understand how to use it productively. For instance, during the first
week of data collection, I noticed in the English notes taken by one of the research assistants that
most of the first part of the interview was spent on explaining to the participant who I was. At
times, my presence also seemed to draw attention in some of the remote villages we visited (in
instances where participants chose to be interviewed in their homes). During the debriefing
period, I had an open discussion with the research team, who revealed that my presence during
the interviews at times created a lot of attention and curiosity, and could potentially lead to
response bias. We decided to see if the types of responses we would get in my absence during
the interview process would be better, and they were. Respondents seemed a bit more relaxed
and were more likely to share about their experiences openly to the two JRP research assistants.
This was because the research assistants were known for working with survivors of sexual
violence and had a firmly established rapport with the community. Even though it meant that I would have to miss out on some parts of the interviewing process, it was important for me to recognize how my presence might affect the data collection and step away for that part of the research process.

In addition, to mitigate other forms of researcher bias concerns discussed under Validity, I made sure that I checked in with the research team and some of the key WAN members during the data analysis. Finally, as themes emerged, I used an iterative process to ensure that the conclusions I made were reflective of what was observed in the field.

Validity

In order to avoid possible threats including researcher bias (described under Researcher Positionality in the previous section) and to test the validity of my conclusions, I employed the following three strategies suggested by Maxwell (2012) and Lincoln and Guba (1985): feedback or “member checking”, triangulation, and “rich data” (Lincoln & Guba, 1985; Maxwell, 2012). To prevent potential researcher bias, or selection of data that “stand out” to the researcher during data analysis (Miles & Huberman, 1994), I debriefed with the JRP team regularly to discuss the results, and get feedback about the emerging themes and the conclusions I was making. In addition, I systematically solicited feedback about the data and conclusions from small group of WAN members. The lead research assistant conducted a focus group with 5 participants to go over the results and hear their thoughts about the conclusions that were made. This allowed me to rule out the possibility of misinterpreting the meaning of what participants said, identify my own biases, and ensure that the results and the discussion of findings were a correct reflection of participants’ actual perception. As a means of triangulation, I collected data from multiple sources (survivors and families of survivors) and used more than one research assistant to
conduct interviews. Due to the qualitative nature of this phase of the study, the data was expected to be naturally “rich” since the questions posed allowed participants to give detailed narratives of their experiences and perspectives. In addition, both interviewers wrote de-brief memos (in English) after each interview which helped me understand aspects of discussions that might not have been captured in the recordings, and be familiar with the data immediately after the interviews.

Quality control was ensured through: 1) selecting research assistants from JRP who had extensive experience working with CRSV survivors in northern Uganda, 2) piloting and back-translation of interview protocols, 3) providing training on the basics of qualitative methods including interviewing and data management techniques to interviewers, and 4) scheduling regular meetings with all team members to review data collection, analysis, and other issues that came up on the field.

Analysis

As is the case with most qualitative research, data collection and data analysis happened concurrently (Strauss & Corbin, 1998). The data analysis was guided by a modified approach to grounded theory, a method that allows theories to emerge from data in an inductive way through data collection and analysis (Charmaz, 2006; Glaser & Strauss, 1967). Grounded theory was developed in the 1960s and is considered to be one of the first methodologically systematic approaches to qualitative inquiry (Saldaña, 2015). The process involves careful analytic rigor by applying specific types of codes to data through a series of cumulative coding cycles that ultimately lead to the development of themes and theory that emerge from the data (Rubin & Rubin, 2011). To help organize the data and facilitate initial coding of the transcripts, I also developed a deductive codebook based on the main topics covered in the interview protocol and
key themes identified from the pilot interviews. The goal of coding is to rearrange the data into categories that facilitate comparison between things in the same category and aid in the development of theoretical concepts and themes (Maxwell, 2012). Using this hybrid method allowed me to categorize segments of the data that seem meaningful in some way based on the issues I was trying to capture through my research questions, while also allowing for an inductive attempt to capture new insights. Data were managed using the qualitative and mixed methods software MAXQDA Analytics Pro 12.

Steps in Data Analysis

After each interview, I read the notes in English produced by one of the research assistants and wrote memos on what I was observing in the data. I then moved to first cycle of coding – an open coding process for the first stages of data analysis where I coded the first five transcripts, splitting the data into individually coded segments. During this process, in vivo coding was used. In vivo is a first cycle coding method used for the first stages of data analysis and allows for participants’ voices to be captured directly from the data (Strauss, 1987). During this process, emergent codes were generated from the data and discussed with the JRP research team. These first set of codes were extracted from the data, and listed randomly as the first iteration of code mapping.21

Next, I transitioned to second cycle coding, an advanced way of reorganizing and reanalyzing data coded through first cycle methods. During this process, I used focused coding, a second cycle analytic process which searched for the most frequent or significant codes to help develop the most salient categories in the data. This procedure requires decisions be made about which initial in vivo codes make the most analytic sense (Charmaz, 2008), and the process was

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21 Code mapping documents how a list of codes gets categorized, recategorized and conceptualized throughout the analytic process and serves as part of the auditing process for the study (Saldaña, 2015).
informed by reexamining the research questions, and discussions with the rest of the JRP team. When there were disagreements, I conducted a secondary review in order to achieve consensus, and changes to the coding were made accordingly (Bernard, 2011). Topical codes were also used to index family members (e.g. parent, spouse, sibling etc.) to compare perspectives and experiences across different groups. Through this process, I developed a final codebook, which I then used to code the rest of the transcripts.

Following second cycle coding, a smaller list of broader categories and themes were developed. These final categories became the major components of the research study and guided the writing of the results section. Participant quotes were used to emphasize or support complex concepts as perceived by participants. The final number of major concepts presented in both chapter four and chapter five followed Creswell’s suggestion to present five to six major themes (Creswell, 2012).
3. Overview of the Ugandan Conflict and Women’s Experience of Intimate Partner Violence

Background

Armed conflicts are known to have long-term consequences that extend beyond deaths of individuals in battle, and can lead to social, economic, and political disintegration. Women, men, children, and families continue to suffer in the post-conflict period due to injuries, permanent disabilities, and psychological problems including sustained trauma as a result of exposure to different forms of violent acts (Murray, King, Lopez, Tomijima, & Krug, 2002). One negative impact of armed conflict that has not been fully explored is its potential linkage to the incidence of higher levels of violence against women, such as intimate-partner violence (IPV) during war and in post-conflict settings. Intimate partner violence is one of the most common forms of violence against women\(^{22}\) and refers to “behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviors” (WHO, 2012). Although women can also be violent in their intimate relationships with men and in same-sex partnerships, the most common perpetrators of violence against women are male intimate partners or ex-partners (Heise, Ellsberg, & Gottemoeller, 1999). As such, this chapter primarily focuses on violence committed against women by male partners. The term ‘domestic violence’ is sometimes used in many countries to refer to partner violence, and can incorporate child or elder abuse, as well as abuse.

\(^{22}\) “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (General Assembly Resolution 48/104 Declaration on the Elimination of Violence against Women, 1993).
Although research on how war exacerbates intimate partner violence is limited, a few studies have assessed how exposure to conflict-related violence can affect relationships between intimate partners. In one study from Latin America, Gutierrez & Gallegos (2016) studied the long-term impact of early exposure to war related violence on the incidence of intimate partner violence in adult relationships. The authors found exposure to civil violent events during early teenage years increased Peruvian women’s risk of becoming victims of intimate partner violence in adult relationships. They also found that women who were exposed to more war related violence were more likely to justify the use of violence against women and remain in violent relationships. Another study from Peru by Leiby, Oestby & Nordås (2018) found that exposure to conflict significantly increased the risk of partner abuse. The authors showed that local exposure to armed conflict violence, and especially conflict-related sexual violence (CRSV)\(^{23}\) increased a woman’s risk of experiencing intimate partner violence in the post-conflict period. The authors posit that the experience of sexualized violence (compared to non-sexualized violence) during war makes a difference in how much violence occurs in intimate relationships during the post-conflict period. They hypothesize that war can potentially desensitize individuals and society to violence so much that individuals may start to normalize its occurrence in intimate relationships. In another study from Colombia, Noe and Rieckmann (2013) analyzed the impact

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\(^{23}\) Conflict-related sexual violence is defined as “rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization and other forms of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is linked, directly or indirectly (temporally, geographically or causally) to a conflict. This link may be evident in the profile of the perpetrator; the profile of the victim; in a climate of impunity or State collapse; in the cross-border dimensions; and/or in violations of the terms of a ceasefire agreement” (Ki-Moon, 2015).
of civil conflict on intimate partner violence and found that women who lived in a district with high conflict intensity had up to ten percent higher chance of being a victim of intimate partner violence compared to women living in district with an average or lower conflict intensity (Noe & Rieckmann, 2013). The authors postulate that civil conflict might have altered the behavior of the population that witnessed the violence towards a more violent pattern, and led to an increased acceptance of violence against women (Noe & Rieckmann, 2013).

In one of the first studies that examined the effect of exposure to armed conflict on attitudes toward intimate partner violence in sub-Saharan Africa, Mattina and Shemyakina (2017) found that men and women who were exposed to conflict at a young age were more likely to internalize and accept intimate partner violence. Moreover, women who experienced conflict between the ages of six and 10 were more likely to report being a victim of intimate partner violence (La Mattina & Shemyakina, 2018). Their findings suggest that growing up in armed conflict could influence one’s future attitudes toward intimate partner violence, and potentially increase the probability that individuals exposed to armed conflict could become a victim or perpetrator of IPV. Similarly, a study from northern Uganda that examined the role of armed conflict on family violence against children found that war-related violence contributed to the continuity of violence against children in the post-conflict period (Saile, Ertl, Neuner, & Catani, 2014).

In Uganda, the incidence of intimate partner violence is high. According to the most recent 2016 Demographic Health Survey (DHS), 56 percent of ever-married women said they had experienced some form of physical, sexual, or emotional violence by their current or most recent spouse or partner. Close to 40 percent of these women experienced such violence in the 12-

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24 The authors’ analysis covered 20 sub-Saharan African countries affected by conflict for which data were available, including Burkina Faso, Burundi, Cameroon, Comoros, Democratic Republic of Congo, Cote d’Ivoire, Ethiopia, Gabon, Ghana, Kenya, Lesotho, Liberia, Madagascar, Mali, Mozambique, Niger, Nigeria, Rwanda, Senegal and Sierra Leone.

25 Ever-married included women who were currently married or in partnerships.
month preceding the survey (Uganda Bureau of Statistics & ICF, 2018). The 2006 UDHS was the first nationally representative survey conducted in the country. Due to insecurity in the northern region because of the armed conflict that lasted between 1986–2006, surveys prior to the 2006 UDHS excluded districts in the north and were not nationally representative. Similarly, the 2006 UDHS was the first survey that included a domestic violence module that measured violence by intimate partners, including spouses.

Intimate partner violence has long-term negative consequences for women who experience it as well as their families and society in general. For instance, it can impact survivors' lifelong health, educational, and professional prospects, as well as a country’s economic, social, and political development (Garcia-Moreno, Jansen, Ellsberg, Heise, & Watts, 2006). Studying the correlation between war related violence and intimate partner violence can improve our understanding of how war impacts violence at home and help inform the design of prevention and response strategies tailored to post-conflict societies. There are currently no studies that have used nationally representative data to explore the prevalence of intimate partner violence in conflict-affected regions of Uganda.

Objectives

In this chapter, my aim was to provide an overview of the geographical prevalence of conflict-events by actors known to use sexual violence in Uganda and ascertain the prevalence of intimate partner violence among women living in districts that were affected by the conflict using a representative sample of women who completed the domestic violence module for the 2006 Ugandan DHS. The research questions are as follows:

26 An individual victim of any form of sexual violence who survived a sexual violence incident.
a) Which parts of Uganda experienced the highest level of conflict-events by actors known to use sexual violence?

b) What is the prevalence of IPV among women living in conflict-affected districts between 2002 and 2006?

c) What is the association between women’s (and men’s) attitudes towards wife beating and living in conflict-affected areas?

Results

Overview of Conflict-events by Armed Actors Using Sexual Violence

The GEO-SVAC dataset for Uganda covers the years 1989 to 2007 and provides information on the spatial patterns of armed actors reported to be using sexual violence during the Ugandan conflict. The two main sides that were involved in the Ugandan conflict were the Ugandan government and the Lord’s Resistance Army (LRA). Although there were six other opposition groups involved in the conflict at some point, the LRA was the main rebel group responsible for 80 percent of the conflict-events (N= 821) reported in the GEO-SVAC for Uganda.

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27 Details about the Lord’s Resistance Army and its involvement in the Ugandan conflict is provided in Chapter one.

28 The other rebel or opposition groups involved were the Congolese Tutsi-led rebel group called the National Congress for the Defense of the People (CNDP), Allied Democratic Forces (ADF), Sudan People’s Liberation Movement/Army (SPLM/A), Uganda People’s Army (UPA), the Uganda National Rescue Front (UNRF II), and the West Nile Bank Front (WNBF).
Figure 3.1. Conflict-events by Actors Reported to be Using Sexual Violence in Uganda between 1989–2007

SOURCE: GEO-SVAC dataset.

Based on the GEO-SVAC dataset, a total of 1012 conflict-events were reported in a total of 38 Ugandan districts. Figure 3.1. shows a temporal stacked area plot of conflict events by actors reported to be using sexual violence in Uganda between 1989 and 2007. The prevalence score is based on the highest prevalence score of all three SVAC sources\(^{29}\) and any of the two actors (i.e. government forces or rebel groups) and were coded as follows: “0” = no mention of sexual violence related to the conflict; “1” = some sexual violence; “2” = several or many instances of sexual violence; and “3” = massive use of sexual violence. The years between 2002 and 2006 saw the highest instances of conflict events by actors known to use sexual violence. Just in these five years, there were a total of 626 conflict-events (93 in 2002; 93 in 2003; 199 in 2004; 163 in

\(^{29}\) The three SVAC data sources reported are United States State Department, Amnesty International, and Human Rights Watch. More details about these sources are found in (Cohen & Nordås, 2014).
2005; and 67 in 2006) out of which 522 (83 percent) involved many instances of sexual violence (see Table 3.1).

Table 3.1. Number of Conflict-events Reported by Prevalence of Sexual Violence in Uganda between 1989–2007

<table>
<thead>
<tr>
<th>Year</th>
<th>No mention of SV</th>
<th>Some SV</th>
<th>Several/Many instances of SV</th>
<th>Massive use of SV</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1989</td>
<td>18</td>
<td>18</td>
<td></td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>1990</td>
<td>15</td>
<td>12</td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>1991</td>
<td>2</td>
<td>7</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>1992</td>
<td>2</td>
<td>12</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>1994</td>
<td>1</td>
<td>15</td>
<td></td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>1995</td>
<td>1</td>
<td>16</td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>1996</td>
<td>57</td>
<td>57</td>
<td></td>
<td></td>
<td>57</td>
</tr>
<tr>
<td>1997</td>
<td>52</td>
<td>53</td>
<td></td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>1998</td>
<td>23</td>
<td>46</td>
<td></td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>1999</td>
<td>32</td>
<td>32</td>
<td></td>
<td></td>
<td>32</td>
</tr>
<tr>
<td>2000</td>
<td>28</td>
<td>18</td>
<td>199</td>
<td>1</td>
<td>60</td>
</tr>
<tr>
<td>2001</td>
<td>13</td>
<td>93</td>
<td></td>
<td></td>
<td>93</td>
</tr>
<tr>
<td>2002</td>
<td>93</td>
<td>163</td>
<td></td>
<td></td>
<td>93</td>
</tr>
<tr>
<td>2004</td>
<td>199</td>
<td>199</td>
<td></td>
<td></td>
<td>199</td>
</tr>
<tr>
<td>2005</td>
<td>163</td>
<td>163</td>
<td></td>
<td></td>
<td>163</td>
</tr>
<tr>
<td>2006</td>
<td>10</td>
<td>67</td>
<td></td>
<td>1</td>
<td>78</td>
</tr>
<tr>
<td>2007</td>
<td>11</td>
<td>11</td>
<td></td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Grand Total</td>
<td>31</td>
<td>251</td>
<td>729</td>
<td>1</td>
<td>1012</td>
</tr>
</tbody>
</table>

SOURCE: GEO-SVAC dataset.

Uganda is divided into four administrative regions: northern, eastern, central and western. These regions are further divided into 111 districts, and one capital city (Kampala). Figure 3.2 shows the 38 districts for which conflict-events were reported between 1989 and 2007 in Uganda. Eighteen of these districts were in the north, 11 were in the western region, seven were in the eastern region, and two (Wakiso and Mubende) were in the central region. All 38 districts are shown under Figure 3.2. The highest number of conflict events were reported in five
northern Ugandan districts: Amuru (N = 182), Gulu (N=118), Kitgum (N = 237), Lira (N = 33), and Pader (N = 203); and two western districts: Bundibugyo (N = 50), and Kasese (N = 49).

Figure 3.2. Conflict-events Perpetrated by Groups known to use Sexual Violence in Uganda between 1989–2007

SOURCE: GEO-SVAC dataset.
Figure 3.3. Conflict-events by Actors Reported to be Using Sexual Violence (SV) for all Ugandan Districts between 2002 and 2006

SOURCE: GEO-SVAC dataset.
Figure 3.3. shows all the conflict-events by actors reported to be using sexual violence for the 19 Ugandan districts where conflict-events were reported between 2002 and 2006. It is important to note that out of these 19 districts, the districts that experienced the highest number of events with many instances of sexual violence were in northern Uganda: Pader, Kitgum, Amuru, Gulu, and Lira.

**Descriptive Summary of Intimate Partner Violence**

The results provided in this section are for women in the DHS sample who were ever married (partnered) and reported living continuously in the village, town, or city where they were interviewed since at least 2002 ($N=1160$). The 2006 Ugandan DHS sample included 56 districts. There were 14 districts that matched with the conflict data available from the GEO-SVAC dataset. Table 3.2. shows the descriptive (weighted) statistics for the women in this sample by key demographic characteristics including age, employment, marital status, region, education, and wealth. The percentage of women in this sample who lived in any of the 14 districts that experienced violence between 2002 and 2006 are also presented.

Overall, 67.7 percent of women in the sample reported experiencing at least one form of intimate partner violence. Over 50 percent of women reported experiencing either emotional or physical violence, while around 31 percent reported experiencing sexual violence. Close to 20 percent of women in this sample lived in one of the conflict-affected districts between 2002 and 2006. Out of the women who lived in conflict-affected districts, close to 28 percent lived in the eastern region, 65.4 percent lived in the northern region, and 49 percent lived in the western region. When looking at the prevalence by areas of conflict, 65.6 percent of women who lived in conflict-affected areas reported experiencing at least one form of IPV.
Table 3.2. Percentage of Ever Married Women Who Experienced Emotional, Physical, or Sexual Violence by their Husband or Partner, Uganda 2006 (weighted)

<table>
<thead>
<tr>
<th>Background characteristic</th>
<th>Emotional violence (EV)</th>
<th>Physical violence (PV)</th>
<th>Sexual violence (SV)</th>
<th>EV, PV or SV</th>
<th>Lived in conflict-affected district*</th>
<th>Number of women</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15-19</td>
<td>38.0</td>
<td>51.1</td>
<td>21.8</td>
<td>53.8</td>
<td>47.4</td>
<td>15</td>
</tr>
<tr>
<td>20-24</td>
<td>47.8</td>
<td>45.4</td>
<td>31.6</td>
<td>67.6</td>
<td>22.7</td>
<td>155</td>
</tr>
<tr>
<td>25-29</td>
<td>44.9</td>
<td>54.7</td>
<td>28.9</td>
<td>71.3</td>
<td>19.5</td>
<td>203</td>
</tr>
<tr>
<td>30-39</td>
<td>54.4</td>
<td>53.8</td>
<td>35.4</td>
<td>71.1</td>
<td>17.4</td>
<td>394</td>
</tr>
<tr>
<td>40-49</td>
<td>50.6</td>
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<td>31.4</td>
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</table>

*Lived in one of the 14 districts for which conflict-events were reported between 2002 and 2006
§Women who were separated, widowed or divorced were excluded

SOURCE: 2006 UDHS.
Women between the ages of 25–39 were more likely to report higher experience of IPV (>70 percent). Women with higher education, and the lowest two wealth quintiles were more likely to report higher levels of IPV when compared to women with less than a secondary education, and in the middle or highest two wealth quintiles. In addition, over 75 percent of women whose partners consumed alcohol reported IPV compared to 57.6 percent of women whose partners did not consume alcohol. Women who witnessed their father’s beating their mother were also more likely to report experiencing IPV compared to women whose father did not beat their mothers (74.9 percent vs. 59.5 percent). In terms of IPV experience, the highest IPV percentages were reported for the southwest (78.3 percent), followed by eastern (76.2 percent) and central 1 (75.9 percent) regions.

Table 3.3. shows background characteristics for the sub-sample of women who had experienced at least one form of intimate partner violence ($N = 693$). Over 76 percent of the women in this subsample had experienced emotional violence, while 74 percent and 46 percent reported experiencing physical and sexual violence respectively. Similar to the full sample, when looking at the women who lived in conflict-affected districts, 86.2 percent of women living in conflict-affected districts reported physical violence compared to 71.2 percent of women living in districts not affected by conflict. When it comes to emotional and sexual violence, women living in districts without conflict reported higher levels of emotional (75 percent vs. 71.9 percent) and sexual violence (47.1 percent vs. 43.6 percent).
Table 3.3. Background Characteristics of Ever Married Women Who Experienced Intimate Partner Violence, Uganda 2006 (weighted)

<table>
<thead>
<tr>
<th>Background characteristic</th>
<th>Emotional violence</th>
<th>Physical violence</th>
<th>Sexual violence</th>
<th>Lived in conflict-affected district</th>
<th>Number of women</th>
</tr>
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<td>61.3</td>
<td>44.8</td>
<td>7.3</td>
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<td>75.2</td>
<td>46.6</td>
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<td>75.8</td>
<td>53.5</td>
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<td>58</td>
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<td>40.7</td>
<td>52.9</td>
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<td>73.9</td>
<td>46.4</td>
<td>19.4</td>
<td>693</td>
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</tbody>
</table>

*Lived in one of the 14 districts for which conflict-events were reported between 2002 and 2006
§Women who were separated, widowed or divorced were excluded

SOURCE: 2006 UDHS.
When it came to reports of different form of IPV, as well as IPV in general, there were no statistically significant differences between women who lived in conflict affected areas and those who lived in areas with no conflict. See Table 3.4. for details.

**Table 3.4. Associations between Living in Conflict-affected Areas and Reporting Intimate Partner Violence**

<table>
<thead>
<tr>
<th></th>
<th>Lived in area with conflict (N = 204) percent</th>
<th>Lived in area with no conflict (N = 820) percent</th>
<th>Designed-based (F) statistic*</th>
<th>(p) value</th>
</tr>
</thead>
<tbody>
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<td>51.1</td>
<td>0.186</td>
<td>0.667</td>
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<td>48.4</td>
<td>2.424</td>
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<td>32.1</td>
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<td>0.490</td>
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<td>65.9</td>
<td>68.1</td>
<td>0.186</td>
<td>0.666</td>
</tr>
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</table>

*The designed-based \(F\) statistic is a corrected weighted Pearson chi square statistic that is appropriate for complex survey designs.

**SOURCE:** 2006 UDHS.

Comparing across age groups, women between the ages of 25 and 39 reported higher percentages of intimate partner violence (~72 percent) compared to women in other ages (Designed-based \(F\) \(13.62\ N = 1143\) = 2.07 \(p = 0.09\)). Some regional differences also emerged regarding experiences of all three forms of IPV (Table 3.5.). Comparing across regions, women living in northern and western region reported significantly lower percentages of emotional and sexual violence, compared to women living in the other six regions. When it came to physical violence, women living in the eastern region reported significantly higher levels of physical violence (~69 percent) followed by women living in southwest (~60 percent), western (59 percent) and northern (~46 percent) regions.
Table 3.5. Percent within Group by Region Reporting Different forms of IPV (women)

<table>
<thead>
<tr>
<th>Region</th>
<th>Central 1 (N = 72) percent</th>
<th>Central 2 (N = 107) percent</th>
<th>Kampala (N = 58) percent</th>
<th>East Central (N = 116) percent</th>
<th>Eastern (N = 172) percent</th>
<th>North (N = 108) percent</th>
<th>West Nile (N = 59) percent</th>
<th>Western (N = 161) percent</th>
<th>Southwest (N = 169) percent</th>
<th>Designed-based F statistic</th>
</tr>
</thead>
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<td>Emotional violence</td>
<td>63.7</td>
<td>37.3</td>
<td>43.7</td>
<td>56.1</td>
<td>53.7</td>
<td>39.3</td>
<td>30.1</td>
<td>44.7</td>
<td>67.6</td>
<td>4.13***</td>
</tr>
<tr>
<td>Physical violence</td>
<td>42.4</td>
<td>34.2</td>
<td>32.3</td>
<td>44.5</td>
<td>68.9</td>
<td>45.6</td>
<td>59.1</td>
<td>47.1</td>
<td>56.9</td>
<td>4.31***</td>
</tr>
<tr>
<td>Sexual violence</td>
<td>37.3</td>
<td>33.4</td>
<td>23.4</td>
<td>42.1</td>
<td>39.9</td>
<td>19.5</td>
<td>9.3</td>
<td>25.1</td>
<td>35.7</td>
<td>3.72***</td>
</tr>
<tr>
<td>Any form of IPV</td>
<td>75.9</td>
<td>54.3</td>
<td>56.4</td>
<td>71.1</td>
<td>76.2</td>
<td>58.4</td>
<td>64.6</td>
<td>61.7</td>
<td>78.3</td>
<td>2.79**</td>
</tr>
</tbody>
</table>

Two-tailed significance: *p < .05; **p < .01; ***p < .001

SOURCE: 2006 UDHS.

In the full sample, over 76 percent of women agreed with at least one specified reason that justified a husband to hit or beat his wife. When comparing women by their place of residence (i.e. living in a conflict affected region vs. living in a region with no conflict), women living in conflict-affected regions were more likely to accept wife beating (82 percent) compared to women living in areas with no conflict (75 percent) (Designed-based $F(1, N = 1103) = 3.97$ $p = 0.04$). No significant differences were found when sorting by type of IPV.

A final analysis looked at the attitude of men who were selected for the domestic violence module, were ever married (partnered), and reported living continuously in the village, town, or city where they were interviewed since at least 2002 ($N = 1511$). Sixty-two percent of men agreed with at least one specified reason that a husband was justified in hitting or beating his wife. However, there were some regional differences in terms of men’s attitudes towards wife beating. Compared to men living in other regions, attitudes towards wife beating was less accepted by men living in the northern (53.1 percent), western (57.3 percent) and southwest (52.1 percent) regions (Design-based $F(6.18, 2168.25) = 3.6205; p = 0.0012$).

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30 The five questions asked women and men whether or not a husband is justified in hitting or beating his wife if she: (a) burns the food, (b) argues with him, (c) goes out without telling him, (d) neglects the children, and (e) refuses to have sexual intercourse with him.
Discussion

In this chapter, I provide an overview of the Ugandan conflict, with a focus on war related events perpetrated by groups known to use sexual violence during war. I used data on conflict events, including those perpetrated by actors known to use sexual violence during war, and a nationally representative sample from the 2006 Ugandan Demographic Health Survey (UDHS), to provide a descriptive summary of women’s experience with different forms of intimate partner violence (IPV) by different demographic characteristics. This included prevalence of IPV for areas that were affected by conflict during the four years (2002–2006) when the Ugandan conflict was at its peak.

The geo-coded conflict-data showed the geographical landscape of violent events perpetrated by governments and other groups that were reported to be using sexual violence in the Ugandan conflict between 1989 to 2007. Most of the areas that experienced conflict-events, and specifically conflict-events perpetrated by groups that were known to use sexual violence were in the northern region. The areas that experienced the highest conflict-events, where several instances of sexual violence were recorded were mostly concentrated in four northern districts: Kitgum, Amuru, Pader, and Gulu. This is consistent with other analysis that have shown that communities in northern Uganda were the ones that suffered the most from the protracted and brutal 20-year conflict (ACCS, 2013).

When it came to intimate partner violence or IPV, the results showed that IPV was quite high in Uganda, with over 67 percent of women in the sample in this study reporting at least emotional, physical or sexual violence. This is consistent with prevalence rates reported in the two subsequent surveys (2011 UDHS and 2016 UDHS) where 59.7 percent and 56 percent of women reported experiencing at least one form of IPV (Uganda Bureau of Statistics & ICF, 2012; Uganda Bureau of Statistics & ICF, 2018). Moreover, Uganda’s IPV prevalence rate is
almost double the global average (30 percent) (Garcia-Moreno et al., 2013). In this study, a higher proportion of women living in non-conflict areas reported experiencing emotional (51 percent vs. 47 percent) and sexual violence (32 percent vs. 29 percent), while a greater proportion of women in conflict-affected areas reported experiencing physical violence (57 percent vs. 48 percent), although the differences between groups were not statistically significant. In the few studies available on this topic, researchers have found exposure to armed conflict events to significantly increase women’s experience of domestic violence in the post-conflict period, see for example Leiby, Oestby & Nordås (2018). Looking at a representative sample from Peru, the authors suggest that women who lived in areas that experienced higher sexual violence were more likely to experience violence in intimate relationships. In this study, the associations between living in areas of conflict and experiencing any form of IPV was examined using multiple logistic regression controlling for socio-demographic characteristics, including living in urban or rural area, age group, education level, marital status, and household wealth index. Given the small sample size, no statistically significant results were obtained. However, the direction of the coefficients mirrored the prevalence results, where women living in conflict-affected areas reported less IPV compared to women living in non-conflict areas. Given this counter-intuitive result, future research should examine how living in a conflict-affected or post-conflict area influences different IPV outcomes for women, and also assess other contextual risk factors.

In the bivariate analysis, statistically significant differences were found between age groups for all three forms of intimate partner violence. Women between the ages of 20–24, and 25–39 reported the highest frequencies for overall IPV, this is similar to other studies in sub-Saharan Africa where young women (aged 20–24) disclose the highest prevalence of partner violence
victimization (McCloskey, Boonzaier, Steinbrenner, & Hunter, 2016). When compared across regions, there was a statistically significant difference between the nine regions for all forms of violence as well as IPV in general. Women living in northern and west Nile regions reported the lowest frequencies for sexual and emotional violence.

Acceptance of wife beating, one type of physical violence towards women, is ubiquitous among both men and women in most low-income countries, especially sub-Saharan Africa. Studies from sub-Saharan Africa that assessed attitudes of women and men towards perpetration of physical violence towards women by an intimate partner found that women and men living in African countries were more likely to find this type of violence acceptable (Tran, Nguyen, & Fisher, 2016). In this study, a higher proportion of men living in non-conflict regions justified wife beating compared to men living in conflict-affected areas. However, when looking at attitudes of women, a higher proportion of women living in conflict-affected areas justified wife beating. It is also worth noting that current measures on attitudes only assess attitudes towards physical abuse and don’t ask about attitudes around emotional or sexual violence. This could potentially underestimate the general acceptance of intimate partner violence against women. Future research could explore how attitudes of both women and men towards different forms of IPV influences women’s experience of IPV.

Limitations

A few limitations should be noted. Although this was the first DHS survey that included the domestic violence module for Uganda, only a subsample of respondents took the domestic violence module which reduced the sample size significantly. Secondly, since the survey did not have a district variable, observations without GPS data were dropped since the district couldn’t be identified, further reducing the sample size. Thirdly, there is no data on sexual violence
prevalence for the Ugandan conflict. Therefore, I used the conflict-events data by actors known
to perpetuate sexual violence as a conservative estimate and proxy for the use of sexual violence
during the Ugandan conflict. However, this might not be a true representation and perhaps an
underestimation of the levels of sexual violence women experienced during the 20-year conflict.

Summary

In conclusion, this chapter provides the first summary of IPV prevalence, accounting for
respondent’s exposure to conflict-events, including those that might have involved the use of
sexual violence. Although the limitations in the data didn’t allow for observing significant effects
for associations between living in conflict-affected areas and experiencing IPV, there are some
interesting observations worth exploring in future studies. These include testing associations
between men’s attitude towards IPV and women’s experience of IPV in conflict-affected
settings; and exploring potential mechanisms between men’s rejection of wife beating and
women’s outcome for various IPV measures.
4. Enduring Consequences of Conflict-Related Sexual Violence: Perspectives of Women Survivors

Background

Sexual violence can have substantial and long-lasting health, social, and economic consequences for survivors (Amowitz et al., 2002; Johnson et al., 2008; Kim et al., 2007). Some of the deleterious physical health consequences of sexual violence include reproductive health problems, such as traumatic genital inflammatory disease, infertility, and HIV/AIDS (Liebling-Kalifani et al., 2013; Longombe, Claude, & Ruminjo, 2008; Ward & Marsh, 2006). Moreover, high levels of mental health issues including anxiety disorders, suicidality, alcohol and substance abuse, as well as post-traumatic stress disorder (PTSD) have been reported among survivors (Joachim, 2005; Liebling-Kalifani et al., 2008; Lunde & Ortmann, 1998).

Sexual violence also exposes survivors to stigmatization and can affect how they are perceived within their families and communities (Josse, 2010). It can also have an impact at the family and community levels. Parents might not be willing to accept a young unmarried daughter who has been raped; rape survivors might be unable to continue caring for their children either for physical or psychological reasons; communities might reject survivors, and children born from an incident of rape might face stigma (Jina & Thomas, 2013).

The above-mentioned consequences can especially be exacerbated when the experience of sexual violence occurs within the context of conflict, in addition to failed health and social institutions. Beyond exposing survivors to stigma and discrimination, experiencing CRSV can

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31 The term survivor is used to describe an individual victim of any form of sexual violence who survived a sexual violence incident.
affect the social standing of survivors and families, limit their access to social services, and prevent them from engaging in the labor market (Josse, 2010). Moreover, families and communities often reject children born from an incident of war-related rape, which might exacerbate survivors’ trauma and efforts to safely reintegrate into their former lives and communities (Smith, 2005).

Due to the risks, threats, and trauma associated with reporting conflict-related sexual violence, it continues to be dramatically underreported and research on its long-term effect on survivors is limited. Although there is some research on the health, social, and economic consequences of rape in war settings (Amowitz et al., 2002; Kim et al., 2007), the impacts of other types of sexual violence including sexual slavery via forced marriages, and forced pregnancy—as was experienced by survivors in northern Uganda—is not well understood.

In northern Uganda, a country that was in protracted conflict for more than 20 years, one in three women report having suffered at least one form of conflict-related sexual violence (CRSV), including abduction, forced marriage, forced pregnancy, and rape (Kinyanda et al., 2010). According to population-based studies, over 26 percent of female youth (aged 14–35) surveyed in northern Uganda said they were abducted by the Lord’s Resistance Army (Annan, Blattman, Mazurana, & Carlson, 2011). Most abducted females were forced into marriages, experienced sexual abuse or forced sex in the context of these unions, and became (unwilling) mothers as a result. Multiple studies have explored the impact of the Ugandan conflict, and specifically the widespread abduction, on the health and status of women who were rescued after the war ended in 2006 see for example (Amone-P'Olak, 2006; Annan, Blattman, & Horton, 2006; Annan & Brier, 2010). Scholars have also explored the specific challenges faced by children born in captivity (Shanahan & Veale, 2016; Veale, McKay, Worthen, & Wessells, 2013; Veale &
However, northern Uganda remains one of the most understudied countries in the region. After a decade since the war ended, there is still a lot we don’t know about what the long-term effects of experiencing conflict-related sexual violence have been on survivors, including how spousal and familial relationships have been affected as a result of this experience.

Objectives

In this chapter, my aim was to assess the persisting impact of conflict-related sexual violence (CRSV) on the health and social well-being of survivors. I explored these issues through the following overarching questions:

1. How has the experience of CRSV continued to affect the physical, psychological, and social well-being of women survivors?

2. How do women survivors think their CRSV experience has impacted their relationship with different family members?

3. What kind of support, including personal relationships and social services do women survivors seek or/and find the most helpful?

Results

In this phase of the study, 30 women who were survivors of at least one form of conflict-related sexual violence were interviewed. All of the women were abducted by the Lord’s Resistance Army between 1989 and 2005, while most women were abducted during mid to late 1990s when Uganda’s insurgency was at its peak. The length of abduction ranged from two weeks to nine years, and average time for the sample was 4.7 years. Participants in this study returned from abduction between 1996 and 2007. By the time this study was conducted between
Oct 2016 and Mar 2017, it had been an average of 14 years since women in the study had returned.

All participants reported experiencing at least two forms of conflict-related sexual violence during their captivity. These included forced marriages (partnerships), rape (both within the context of forced marriages and by multiple rebels or government forces at different times), and forced pregnancy. The average age for the sample at the time of the interview was 37, and ranged from 23 to 60. The age at which participants reported being abducted ranged from when they were eight years old to 36 years. Twenty-six women (87 percent) returned with at least one child; seven of these women came back with two or more children. At the time of the interview, seventy percent (N=21) women in the sample were either married on in a partnership. Full details on the key demographic features of all participants, including current marital status, occupation, and education is shown in Table 4.1.

Findings are divided into four sections. The first section describes the persisting health related challenges participants reported as a result of experiencing conflict-related sexual violence. In general, participants opinions about the persisting impact of CRSV on their health fell into two main areas: physical, and emotional (psychological) health issues they continue to face. These include chest pain, untreated sexually transmitted infections, and a range of psychological problems such as anxiety, depression, and nightmares.

The second section focuses on issues more specific to participants’ opinions about what factors affected their relationship with family members and intimate partners after they returned from abduction and rejoined families. The three main themes that emerged were related to rejection by family members and intimate partners, impact of CRSV on new or old intimate relationships, and challenges related to children born in captivity.
The third section focuses on the types of formal and informal care that survivors sought, barriers to accessing health and other social services, and types of support they found to be the most helpful. Most participants identified fear of disclosure of CRSV to family members, not knowing how to look for help, and being unable to find the type of healthcare they needed as some of the main reasons they didn’t seek care. For almost all participants, the most helpful source of support came from women who had gone through a similar ordeal.

The last section presents recommendations participants had for improving their access to formal and informal care, as well as the types of coping mechanisms that helped them become resilient. The three main themes that emerged were around forgiveness, seeking counseling, and finding peer support among the community of women that experienced sexual violence during the war. I provide a detailed discussion for each of the four sections using illustrative quotes directly from participants.

Persisting Health Challenges

Physical health

When asked about the types of problems they are currently facing, over two thirds of participants (N=27) raised issues surrounding persisting physical health problems related to their CRSV experience and abduction. These included, chronic chest pain, untreated sexually transmitted infections, and anal cancer in a few instances. Ajok, a 31-year-old survivor from Gulu reported,

I faced sexual violence over and above all other problems because in the first place, I was given to an older person. Secondly, when he wanted to make me his wife, I was beaten and I became unconscious and eventually he forced me to become his wife but it was against my will. And as a result, currently the area
around my pelvic is not fine no matter what kind of treatment I receive for it. I do not know whether it is because of the forceful sexual activity?

Ajok, who was abducted when she was 13 years old and returned eight years later with a child, spoke about how in addition to the chronic pelvic pain, she also experienced persisting chest pain as well as emotional problems related to her experience. Similarly, Alanyo, a 34-year-old survivor from Gulu who was abducted at the age of 14 and returned with four children after two years, described the persisting chest pain she experienced which remains untreated. She continues to get no treatment for this condition due to her inability to afford medication.

My chest does not allow me to do hard work so I would need assistance for it to be checked. Unfortunately, my current job requires me to sit for many hours, sometimes I get difficulty in breathing. I need treatment to heal.

In addition to chest pain, some participants raised issues about untreated sexually transmitted diseases, including recurring vaginal infections, and incontinence due to injuries sustained after repeated instances of rape. Likewise, Acola, a 33-year-old survivor from Gulu, who was abducted when she was 13 and returned with two children after nine years, described the many gynecological problems she faced as a result of the sexual violence she suffered.

One of the problems is that there might be damage in my bladder as a result of the flesh that came out at birth. Currently when I am feeling like to urinate, I have to do it at once otherwise it comes out. Maybe my bladder has enlarged, I do not know. I went to the hospital still with support from JRP [the Justice and Reconciliation Project] and I was given medicine but I still experience it. It does not flow uncontrollably like the case with fistula but I cannot hold urine. I am not seeking any medical service currently. As for my chest, I know that it cannot get cured. When it starts to hurt, and I feel pain, if I have money I buy medicine, otherwise I do not go to the hospital.
Like most of the women in the sample, she didn’t seek health care due to a range of structural barriers including lack of access to the type of care she needed, as well as high costs of medication.\textsuperscript{32}

Emotional and psychological health

In addition to persisting physical health problems, participants also raised issues around their emotional and psychological health. To most participants, it was deeply concerning that they still experienced a lot of resentment and psychological disorders that impacted their daily life, including bitterness, anger, thoughts of self-harm, and nightmares related to their experience in the bush.\textsuperscript{33} The most frequent psychological disorders participants expressed still experiencing were anxiety and depression, followed by nightmares and occasional suicidal ideation and thoughts of self-harm. Women described that most of these experiences were tied to their inability to forget what happened and exacerbated by insults and stigma in their surroundings, as well as their inability to care for the child(ren) they came back with from captivity. Apiyo, a 35-year-old survivor from Barlonyo who was abducted when she was eight, remained in captivity for nine years, and came back with two children, described how she continued to suffer from nightmares, and explained different triggers that provoked negative emotions, including insults and loud noises.

The things that I saw in the bush have affected me psychologically. Sometimes I dream that I am killing a person or that gunshots are soaring but prayers have helped a bit.

Today I dreamt that we were being shot at and we ran and left behind our clothes. We went and found a big water body that we struggled to cross with ropes. You know we would connect ropes and use for crossing rivers. That I was swimming on top of the

\textsuperscript{32} Further details on the many barriers women identified to seeking care is provided under the section Care Sought.

\textsuperscript{33} Term used by participants to describe the place abducted women were taken to by the Lord’s Resistance Army (LRA) rebels.
water with my bag and saucepan behind my back. Imagine these things happened many years ago but today when I get angry or think a lot, I relive these experiences that are fresh in my memory, especially when I am insulted about my life in the bush. When I had just returned, I would not reason well in places were many people are gathered. Even when I went to the market, I would have to find a secluded quite place. I get traumatized at noises and screams. My head tells me all those are orders from government soldiers to shoot at us.

Another survivor from Barlonyo, Lamaro was abducted when she was 23 (now 43 years old) and stayed in the bush for seven months. Upon her return, she experienced a platitude of health challenges including diabetes, gynecological problems, as well mental health problems such as anger, and anxiety.

The pain I returned with from the bush has affected me psychologically. There is so much anger and bitterness in my heart. I want to work but I lack skills and the knowledge to do many things.

Similarly, most participants shared experiencing a plethora of mental health problems including anger, bitterness, nightmares related to their experience in the bush, and at times, suicidal thoughts. Most shared that they were disturbed by their inability to move on, and believed having these unresolved feelings affected multiple areas of their lives including their relationship with families, intimate partners, and their children born in captivity.
Impact on Relationships

Acceptance or rejection (stigma)

Participants had varied experiences when it came to the ways in which family members, intimate partners, and community members treated them (and their children) upon their return. Almost two thirds of women in the sample said they were rejected by some family members, which severed close alliances, and at times led to the breakup of families and relationships. In some cases, this was because families and others in the community had the impression that survivors had killed people during their time in the bush, and might have turned into a rebel themselves. Aparo, a survivor from Gulu, who was abducted at the age of 13 and returned with two children shared how some family members pressed her to admit whether or not she had killed someone, and how she used that opening to explain how even for those who might have killed someone, it would usually be under orders, with little choice given in the matter.

Fear started building based on the assumption that when you stay in the bush (are a rebel) you have killed. They asked me whether I had killed but I did not kill anyone. For sure I beat someone under orders and because if I didn’t I could have been beaten as well but I did not kill anyone, unless it happened during battle for which I cannot know.

These negative sentiments also extended to survivors’ intimate relationship where how others perceived them, including some family members, affected the relationship they had with their former spouses or new partners. Amony, A 26-year-old survivor from Barlonyo, who was abducted at the age of 15 for four months described how people in the community tried to dissuade potential suitors because she was a former abductee.

People told my husband not to marry me because my mind was filled with Kony’s [LRA leader] activities. When someone is interested in marrying me, they persuade him to not consider me because I returned from the bush.
Survivors’ past experiences made it hard for some family members to accept them (and their children) and in most cases, participants shared that what they experienced during abduction was used as a justification for their rejection. For instance, Akello, a participant from Gulu shared her struggle with some of her family members who were convinced that she was ‘insane’ because of what they assumed she must have experienced in the bush. This strained her relationship at home, and she felt like she constantly had to defend her sanity while also trying to prove that she hadn’t turned into a rebel.

The way I see it, I think they think that since I have been abducted, I am worthless and that I may not be completely sane. By the way, I also think about it but I cannot get an answer. One day I told them that I am a sane person and there is nothing wrong with me. I told them there is nothing I did from the bush that I feel ashamed about. I feel that because of the abduction and movement in the wilderness people think that I am worthless. That is what Acholi people think, that you are like some unruly child who wandered and even when you return, you can never be loved the same way.

In a few cases, however, women shared positive reception from their families. In these cases, the families had lost multiple children to abduction during the war, and the women in this study were the only women (abducted family member) that came back (were rescued). In addition, the survivors chose to refrain from sharing details about what they experienced during their abduction, even in cases where the woman came back with a child born in captivity. Akwero, a 23-year-old survivor from Acholibur who was abducted when she was ten and came back after two and a half years with a child, described how grateful her father and brothers were after she returned.

The people who were most touched about our abduction are my father and my brothers. My father ran after the rebels and he was beaten severely with cassava stem. He was so
devastated. One of his abducted children returned and spent two nights and thereafter two more were abducted; no parent can remain at ease with such a tragedy. They had no hope of us returning but God was great, because I did.

Likewise, Adong, another participant from Acholibur who came back with a child shared how she decided early on that she would only share hardships she experienced during abduction (excluding sexual violence) because she was concerned that if she told her family about how she was sexually abused, they might reject her and stigmatize her and the child she came back with. Therefore, she carefully selected what she shared about her experience in the bush.

They only know about the other atrocities. Like I said they [LRA rebels] even tried to kill me. I found it irrelevant to tell anybody about the [sexual] abuse. I also feared that if I share it, people may start to point fingers or stigmatize me. So, I did not tell anyone about what I experienced. My relationship with relatives is good…nothing changed; up until now our relationship is intact…I usually share with them the problems that I am facing raising the children but I cannot bring out this secret [rape incident].

It is important to note that participants who said they had a positive reception from family members chose to not share about the sexual abuse they experienced during their time in abduction. In addition to the stigma they feared they themselves would experience, they were worried that the stigma, and rejection would extend to the children they came back with.

Effect of CRSV on Intimate Relationships

None of the participants in this study indicated having a positive relationship with their current husband or partner. Most women who were married or in a partnership reported difficulties (problems) in their current intimate relationship, which they ascribed to their past CRSV experience. Participants shared that in most cases, although their current partners generally knew that they had either been forcibly married or sexually abused during their
abduction, they rarely discussed it. However, partners or spouses seemed to use women’s past experiences against them during arguments or misunderstandings, which participants said made them resentful of both the partner and the relationship in general. Amito, a 38-year-old survivor from Aromo, who was abducted at the age of 15 and returned two weeks later described her feelings about how her past experience affected her relationship with her husband.

Rape ruins relationship between husband and wife because each time you have a misunderstanding reference is made to the rape incident…insults like you were raped, ‘you were wife of the rebels’. It makes life difficult.

A few women described leaving relationships because the emotional abuse had become unbearable. Adokorach, a 27-year-old survivor from Acholibur who returned with a child after a year and a half in abduction left her husband because she could no longer bear the insults towards her and her daughter.

If I had been married to a good person he would have supported me but now I have returned with her [a daughter born during captivity], he became so insulting. He said he couldn’t live with someone who returned from the bush, that people from the bush do not reason well. It happens to many young women who return from the bush. The insults are too much.

For other women like Aol, who returned with two children after six years in abduction, the situation with her husband was exacerbated by how her family (negatively) responded to her concerns when she went to them for help. Family members had the impression that she had killed during her abduction, and treated her badly, which led her to leave her husband with her daughter.

What happened affected the relationship between my husband and I, it also ruined the relationship with my brothers and all of my clan. Even my own family, the relationship is
ruined. There is nothing good that anybody hopes or wishes for me. For example, even if I take issues of misunderstanding between my husband and I home to my people, nobody wants to settle it. They say, ‘go and bring the one that you killed in the bush’. The way my uncle started to talk when I arrived did not give me any peace from that very moment, instead it tormented me more, it fueled my anger. For that reason, I escaped and started living on the other side of [name of river] river, and no rebel came around to abduct me and my child. I wanted to be abducted and killed. I lived there in the wild bushes but I think God did not will for me to die.

Unlike women like Aol who decided to leave emotionally abusive relationships, most women in the sample said they decided to stay in relationships they did not want for economic reasons. They described that because of the many health, and social challenges they were facing related to their experience in the bush, they knew it would be difficult to support themselves and their child(ren) if they ventured out on their own. Aparo, a 33-year-old survivor from Gulu shared how she would rather be alone but chose to stay in her current relationship even though she still didn’t feel fully supported by her partner.

I am with a man but I have no love for men. It may be due to the current status of my relationship but I feel that I could be happier alone. At least if he was supporting me… but now sometimes he gives me UGX 5,000 ($ 1.35) for the day and sometimes nothing at all. At least when I was doing tailoring I could fend for us but now I can’t, all the children are at home.

Likewise, Acola, a 33-year-old survivor from Gulu described how she did not feel respected or supported by her current partner, especially when it came to providing for the three children she came back with from the war.

I am with a man because of necessity, but I have no love. You can only love a man when there is mutual understanding. For me to love you, I have to make a good judgement of
your intentions for us based on how you treat me and my children. I am only with a man because I have to be with a man.

For six of the women in the sample who decided to venture on their own, either by leaving their current relationship or not getting married at all, life was hard. They struggled to get help from family members or the larger community that blamed them for choosing to stay on their own. Lamunu, a 49-year-old catholic nun who was abducted for an unknown number of years, and had a stillborn child during her captivity described how she struggled after she came back. Knowing that she wouldn’t be able to go back to the nunnery, she decided to raise her late brother’s children. However, she received no support from family or her former community, which instead ostracized her for experiencing sexual violence as a nun.

Some people understand but you know things have changed a lot in our community. Now that I have decided not to get a husband, when I need help, nobody can come to my rescue. I have to struggle to dig to survive. I survive completely on myself. The other issue is the current situation; there is hunger; if you do not work you cannot get even food to eat. To go to the hospital needs money. I also felt that it would be good to live with closer family members so I take care of four of my late brother’s children. That brother of mine died in a car accident. I help them while they also help me otherwise generally speaking, relatives do not support me. Due to the incident that happened to me the respect that the community and family used to give me is no longer there. The friends I used to have are no more.

Children born in captivity

More than 80 percent ($N = 25$) of women interviewed came back with children. Participants identified three major challenges related to coming back from abduction with children born during their captivity. These included, challenges of raising children born of war (especially
within the context of new relationships and new children), issues related to the children’s (non)belonging and inability to inherit land, and lack of financial support for the children’s education.

Some women entered their new partner’s or husband’s home with children born in captivity. The presence of the children in new intimate relationships was often a source of conflict. Even in instances where some of the women got remarried, their new husbands didn’t support the education of the children who were born from captivity. Piloya, a 30-year-old survivor from Acholibur who returned from abduction with a daughter after five years shared that her daughter faced stigma and discrimination both from her family and her new partner. Eventually, Piloya left the relationship.

When they [family members] talk about the need to care for children, reference is made to her as not a child of that family. As a result, nobody supports her. He [current partner] is paying for his children’s schooling, but not the one I returned with from the bush.

Moreover, the way children born in abduction were treated by family members, and partners had a lot to do with how the family and the community in general perceived their place in Ugandan society, which at times was as children produced by the enemy (more on this under Discussion). This created a lot of issues in terms of identify and a sense of (non)belonging for the children. Akwero, a 23-year-old survivor from Acholibur described her concerns about her daughter’s place in the family.

My biggest problem is this child that I returned with. When I look around, I do not see where she truly belongs. I anticipate that when she grows up and becomes independent, the question about her true home, place, and identity will emerge. As her mother, I cannot begin to speak about it when my family is not because it would appear like I am the one
engineering a problem. I keep thinking about it although I haven’t mentioned it to anyone.

The issues of belonging are tightly tied with other greater problems women are facing, including their male children’s inability to inherit land, as rights to land and inheritance are deeply tied to paternal lineage. For children who don’t know their fathers or don’t have access to their fathers’ families, inheriting land is almost impossible. Lawino, a 30-year-old survivor from Gulu who returned from captivity with a son shared how her family was mostly favorable towards her but not her son.

The relationship is good with me but not with my children because there is no place for my child. The child does not know his clan, he does not know where to go. I say the relationship is bad because land is wealth, but no family member has told me, ‘here is land for the child that you returned with’. They have a place for me in that when I go they welcome me at home but I have not been given land so I fear for my child. The other reason I say the relationship is bad is because when they are doing something for children in that family, they do not mention my child and I cannot ask because it might cause more trouble. I only pray that God prepares a place for my child, to open doors of life and opportunities for him.

Acen, another participant from Barlonyo who also came back from captivity with a son described how although she currently farms on borrowed land, she was concerned about her son’s future because he wouldn’t be able to inherit land due to the absence of his paternal lineage.

The other problem is land. Currently I borrow land for farming and so I worry that whether he [son] will have land to use in the future. I worry because I have no means to support him to stand on his own in the future.
Despite the uncertainty surrounding land inheritance for male children (17 women in the study came back with male children), most women in the study were hopeful that their sons would still be able to have a good future as long as they were educated. However, according to participants, this was not easily achievable since they didn’t have the financial resources to send these children to school. Arac, a 31-year-old mother from Gulu, who was raising her daughter as a single parent, detailed her struggles to afford school fees for her daughter.

The problem that I am facing is paying school fees because there is no one to support me. I did not take my child to nursery, I waited for her to reach seven years then I took her straight to P1 [primary school]. I worry that when she passes to go to secondary level, who will support me with her education? I see no prospects for her to continue to secondary level because I have not yet seen where I am going to get money.

Other women shared similar sentiments and lamented their inability to secure financial resources for their children’s education. Most women sought assistance from local organizations and other support groups but were still unable to get any aid. A few participants shared they even tried to get loans but were unable to since they did not have any collateral. Lawino, a 30-year-old mother who came back with two sons described,

I think about one thing only; I want doors of education to be open for my child. He is the older one and I see that he can make of himself something good in the future.

However, few participants said they had some family support, and in addition, decided to look for the families of their child(ren)’s father in the hopes that they would want to be connected with these children. Akiyo, a 33-year-old survivor from Acholibur who came back pregnant described how her mother showed her support upon her return and reassured her that she would support caring for her child.
When I returned, I was carrying a baby and there was nothing I could do about it. My mother comforted me. She said ‘my child, I’m glad that you returned, not your abduction or this child you are carrying was in your wish. If God wills and you give birth, we shall care for the child together. If you find a man and want to go, I can remain with him and we unite in supporting him’. Currently I do not think about what happened to me in the bush. I only think about supporting my child so that he can reach senior four at the very least. Even if I am to be angry or bitter it does not help me. I only pray for good health so that I can stand with my son who has only me for a parent.

Care Sought
All participants were asked about their perspectives on and experience with seeking health related and other support. Specifically, they were asked about their access to and engagement with care for their persisting physical and emotional health problems, as well as other support they sought. Women reported varying experiences and insights regarding barriers to care and the kinds of support systems that they found the most helpful.

Barriers to care
Most women in this study shared that apart from the care they received when they entered through reception centers upon their rescue from the LRA, they did not continue to seek or receive formal care from health or other social institutions. Overall, participants identified three main personal and structural barriers including anxiety and fear related to sharing about the sexual abuse they experienced, not knowing how and where to look for help, and being unable to afford or find the type of healthcare they needed close to where they lived. Lawino shared the fear she had about sharing what happened to her and preferred to seek help through prayer and church instead. She worried that people would use the information she would share about her experience against her and use it as a reason to mistreat her.
I don’t like to share issues. When something is pressing me… I run to the church and I cry to God because some people when you share with them your issue they use it to insult you. What I have found easy for me is running to God with prayers.

Although she didn’t seek help for the psychological problems she suffered, Lawino sought and received some health care for the chronic chest pain she continues to experience. In some cases, women found it easier (felt more comfortable) to share about what happened to them once they realized that other women had undergone similar experiences. Lajara, a 31-year-old survivor from Acholibur described,

I had a lot of anxiety and fear. I had decided not to share it but I learnt that so many people had gone through similar abuse.

Others described not seeking care because they didn’t know how. This was especially difficult for women who did not tell anyone about the sexual abuse they experienced, which made it even more difficult to ask for help. These women also reported experiencing extreme emotional pain, anxiety, and PTSD like symptoms including flashbacks, and nightmares.

Finding strength in each other

For nearly all women in the study, one of the most important source of support was found amongst other women who had also been abducted and shared similar experiences of abuse. Through organizations like the Women’s Advocacy Network, that have worked at the grassroots level to destigmatize attitudes towards survivors of CRSV, participants said they were able to connect with each other and find strength through sharing of experiences and helping each other find support. Like most women, for Akello, finding a trustworthy community among

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34 The Women’s Advocacy Network is a civil society organization that was founded in 2011 by former abductees of the Lord’s Resistance Army who had experienced sexual violence, and came back with children born in captivity. It currently has more than 900 war-affected members. Currently, it is comprised of sixteen grassroots women’s groups within Acholi sub-region and has widened its scope to include voices of conflict-affected women from Teso, West Nile and Lango sub-regions.
other women who had similar experiences was important in her decision to seek support. She described how she felt comfortable sharing her experiences with women whom she trusted, which allowed her to deal with her trauma in an environment where she knew what she shared would remain confidential.

First of all, the love among us who have returned is great; we feel as though another person’s problem is our own. When a colleague is suffering it’s as if we are the ones suffering. That is why we are able to console and counsel each other with care. You leave feeling comforted. But if you take your issue to someone who did not go through a similar experience, the moment you leave is the time when the information you shared spreads out. When we share amongst us, the issue stays with us because our experiences are very similar.

Most participants had a hard time talking about their experiences with their family members and spouses for a variety of reasons including fear of judgment, being blamed for what happened to them, and a strong sense (of resentment) that people who did not experience similar abuse wouldn’t be able to truly empathize. However, they reported finding emotional support from other women. Acola, who experienced a lot of stigma from her family and partner described how the people she could count on were women who were former abductees.

I have my relatives and they do not hate me but I think I’m the one who hates them. I have lost the feeling of love for them. Not only that, when I am in difficulty the people with whom I experienced life in the bush are the ones who first come to my rescue. That’s how things are different for me.

What Survivors Found Helpful

All participants were asked if they had any suggestions or recommendations for improving formal and informal services including their access to health care services, and other coping
mechanisms or support systems they found to be most useful. In addition to access to health care services for persisting and chronic physical health issues, participants identified three things they said helped alleviate the trauma they experienced during abduction and made the reintegration process easier. These included forgiving their abusers (and themselves), seeking out counseling from both professional providers and each other, and joining support groups led by women survivors. Lawino, a 30-year-old survivor from Gulu described how she was initially filled with anger and resentment but started to forgive herself after going to church and getting counseling and support from church elders and other women in her community.

Abduction sowed bitter seeds in my life because I started seeing bad things as a child and grew up doing bad things for 19 years. I thought that was the normal way of life, until I decided to return but I still carry that poison in me. The other thing that has changed my life is the word of God that everything happens for a reason and at its time. Then I started forgiving myself, otherwise I had given up on life because when I returned I found both my parent’s dead. No one to take care of me. I had become an adult but without anywhere to go. It is my little brother, our last born, who took me in and started caring for me like a child. It took so long for that bitterness to leave my life. I started to release the poison in my life gradually when I went to church and got to know God. I started imagining the future of my child, I started planning for him but before that I saw him as a complete accident in my life. I would only think about what his father did to me and I would get so irritated. When I got saved by God is when I let go of every bad thing that was done to me, I started to forgive myself; I forgave my child; I started feeling relieved and that made me to forget some of the experiences I went through in the past.

Other women also shared similar stories regarding their journey to self-forgiveness and healing. Getting counseling from women in their communities not only allowed them to forgive themselves, but also forgive those who abused them. For some women, it was easier to forgive
their perpetrators when they accepted that perpetrators themselves had very little choice on decisions that were made by their superiors, which could have been the case in some instances since some of the rebels were forcibly abducted and turned into soldiers by the Lord’s Resistance Army. Lamaro described how she counseled other women in this regard.

I advise them to endure because above all we have survived, and that is important. They should avoid anger even when insulted. Forgive. Our rights were abused but we must forgive because some of the people who did that to us also did it against their will, they were also abducted. Let us console one another.

Another area where most women said they wanted support from local groups and organizations working with conflict-affected communities was around counseling women who were entering new intimate relationships. Participants described that there were complex challenges related to entering those unions with children born during captivity. In some cases, survivors either left these children with their families (e.g. mothers) or abandoned them altogether. Laruni, a 33-year-old survivor from Gulu narrated the many challenges women like her and their children faced.

You should help mothers who have returned, especially those who have found partners. Most of those relationships are not working out. We enter these relationships, have children then we break up. I am a victim of this problem. Nobody prevents us from having more children but we should know that most of those children shall not have their fathers present to support them. If you return with two children from the bush then you add more from home. Many of us think that we are young but remember that at the end, all of the burden rest on you. I would be so grateful if you could start to hold discussions with women. Most of the women who returned with children from the bush are not living with those children. If you follow through to the villages, some of these children have been abandoned and rejected by their mothers who claim that they too have been rejected
by their own parents. The children that we are rejecting have very limited network for social support. We need your help on this issue. In addition, some people beat children so severely and utter insults at them that you just feel pity for the child…it was not in your will to be abducted so neither the child nor you are to blame for the circumstances. Most of my advice goes to the women who returned with children from abduction. It might be that you have traced the home of your child and found it but not all of the child’s family members may want or like him or her. As their mothers, we should stay close to them and educate them and should not always expect this kind of support from outside. Some of the mothers have given their children to relatives and do not know how the children are living or being treated. You may start to hear that the child is a thief or has done something bad and yet it may not be true, but it is easy for people to blame them due to the circumstances of their birth.

Most women who came with children noted that although it was painful for them to be forced into unwanted unions and pregnancies, the counseling they received and the support they found amongst each other helped them deal with their initial resentment and anger they had towards their children, and work towards giving them a better future.
Discussion

In this phase of the study, my goal was to explore the ongoing challenges Ugandan survivors continue to face in the aftermath of experiencing various forms of conflict-related sexual violence. I had three specific objectives: first, to identify the persisting health impacts of conflict-related sexual violence (CRSV) continues to have on survivors; second, to understand how the CRSV experience affected relationships with family members, and the role those interactions played in the survivor’s reintegration process, and third, to learn more about the types of formal and informal care survivors sought, identity key barriers to accessing care, as well as support systems that survivors found to be the most useful.

A total of 30 survivors were interviewed from four towns in three post-conflict districts in northern Uganda: Gulu, Lira, and Pader. All women in the study had experienced at least two forms of conflict-related sexual violence including abduction, forced marriages, sexual abuse in the context of forced partnerships, rape by rebel groups, and forced pregnancy. The women in this study reported facing continued challenges related to their abduction and the different forms of sexual violence they experienced.

A 2017 population based survey conducted on attitudes about peace, justice, and social reconstruction in northern Uganda found health to be the priority for women affected by the conflict (Pham & Vinck, 2007). Unfortunately, ten years later, women continue to experience health problems related to sexual and other forms of abuse they experienced during abduction. Most of the women in the study reported suffering from untreated chronic physical health problems related to the sexual abuse they experienced over a decade ago. These included physical aches and pains such as chronic chest and abdominal pain, untreated sexually transmitted infections (STIs) and other forms of physical disabilities associated with sexual abuse and physical assault. Similar findings were noted by Liebling-Kalifani et al. (2008) who
argued for the use of human right frameworks in order to address the dire reproductive and gynecological health needs of Ugandan women who experienced sexual violence as a direct result of the Ugandan conflict (Liebling-Kalifani et al., 2008). Sexual abuse history is an important risk factor for later health problems, and women with a history of sexual abuse report a higher level of medical symptoms including pelvic pain, headaches, and a higher disability in all areas of functioning including work, and home management (Drossman et al., 1990). My findings suggest that Ugandan survivors’ needs for specialized and continued gynecological and reproductive health care is still unmet (Liebling-Kalifani, Bradby, & Hundt, 2016).

In addition to chronic physical health issues, most women in the study suffered from a range of sustained psychological problems directly triggered by their experience during abduction. This finding supports previous research that has shown high prevalence of psychological distress and mental disorders including posttraumatic stress disorder, substance abuse and suicidal ideation among survivors of sexual and gender-based violence living in areas affected by armed conflict (Johnson et al., 2008; Kelly, Betancourt, Mukwege, Lipton, & VanRooyen, 2011; Kinyanda et al., 2010). It’s important to note that it’s difficult to discuss mental health care for Ugandans affected by conflict without addressing the larger context of mental health care in the country. Mental health services in Uganda are generally scarce and cannot meet the treatment need for 90 percent of Ugandans with mental illness (WHO, 2006). Barriers to care in the country include lack of trained staff and effective treatments, as well as pervasive stigma towards mental health seeking behavior (Molodynski, Cusack, & Nixon, 2017). These barriers are amplified in the context of conflict, which specifically makes it difficult for survivors of CRSV to access care. In addition, there has not been ample evidence of effectiveness of mental health interventions for survivors of CRSV in low-income settings (Tol et al., 2013). However, a randomized controlled
trial of cognitive processing therapy (CPT) among Congolese survivors of sexual violence has been found to reduce PTSD, depression, and anxiety symptoms as well as improve functioning (Bass et al., 2013). This study was one of the first to show psychotherapeutic treatments such as CPT could be successfully implemented in low-income, conflict-affected settings with few mental health professionals. Given the similarity in both experience of CRSV and context, survivors in Uganda might benefit from a similar intervention.

When it comes to the impact of CRSV on relationships, most participants reported facing stigma and poor relations with family members and intimate partners as a result of their war experiences. Survivors identified a few factors they thought contributed to soured relationships including disclosure of CRSV experience, and misguided ideas people had about former abductees turning to rebels. These findings imply that women who were abducted by rebel forces may be more prone to facing compounded stigma due to people’s views towards former abductees. This is consistent with previous studies that have shown that for women who return from abduction, especially with children born in captivity, re-establishing relationships with family and communities is a difficult process (Veale et al., 2013). In terms of intimate partnerships, most participants revealed that their relationships were challenging, and were exacerbated when they entered these unions with children born in captivity. A striking finding in this regard was how some women shared they stayed in these relationships for mainly economic reasons, and would have preferred to be alone if they could support themselves.

Moreover, stigma and severed relationships (specifically related to fear of disclosure) adversely affected the general care seeking behavior of women in this study. Similar observations have been made in northern Uganda, where poor functioning among formerly abducted girls was found to be largely mediated by stigma and poor community relations.
(Amonoe-P’Olak et al., 2016). With regards to care seeking behavior, most participants noted that lack of trust was one of the main factors that dissuaded them from seeking care. In addition, lack of access to medical services and cost of continued care were identified as major barriers. In addition to stigma surrounding sexual violence and being a former abductee, other studies have also identified lack of means to access medical care, and awareness of available services to be some of the main structural barriers to seeking care (Bartels et al., 2012; Casey et al., 2011).

It is hopeful, however, that women found strength and support from joining women’s groups led by other women who were survivors of CRSV. Being part of these groups not only helped them feel less alone in their experiences, but enabled them to freely discuss the challenges they were facing in a safe and non-judgmental environment. In addition, the social support they found in each other helped them develop positive coping skills, which helped mitigate some of the negative effects of the trauma they experienced (Leech & Littlefield, 2011).
Limitations

A few study limitations should be noted. Specifically, data were collected from women survivors who were identified by the Women’s Advocacy Network (WAN), and had somehow successfully found support through WAN and similar groups. Thus, the perceptions and experiences reflected in this assessment might be biased toward those who were willing and able to participate in the interviews, and their concern may underrepresent the magnitude and scope of barriers faced by CRSV survivors that might not access any sort of support due to stigma and other barriers. Therefore, although the findings provide an important insight into the challenges women survivors in northern Uganda continue to face, as well as the support systems they have found within the community, it is unclear whether the same issues would be identified by women (and men) survivors who might be living on the margins of society and might be living in isolation with no access to social support or networks. Finally, this study only focused on women survivors living in three of the districts that were impacted by the Ugandan conflict, and might not be generalizable to other similar populations, including men survivors of CRSV. However, I expect the barriers faced to provision of care, and the tensions that arose in relationships due to the CRSV experience to remain qualitatively similar across similar populations. Further research with larger and more diverse sample is needed to fully examine if what was observed in this study is applicable to the larger population of CRSV survivors in northern Uganda.
Summary

This study demonstrated that survivors of CRSV continue to face multifaceted problems in the post-conflict period. Participants in this study faced challenges with maintaining strong links with family members and intimate partners, stigma related to their experiences during abduction that also extended to their children born in captivity, and difficulty with accessing and affording sustained health services. However, participants were able to get a strong sense of emotional and moral support from other women who had similar experiences. Most health-related programs that were set up at the end of the war in northern Uganda are no longer available, and the current programmatic priority is on transitional justice programs. However, none of the participants interviewed identified justice as a priority. Organizations currently working in war-affected communities in Uganda should consider re-evaluating their priorities and assess whether or not they align with the needs of survivors. In addition, there is a need for economic opportunities for survivors, especially for women who stay in unfavorable partnerships mostly for economic reasons.
Table 4.1. Characteristics of Women Survivors of CRSV

<table>
<thead>
<tr>
<th>Name*</th>
<th>Current Age</th>
<th>Age at abduction</th>
<th>Married or in a partnership</th>
<th>City of residence</th>
<th>Current occupation</th>
<th>Year of abduction</th>
<th>Education</th>
<th>Length of abduction</th>
<th>Bore child(ren) with LRA</th>
<th>Number of People in the household</th>
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*All names are pseudonyms to maintain confidentiality of respondents.

Not Available (NA) is used for cases where participants didn't remember details about dates, circumstances, or asked to skip the question.

Background

Sexual violence against civilians in conflict zones has grave physical, psychological, and social repercussions (Ba & Bhopal, 2017). Studies have shown that conflict-related sexual violence (CRSV)\(^{35}\) can have complex and long-lasting health as well as social and economic consequences for survivors (Amowitz et al., 2002; Johnson et al., 2008; Kim et al., 2007). Some of the deleterious physical health consequences of CRSV include reproductive health problems such as traumatic genital inflammatory disease, infertility, and HIV/AIDS (Liebling-Kalifani et al., 2008; Longombe et al., 2008; Ward & Marsh, 2006). Moreover, high levels of behavioral health problems including anxiety disorders, suicidality, alcohol and substance abuse, and post-traumatic stress disorder (PTSD) have been reported among this population (Joachim, 2005; Liebling-Kalifani et al., 2008; Lunde & Ortmann, 1998). Although the physical, psychological, and cultural ramifications that survivors of sexual assault experience have been well documented, little empirical data exists on the impact of sexual violence, particularly sexual violence committed under the context of war, on family members of survivors, whom I refer to here as secondary survivors.\(^{36}\) When family members or spouses of survivors are considered in

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\(^{35}\) The definition of CRSV used in this dissertation accords with the most recent definition provided by the United Nations Security Council that defines it as “rape, sexual slavery, forced prostitution, forced pregnancy, enforced sterilization and other forms of sexual violence of comparable gravity perpetrated against women, men, girls or boys that is linked, directly or indirectly (temporally, geographically or causally) to a conflict. This link may be evident in the profile of the perpetrator; the profile of the victim; in a climate of impunity or State collapse; in the cross-border dimensions; and/or in violations of the terms of a ceasefire agreement” (Ki-Moon, 2015). Perpetrators can be state actors including military, police, or paramilitary organizations under the direct command of other state actors as well as non-state actors including rebel and militia organizations (Wood, 2014).

\(^{36}\) In this dissertation, I use the term secondary survivors to refer to individuals who are the loved ones of the survivor and can include anyone in the support system, such as family members, spouses or partners, and friends. However, for the purpose of this dissertation, I only focus on family members, spouses or partners. This description
the literature, the focus has often been on how their response to the survivor’s experiences helped or hindered the survivor’s recovery, rather than assessing the indirect effects of the sexual violence on them (Christian et al., 2011; Kelly, VanRooyen, Kabanga, Maclin, & Mullen, 2011; Smith, 2005). In this chapter, I explore the ripple effects of CRSV on families of women survivors, including parents, siblings, and spouses.

**Secondary Survivors**

The literature on the impact of exposure to sexual violence on secondary survivors is very scant. In one of the earliest studies related to partners of sexual assault survivors, Davis et al. (1995) explored the effects of crime on a sample of persons named by victims of sexual and non-sexual assault as their primary significant others (Davis, Taylor, & Bench, 1995). According to their findings, when compared to partners of non-sexual assault survivors, partners of sexual assault survivors exhibited higher levels of unsupportive behavior towards the survivor (Davis et al., 1995). The few other studies that are available are focused on intimate partners (Smith, 2005), and find that individuals who have an intimate partner who is a rape survivor suffer various forms of vicarious trauma including anxiety, sadness, and depression (Kelly et al., 2011). There is especially little research devoted to the secondary trauma of parents and other family members of survivors of sexual violence in conflict-settings. The only research available on secondary survivors focuses on their role in the recovery of the primary survivor.

Additional work from the Democratic Republic of Congo by Christian et al. (2011) has shown that the mental health recovery of male survivors was highly contingent upon how those closest to them reacted to the experience and treated them afterwards (Christian et al., 2011). Another study from Central and West Africa (Tol et al., 2013) found that family members and

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is based on Navarro and Clevenger’s (2017) definition of *secondary victim*, outlined similarly. I use a modified version of this definition, where I use the term ‘survivor’ instead of ‘victim’ (Navarro & Clevenger, 2017).
intimate partners were interested in learning how to better support rape survivors in their households. In northern Uganda, researchers have found that many people in conflict-affected communities displayed significant physical and psychological war-related trauma including post-traumatic stress disorder (Musisi, Kinyanda, & Liebling, 2000).

**Families in Northern Uganda**

Studies have shown that war related sexual violence was widespread during the twenty-year conflict in northern Uganda and included rape, abduction, and forced incest (Kinyanda et al., 2010; Vinck, Pham, Stover, & Weinstein, 2007). Population-based surveys indicate 26 percent of girls and 47 percent of boys were abducted by the Lord’s Resistance Army (Annan et al., 2011). Most of abductees were forced into marriages or unions with rebel groups, where they experienced sexual violence and were forced to bear children (Annan, Blattman, Carlson, & Mazurana, 2008). Moreover, one in three women in the region report having experienced at least one form of conflict-related sexual violence (CRSV) including rape, forced marriage, and forced pregnancy (Kinyanda et al., 2010). Subsequently, it is estimated that over 50 percent of all forced wives gave birth to children during captivity or were pregnant when rescued (Annan et al., 2006). Both the numbers of individuals abducted, and those that returned are expected to be underestimates, given challenges with conducting reliable surveys around these sensitive topics, especially in conflict and post-conflict settings. However, even looking at the number of victimized individuals, one can assume that there is at least one person (often more) that cared for a survivor upon her return, and was exposed to what happened to the survivor. As such, there is likely a doubling or tripling of the number of secondary survivors that might be suffering and

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37 The authors believed that sexual violence was under-reported by abducted females, and attribute this to the taboo (for the survivor).
coping as a result of their indirect exposure to the experience of the primary survivor. Moreover, substantial gaps remain about the impact of these experiences on family relationships, the types of challenges families might encounter, and their care seeking behaviors. This study is focused on understanding the experiences of one type of secondary survivors—family members—through their own perspectives.

Objectives
Given the dearth of evidence on the experience of family members of CRSV survivors, the goal of this phase of the study was to gain a better understanding of how conflict-related sexual violence (CRSV) affected families of women survivors in northern Uganda. My aim was to examine families’ perceived experiences as an indirect witness to CRSV, and how this might have affected them as a result. These objectives were guided by the main research questions listed below:

1. How do family members of CRSV survivors perceive the experience of the survivor to have affected them, and their relationship with the survivor?
2. How did the indirect exposure to the survivor’s CRSV experience affect the health and well-being of family members?
3. What kind of support or services related to the experience of war did family members of survivors seek (if any) or found the most helpful?
Results

In this phase of the study, 22 participants who were family members of women survivors of conflict-related sexual violence were interviewed in northern Uganda. It included eleven mothers, two fathers, four husbands, and four siblings. All participants had at least one woman in their immediate family who experienced conflict-related sexual violence (CRSV) in the context of being abducted by the Lord’s Resistance Army (LRA). During the interview, eight participants revealed that they were also abducted by the LRA at different times, except for one participant (Akiki) who was abducted with the survivor (his niece) simultaneously. Given that this phase of the project was focused on exploring the experiences of family members (which is the criteria under which all participants were recruited), questions about their own abduction experience were not asked. However, in cases where participants chose to share information related to their experience, relevant follow-up questions were asked. This was useful in getting a full understanding of how their experience, coupled with the CRSV experience of the survivor in the family, affected the various issues explored. Details on the key demographic features of the participants, as well as information on the survivor they cared for including the age at which the survivor was abducted, whether or not the survivor came back with children, and the year and length of abduction is shown in Table 5.1.

Findings are divided into five sections. The first section addresses the first research question and describes participants’ relationships with the CRSV survivor in the family after the survivor returned from abduction, and themes related to issues that affected the relationship the survivor

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38 The term survivor is used to describe an individual victim of any form of sexual violence who survived a sexual violence incident.
39 Although the context under which most women in northern Uganda experienced conflict-related sexual violence was as an abductee by the Lord’s Resistance Army, it is possible to experience sexual violence during war without being abducted or forced into a marriage with a rebel.
40 Women who were abducted by the LRA were usually forced into marriages with LRA commanders or fighters (Annan et al., 2011; McKay & Mazurana, 2004).
had with the participant and other family members. These included: 1) learning details about what the survivor experienced during abduction, 2) respondent’s (as well as family members’ and the community’s) reaction to survivor’s CRSV experience, and 3) how this altered survivor’s ability to live in the household, and re-integrate back in the community.

The second section addresses the research question around the impact of CRSV on family members and focuses on issues more specific to participants’ perception of how they were personally impacted by the indirect exposure to what the woman in their family experienced. The following themes emerged: 1) signs of secondary traumatic stress 2) caring for children born during captivity, and 3) community (family) stigma towards the family.

The research questions around participants care seeking behavior are addressed in the following two sections. The third section focuses on the types of formal and informal care family members sought for themselves and the survivor and barriers (including societal and structural) that prevented them from pursuing or accessing desired health and other social services. The fourth section focuses on methods of coping respondents used to deal with their secondary exposure to CRSV in order to help the survivor, themselves, and others in the family become more resilient. These attributes (protective factors) included: 1) focusing on religion and spirituality, 2) seeking and depending on support from social connections, and 3) emphasis on forgetting the past as a tool for healing.

The final section focuses on respondents’ advice for other families facing similar challenges, where the following themes emerged: 1) restraining from judging and blaming the survivor and 2) identifying counseling resources for survivors and partners. Themes on forgetting the past as a form of healing, and focusing on prayer (God) also re-emerged with regards to what participants considered to be some of the key tools that families could use to care for survivors and
themselves. I provide a detailed discussion for each of the five themes in the next section, using verbatim quotes from different family members.

**Impact on Relationships**

**Learning about survivor’s CRSV experience**

Nearly all participants, and especially those that witnessed the abduction of the woman survivor in the family, gave detailed accounts of the day the survivor was abducted, and the emotional, social, and economic challenges that followed. In most cases, participants learned about what happened to survivors through the narratives survivors shared about their experiences, in addition to observations regarding the woman’s condition. This included the survivor returning visibly pregnant or with child(ren). Abbo, a 51-year-old mother from Gulu, reported,

> When she returned, she told me about the kind of life they lived while in the bush. When she is narrating and reaches somewhere so touching, she keeps quiet. Then after some time, another day she tells some more. She told me all about how she was given to men, men with many wives. I would not ask her to know deeper than what she said because I knew it had been a tough path for her.

In most cases, participants recognized that the survivor needed to share what had happened and they listened. None of the family members interviewed said at any point that they had asked the survivor to stop sharing, even when they knew they didn’t have the emotional capacity to absorb and process the type of information being shared. A few participants said survivors did not share detailed accounts of what they experienced in the bush.\(^41\) In contrast, participants learned about (or imagined) what the survivor experienced during her abduction because she

\(^{41}\) Term used by participants to describe the place abducted women were taken to by the Lord’s Resistance Army (LRA) rebels.
came back pregnant or with child(ren). Miremba, a 60-year-old mother from Gulu, said although her daughter didn’t tell her she was sexually abused, she concluded she was because she came back with children.

She was abducted when she was 12 years old in P6 [middle school]. I did not have hope that she would return because she took many years there and her brother with whom she was abducted the same day died in the bush. Then I saw her return with three children but she did not tell me that she was sexually abused.

Reaction to survivor’s CRSV experience

Most reactions to women’s return was positive, even if hearing about the abuse they experienced in the bush caused psychological distress for family members, created distance, and changed the dynamic of the relationship in the family. In addition to playing the role of the comforter and caretaker, family members had to manage complicated trauma the survivor was experiencing (which was not being treated by health professionals), along with their own emotional turmoil as a result of being a secondary witness to the traumatic experiences of a loved one. Achen, a 62-year old mother from Gulu described how the relationship was affected by acute stress reaction type behaviors her daughter was experiencing, including disturbed sleep, flashbacks, and thoughts of self-harm,

There was a time she went out and wanted to be knocked by a vehicle but we managed to stop her. Sometimes she wakes up in the night, walks for a long distance and returns. She tells me that she finds herself in a faraway place, she does not meet anyone or if she does they do not touch her. That she hears something commanding her to get up and go. Many people say that I should go to
a witch doctor. That is the reason for the problem between us (me and her), but for me I’m standing on prayer.

In northern Uganda, flashbacks and nightmares are perceived as manifestations of spirits haunting those who either witnessed or perpetrated killings (Harlacher, 2009). Partaking in ceremonies with traditional healers or witch doctors is seen as a solution to rid former abductees (including former child soldiers and those that experienced sexual violence) from spirits (Annan et al., 2006).

Ochieng, a 37-year-old husband from Aromo, who was also abducted for five years prior to his wife’s abduction, shared that his own personal abduction helped him understand what his wife was going through once she returned,

The people counseled me thinking that I was going to leave her, but instead it was me who counseled her and stayed with her. I knew that for a girl to be abducted in the bush, you are forced to buy your life…so you do anything to keep alive.

In the same way, the other seven family members who were also abducted shared similar stories about how the abduction experience, even when it didn’t involve sexual violence, helped them navigate the difficult emotional and social transition process women survivors in the family were facing. Although most participants were still very resentful about the consequence of the war’s effect on their lives and that of their families, they were grateful that the women finally came home.

Changes with Reintegration

Issues related to survivors’ CRSV experience, unfavorable responses by some family members combined with how some part of the community was treating them and their families
led some of the survivors to seek refuge elsewhere. They either found new partners or moved to different towns where people didn’t know them. Bwanbale, a 46-year-old woman from Gulu whose sister-in-law was abducted described,

> She lived with me for one year and after went to her home. Then she came and told me that the people at her new home call her a rebel. I told her do not mind, you were not the first to be abducted by the rebels.

Similarly, other participants described circumstances where although the survivor had largely been welcomed at home, the treatment from outside the home made it difficult for her to stay. Akiki, a 32-year-old man from Barlonyo, who was abducted with his niece, shared how although they were welcomed at home, people’s insults and rejection made it difficult to stay.

> When we had just returned, people close by were using bad language (insulting) on us saying we are the children of Kony. But our family received us so well.

Akiki described that his niece, who is currently married, had recurrent nightmares and flashbacks. He worried that should these problems continue, her husband and his family may decide to send her back to the family, and she wouldn’t want to live with them because of how she was treated by the community. Studies assessing exit patterns for formerly abducted females have found that a majority of them are directly reintegrated into their families and villages without passing through reception centers (Verhey, 2004). In most cases, families are not prepared (both emotionally and financially) to help survivors have a successful re-integration process.
Effects of Indirect Exposure to CRSV

Secondary traumatic stress

One of the most striking findings from this study was how all 22 participants said they experienced negative psychological, physical, and emotional reactions and behavioral changes due to their indirect exposure to the traumatic experiences the CRSV survivors experienced. These included distress, depression, anxiety, feelings of hopelessness, and physical body tension.

Sanyu, a 37-year-old husband to a survivor described,

Being a witness to the abuse hurt me so deeply and it tortured me emotionally but since I was not in position to do anything, I remained silent. I knew I would have to live with the experience.

Similar sentiments were shared by the other two spouses in the study. Ochieng, a 37-year-old man from Aromo who was also abducted, and whose wife died in 2016, shared how his wife’s abduction and experience affected him and the challenges he continues to face not only emotionally, but as the sole caretaker of their children.

It was too painful. Because if your wife is abducted and raped you feel so bitter. I felt so devastated ... but I was helpless at the same time... it [abduction] continues to affect me...even after she died, now I am left with the responsibility of taking care of the children alone. The problem that I have is that I have to plan and act single-handedly because when you bring a wife [remarry] anyhow you can have more problems than you had before. So, it made me to decide at once that I will stay without a wife.

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Figley (1995) introduced the term ‘secondary traumatic stress’ to describe the behaviors and emotions resulting from helping or wanting to help a traumatized person (Figley, 1995).
In the same way, the limited research available on the impact of rape on significant others of survivors has shown that partners often reported experiencing high levels of stress and anxiety (Nelson & Wampler, 2003) as well as discontent and grief (Champion-de-Crespigny, 1996).

In addition to the significant others, the eleven mothers in this study also reported feeling helpless, vulnerable, and panic-stricken when their daughters told them details about what happened to them in the bush. Kaikara, a 55-year-old mother from Barlonyo recalled the physical and emotional reaction she had to her daughter’s story about what was done to her.

I asked her but as soon as she started narrating I was so angry and immediately

felt a huge congestion in my chest and I was rushed to [name of hospital] hospital. The doctors said it was a result of overthinking.

Natukunda, a 60-year-old mother from Acholibur, described the different stages of grief and withdrawal she underwent as she waited to take her daughter from the reception centers⁴³ (after someone had told her that she had returned with a child).

I felt so sad. I was so heartbroken again and I cried. Even when I went to see her from World Vision⁴⁴ I cried so much that I was withdrawn not to meet her with that kind of mood and emotion. When I returned people comforted and counseled me then I felt better. The pain was seeing how my child had suffered and thinking how her future had been ruined.

Caring for children born during captivity

Afiya, a 55-year-old mother from Acholibur described how she continued to care for her grandchildren even after her daughter died in late 2016.

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⁴³ These were centers where formally abducted men, women, and their children were brought to for rehabilitation right after being rescued from the rebels.

⁴⁴ World Vision was one of the organizations that operated a rehabilitation center for former abductees in northern Uganda.
They left the children in my care. So, the children in my care include the twins and my son. As you know according to our culture, when a woman is not married, the children belong to the mother’s clan. What happened to her was totally against her wish and her death caused me so much pain. I have decided to continue loving her by caring for her children.

Subsequently, parents of survivors (mainly mothers) were charged with caring for their grandchildren and providing for them in the absence of the survivor. Most of the mothers interviewed in this study were happy to have their daughters back and were willing to take care of their grandchildren. However, they shared that they did not have the resources to adequately provide for the basic needs of the children including health care, and education. Miremba described how she experienced anxiety over her inability to care for her daughter, and the children she came back with.

It has affected my health because I have a lot of worry and anxiety. Although she has returned, we cannot afford to give her a better chance in life. There is no land for her to settle in with her children. It is me who is weak who is taking care of her plus all her children.

Participants shared that the children born in captivity didn’t face a lot of stigma from family members, rather, the most prominent issue that emerged concerning the children was the inability of family members to provide for their care. Nasiche, a 72-year old mother from Barlonyo described her sense of failure as a result of her inability to provide for her grandchildren.

As you know, no man can accept any woman who has returned from the bush to be his wife. Her child’s general welfare, schooling, health care is my
responsibility. My main problem is that there is no source of livelihood to support them. I have failed.

Stigma

Unlike the children, participants reported survivors faced much more stigma from the community, and even some close family members. Achen described how her relationship with her daughter turned sour as a result of the stigma and discrimination she faced in the community. When Achen advised her daughter to ignore what people were saying, her daughter interpreted it as lack of concern and understanding, which further exacerbated their relationship.

All was good when she had just returned when nobody knew and there was no discrimination on her. The problem started with discrimination because when I would tell her to let go what people are saying, she would think that I do not like her, I should be doing something about it...when I tell her to endure, she says I do not love her because I am telling her to bear something that is unbearable. Her heart tells her to retaliate violently but since I stop her it means I do not care about her. I do not know what she is going through. She is in a very hard place and cannot endure anymore.

Participants also tried to encourage survivors by contextualizing the stigma they faced as something most returnees faced rather than an issue that only affected the woman in their family. Kizza, a 42-year-old man from Aromo described the approach he took to reassure his sister who was facing stigma in the community.

Some people insulted her that she is the wife of rebels and laughed at the circumstance of her pregnancy. Due to the insults, sometimes it was difficult to control her. Sometimes she would cry. I would comfort her and reassure her that
what happened was against her will. I also told her she was not the only one who was abducted, returned and is facing the problem of stigma.

Furthermore, participants shared the role community and family stigma played in breaking intimate relationships of the survivor as well as the family member. Amara, a 54-year-old mother from Acholibur described how her husband’s negative reaction to their daughter’s return with a child affected their marriage, and eventually led her to leave her husband.

I met a lot of challenges. People would insult me saying why do I care for a daughter who has returned from the bush? Even her own father would say how do you care for a kid rebel, what will she help you with? ‘Pick all your children and return to your parent’s home’ he would say. I faced insults from my family and the community alike. I made a decision to care for her because I know she was abducted against her will. I want her child that she returned with to study but I am having challenges getting school fees.

According to Adroa, a 57-year-old father from Barlonyo, his daughter faced emotional abuse from her new husband, in addition to the stigma they were facing as a couple from the community. Even for survivors who eventually re-married, like Adroa’s daughter, the stigma continued in their new communities and extended beyond the survivor to affect her new partner. This ultimately lead to the dissolution of the relationship. Adroa described,

People were insulting her and her husband. It is precisely the reason they separated because whenever he would go to hang out, people use his wife’s experience to insult him. And he too would insult her whenever he returns from drinking.
Barriers to (Health) Care

Many survivors of conflict-related sexual violence suffer from immediate and prolonged gynecological problems and general ill-health, but it is not known if the help seeking behavior of these individuals is tied to the response of family members. In this study, I was interested in learning more about the experiences family members had with seeking both formal and informal care for themselves (while experiencing secondary trauma) as well as the survivor in the family. I was also interested in learning about the types of coping mechanisms participants used, especially those who did not seek formal health services (discussed under Methods of Coping).

There were some differences in care seeking behavior among the sample of participants interviewed. Mothers of survivors were more likely to say they didn’t seek (formal) care, either because they were afraid of negative perception from community members or generally overwhelmed by the emotional toll the experience of their daughter had on them. During a conversation with Namazzi, a mother from Barlonyo, she described her decision not to seek care because of multiple factors including feeling alone dealing with the issues she was facing, and also because she was afraid of what people would say if they saw her seeking formal care.

Q. Why didn’t you try to seek care?

A.: Because I was alone and consumed by worry...some people mock you when you take your issue to them to seek counseling or assistance so I thought I should decide independently and see the result.

Bwanbale, a participant whose sister-in-law was a survivor shared how her sister-in-law only sought care when she had physical symptoms.
She returned but did not receive any service...she only went to the hospital when she was feeling pain in her head and she was given medicine. She does not complain anymore. The pain comes once in a while.

Bwanbale went on to explain how although she at times felt emotional distress because of what her sister-in-law was going through, she didn’t think that she could seek formal services for herself. This is not surprising given that formal care, even for those returning from abduction, was hard to come by in the region due to scarce resources and limited number of health providers.

Conversely, most of the 10 male family members in the study said they were either aware of the importance of counseling services for survivors, or sought it themselves (if they were abducted). They also reported their concerns regarding insults towards the survivor by community members to local authorities and leaders. Mukisa, whose sister was abducted, shared how he thought receiving counseling would have been good for her sister, although she didn’t seek care mostly due to stigma.

Upon her return, we observed that she was pregnant. We unanimously agreed that we should take good care of her because we had a reason to be happy that she is alive. We made the local council chairperson know about the insults that she was facing from people because it was affecting her healing...she has not received any counselling for healing since she returned...but I think it would have been good for her.

**Methods of Coping**

Faith matters

In addition to the formal and informal services that family members of CRSV survivors sought for themselves and the survivor(s) in the family, I was also interested in identifying other
protective factors that helped them become more resilient. One of the key factors identified was faith in God. Faced with overwhelming challenges, almost all of the participants interviewed said their belief in God⁴⁵ was the most important factor that helped them deal with the sadness and sorrow they felt when the family member was abducted, and the challenges they faced upon her return. Achen, a mother from Gulu, described how she rationalized what happened to her daughter (and to her as a result) as something she could neither explain nor control, but a situation that she needed to accept nonetheless.

It touched me so deeply but I am someone who knows God and I know that temptation happens all the time. When Satan sees that you love God, he brings situations for you to backslide or fail. So, when I turn to God, I find that it happens, not to me alone, but to anybody as He wills. I try to console myself but it touched me deeply. I think that I should surrender everything to God. She was abducted when she was young and had no way to leave that place. The result was bad but it happened and God knows why it did.

Most participants sought connection with God and their faith independent of religious leaders or organizations, although leaders in the community (both religious and others) were an important source of support for families. Natukunda, a mother from Acholibur, described how prayers from religious leaders helped ease the families’ pain.

At the time that she was abducted, we mourned her a lot. Religious leaders conducted prayers to ease our emotions and send good omen her way in case she was not yet dead. Time came and I forgot about her.

⁴⁵ Most participants said they were born-again Christians, because they needed strengthened faith in order to come to terms with what was happening to themselves, their families, and communities during and after the war.
Nearly all participants seemed to hold on to the belief that only God knew why these things happened to them and their families, and drew strength from the knowledge that God, who they saw as an ally, was with them. Believing that God would be with them was a reassurance that their problems and what they faced was part of a greater plan. Overall, the attitude that people had on this issue encouraged them to seek support.

Support from social connections

Social connections are considered to be crucial to individuals’ well-being and resilience. Inability to access these networks can especially be a big loss for families and survivors living in post-conflict settings. In addition to depending on their faith for comfort, and confiding in other family members, most participants in this study said they sought support from leaders within their communities. The role of friends and community leaders was especially evident in cases where participants needed encouragement and advice on how to deal with the abduction of the survivor. Ocan, a 60-year-old father from Acholibur, talked in detail about the deep depression that he and his wife experienced when their daughter was abducted and how advice from the community, especially those whose children were also abducted, helped them stay positive.

I worried a lot but I did not go to the hospital. We endured the emotional pain.

We were consoled by other people who said when your loved one is abducted, do not over worry...yes, the counsel from people played a big role in our lives. If it were up to the two of us we could have taken inappropriate steps [self-harm].

Community leaders were also a source of support when survivors in the family faced continued stigma from others in the community, including insults and blame for being a former ‘wife’ to a rebel and bearing a child as a result. Community leaders often reprimanded members of the community who were verbally abusing survivors, and provided counseling to survivors
and family members who were facing stigma. Kizza, who’s sister was a former abductee who came back with a child, described the role of the community leaders.

Since many people experienced the brutal rebel activities, they were mindful of people who returned from abduction. They gave examples and advised returnees to cope since what happened did not affect them only and not to focus on their experience in the past.

Parents also took on the role of counselor at times and reiterated to the survivor that they were happy with her return. This was especially significant for women who were facing stigma from outside the home, and having difficultly fully reintegrating back into the family.

Forgetting the past

All 22 participants shared the most important advice they gave survivors regarding what they experienced was to forget it and ‘move on’ with life. Family members had a strong perception that talking about the past and reliving what happened would not be helpful, both to their own mental health, as well as the survivor’s recovery process. Most participants considered helping women survivors forget about the past (by not talking about it repeatedly, and focusing on other matters) as one of their most important roles. Abbo, a mother from Gulu, whose daughter returned pregnant and with a child shared how her daughter tried to talk to her about what happened on different occasions, but struggled to talk about it. Abbo saw this as a sign that talking about it was causing more harm than good, and helping her forget what happened was preferable.

The strategy was counselling her. I told her to remove the past from her heart and thoughts. For her to forget, it begins with the parents. When she is provided with what she wants and asks for, it can help her to forget what she went through. That
responsibility rests with the parents. If you are a parent whose child has been in abduction, you should treat that child well. Do not keep the child in the memory of things that happened in the past. For her to get a change in the mindset, you, the parent, should treat her well. Give whatever she wants, so that she can forget, so that she is not disgruntled.

In addition to considering ‘forgetting the past’ as the best option for the survivor, some family members also shared that with everything they had to deal with regarding their family member’s abduction, return, and the challenges that followed, they simply didn’t have the emotional capability to talk about the past with the survivor. Afiya, a mother from Acholibur, who faced stigma from her husband’s family after her daughter’s return shared how she had to convince herself that she had to remain strong not only for her daughter but for herself as well. She counseled her daughter to let go of the past.

There are too many things that go on in my head. If I am to give you my head, you will collapse. Reduce worry. Let the past be gone. Think about tomorrow. It [abduction, sexual violence, forced marriage] has already happened.

Advice for Other Families

Restrain from judgement and blame

During each interview, all participants were asked if they had any suggestions for other family members who were affected by the consequences of abduction and sexual violence during war. All participants gave at least one suggestion. The two most prevailing themes that emerged were around reducing stigma and blame towards survivors, and expanding access to counseling services for survivors and their new partners. Ocan, a father from Acholibur, shared how he was worried his daughter would face heightened stigma. In addition to being a former abductee, and returning with a child born in captivity, she had a physical disability from a gunshot wound to
the knee. He advised that everything that happened to former abductees was against their will, and it was vital for families and communities to recognize and accept that.

I repeat that I would guide them on the way to live since they have returned. Do not point fingers at your colleagues, let us live normally as we did in the past. It was against their wish so you should not hold anything against them.

Another essential point participants raised was to try and make people understand that what happened to their communities was not something only particular to northern Uganda, that families in other war-torn countries were experiencing similar things. Adroa, a father from Barlonyo, described how his daughter’s marriage ended mainly because of the insults and stigma from the community towards both her and her husband. He shared how it was important to realize that what happened in northern Uganda wasn’t unique, and there were many people in the region and across the world facing similar challenges.

Let us remain strong. This kind of violence is happening in many parts of the world. You hear stories of children being abducted and atrocious things being done to them. It can never be in the will of one to seek such experience so let us stay strong.

Counseling services for survivors (and partners)

Most respondents said they didn’t seek formal counseling services, and neither did the survivors in their household. This was mainly due to the fact that they didn’t think it was something they needed or could ask for. This was mainly because they didn’t know they needed help, even though they were experiencing physical and emotional problems due to being exposed to what happened to the survivor. More importantly, counseling services weren’t readily available and were rarely advertised for anyone apart from the survivor. Despite this, most
participants felt strongly about the need to access counseling services not only for themselves, and survivors, but new partners of survivors as well. Achen, a mother from Gulu, described how counseling would have saved her daughter’s marriage.

A counsellor should be available so that if it is necessary, counselling can be given to calm the affected person down. As for our daughter, her Aunt took her and so we didn’t think of getting her a counsellor…her partner should have received counselling because that was her chance of having a good life if their relationship had worked. She had started forgetting but when he left her after having children with her, her recovery relapsed.

Furthermore, participants saw counseling as an important part of the healing journey for survivors. Ochieng, whose wife was abducted, shared how in addition to respectful treatment from the community, counseling was important for the survivors healing journey.

When one goes through such difficult experience, they must be treated fairly in order for them to feel human...if you have an obstacle in life and would like to deal with it speak to someone who can counsel you so that you get healing. Counselling is important for you the victim because it helps you to leave behind your past, speak to someone who can counsel you so that you get healing.

Discussion

The northern Ugandan conflict lasted for over 20 years, and resulted in tens of thousands of deaths, extensive displacement, and the breakdown of families and communities (Tiessen & Thomas, 2014). Moreover, a decade after the war ended, the long-lasting consequences of conflict-related sexual violence (CRSV) are still being experienced by survivors, families, and communities. It is well known that sexual violence can leave deep and long-lasting physical,
mental, and psychological impacts on survivors (Johnson et al., 2008; Liebling-Kalifani et al., 2008; Ward & Marsh, 2006). However, less is known about the effects of sexual violence committed during war on secondary survivors (Navarro & Clevenger, 2017). These are individuals who are the loved ones of the survivor and include anyone in the support system, such as family members, spouses, and friends. To the extent that secondary survivors are considered in the literature, the focus is usually on how their response to the survivor’s experiences helped or stalled the primary survivor’s recovery, and not on the impact of sexual violence on these individuals themselves, see for example (Christian et al., 2011; Kelly et al., 2011; Smith, 2005).

In this study, my goal was to explore the indirect impact of conflict-related sexual violence on immediate family members of women survivors living in post-conflict regions of northern Uganda. A total of 22 immediate family members, including mothers, fathers, and spouses, were interviewed from three post-conflict districts in northern Uganda: Gulu, Pader and Lira. The participants in this study described multiple challenges they experienced as a result of their indirect exposure to their loved one’s sexual assault and its aftermath. These included: how learning about the survivor’s abduction and sexual assault altered their relationships, the types of secondary traumatic stress participants experienced as a result, challenges of caring for children born during captivity, the different types of coping mechanisms they used to remain resilient, and overall care seeking behavior. I discuss each of these points below.

The interviews suggest that while family members were happy that the survivors came back from abduction, the disclosure process and learning about what happened in the bush put a strain on their relationship with the survivor and at times, changed the relationship dynamic in the family. Remer and Ferguson (1995) describe that initial disclosures of sexual assault might be
followed by a period of crisis and disorientation in which the partner or family member must adjust to the news that their loved one was victimized (Remer & Ferguson, 1995). The four husbands interviewed in this study (three of whom were abducted at some point during the war), experienced deep sadness and helplessness at what had happened to their wives in the bush. This is despite their ability to empathize with the survivor, mainly due to their own abduction experience. Although there is a dearth of research exploring similar concepts in war-affected countries, these findings are consistent with other research from non-conflict settings that have shown how sexual assault affects intimate relationships. In one of the earlier studies on the topic, Holmstrom and Burgess (1979) found that some men in their study perceived the rape of their partners not only as an act of violence causing injury to the survivor, but also as an act that caused emotional harm (stigma) to themselves and the relationship (Holmstrom & Burgess, 1979). Other studies have shown male partners reported significant stress and anxiety (Nelson & Wampler, 2003) as well as feelings of guilt and shame (Malata & Shay, 1995) because of what their female partner experienced. Reintegration is a two-way process that requires reciprocal readjustment to the new relational patterns and context with which the survivors and members of their families and communities contend (Derluyn, Vindevogel, & De Haene, 2013).

One of the most striking aspects of the family members’ interviews was the secondary traumatic stress participants said they experienced as a result of constant exposure to their loved one’s trauma. This has little focus in the literature compared to the focus of secondary trauma or vicarious traumatization.46 Most of the research around vicarious traumatization and sexual

46 McCann and Pearlman (1990) conceptualized the risks of working with trauma clients as vicarious traumatization. This refers to the transformation that is thought to take place within the counselor as a result of empathic engagement with the trauma client. Vicarious traumatization views the counselor’s response to the client’s trauma as formed by aspects intrinsic to the individual therapist as well as characteristic of the situation (McCann & Pearlman, 1990). Some counselors experience nightmares, intrusive thoughts, and disturbing imagery along with affective
violence has been on counselors who work with sexual violence survivors (Steed & Downing, 1998). Similarly, the limited research on the experiences of significant others of sexual violence survivors is mostly focused on how they help the survivors or problems they encounter while they assist the survivor through the recovery process, see for example (Burge, 1983; Cohen, 1988). Although this has led to some important findings about how the aftermath of sexual violence affects intimate relationships (Nelson & Wampler, 2003), the existing research neither captures the struggles partners and family members face from their own point of view, nor identifies how they cope individually, especially in resource limited settings like post-conflict northern Uganda where adequate care is not readily available. The participants in this study, who were family members who cared for women survivors of conflict-related sexual violence, experienced similar symptoms described in the vicarious trauma literature, including anger, anxiety, sadness, and withdrawal (McCann & Pearlman, 1990). This is an important finding in understanding how the vicarious traumatization framework can be extended beyond professional counsellors and therapists; in order to assess how family members and others who care for and informally counsel sexual violence survivors are affected by the ripple effects of sexual violence.

For parents of women CRSV survivors in this study, and especially mothers, their relationship with the survivors was at times complicated because of their grandchildren born in captivity. All of the family members interviewed reported that they were happy to take care of these children, especially when the survivor could not, either for emotional reasons or because her new partner would not accept her children. In most cases, family members already had large households and did not have the financial resources to take care of another person, which caused states such as anger, sadness, and anxiety that relate to their clients’ traumatic experience. These experiences are said to lead to short or long term defensive reactions including psychological numbing, denial and distancing.
problems within the family, especially when other family members saw the child(ren) born of war as an unwelcomed burden. In some cases, it also led to the dissolution of marriages (when the father did not agree with caring for his grandchildren born of war). Some of these findings are in line with previous studies that have shown that for women who return pregnant or with children, reestablishing relationships with families and communities is a complicated process (Veale et al., 2013). Studies from northern Uganda have shown that formerly abducted young mothers mediate the social integration of their children conceived of forced marriage by engaging in strategies to support and foster their well-being and social relationships (Shanahan & Veale, 2016; Veale & Stavrou, 2007). However, little is known about the role parents play in making the survivor’s transition smoother, and the toll that can take on their relationship both with the survivor and other family members. This study provides some new insights on the role mothers of survivors play to help survivors move on with a new life, and help their grandchildren integrate into their families and communities, even when the costs to do so might be high.

Another significant finding is how family members emphasized forgetting the past or repressing memories of the abuse experienced during abduction as one of the most important coping mechanisms they used, and it was what they advised the survivors they cared for to do. According to the psychology literature, memory repression, the exclusion of threatening or painful thoughts and experiences from conscious awareness, is one of the psychological defense mechanisms survivors use to deal with sexual assault (Ward, 1988). In addition, avoidance coping strategies 47 are frequently used during childhood in response to sexual abuse situations (Sigmon, Greene, Rohan, & Nichols, 1997). However, there is no literature on whether or not

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47 Avoidance coping involves cognitive and behavioral effects oriented toward denying, minimizing, or avoiding dealing directly with stressful demands and is closely linked to distress and depression (Penley, Tomaka, & Wiebe, 2002).
family members or intimate partners of sexual violence survivors use similar strategies as a coping mechanism. The findings from this study provide one of the first insights into our understanding of how family members cope after being indirectly exposed to sexual violence committed during war. Furthermore, given that avoidance coping strategies are associated with higher levels of distress in adulthood, the reliance upon these mechanisms in response to trauma needs to be addressed (Sigmon et al., 1997). On repressed memories, Levine (1993) asserts that dissociated parts of the personality are continually trying to work out trauma, and that they will be repeated until remembered and resolved (Levine, 1993). This raises concerns about family members of CRSV survivors’ long-term psychological well-being when it comes to living with secondary trauma that is repressed and untreated.

Another source of support participants in this study identified was their faith, which they considered to be a personal source of support independent of religious leaders or organizations. Most participants in this study considered God an ally, someone who understood their problems, and depending on him helped them look for help and understanding. This is in line with other research on how survivors of sexual violence use faith and spirituality to respond to, or recover from, their experiences (Knapik, Martsolf, & Draucker, 2008).

Finally, a key challenge for community rehabilitation in post-conflict northern Uganda is the absence of adequate health programming and psychological support and counseling (Tiessen & Thomas, 2014). Most of the family members in this study said they would have benefited from having access to counseling and other types of health services. However, they didn’t know if what they were experiencing warranted help, or where they could access services. Although there are some counseling services available for survivors of CRSV in northern Uganda,

48 Repression is also one of the foundation stones on which the structure of psychoanalysis is built (Loftus, 1993).
counseling and other health services are not readily available for family members who might experience secondary trauma. Most of the reception centers in northern Uganda helping reintegrate former LRA abductees are now closed, although a few organizations such as World Vision, GWED-G,⁴⁹ and Thrive Gulu continue to provide rehabilitation care for survivors. In most cases, these reception centers were the main providers of psychosocial support, facilitated first contact between returnees and families, and made the transition process for former abductees smoother. There is some evidence that former abductees who spent time in these centers had improved mental health and psychosocial well-being compared to returnees who returned directly to families and communities that were not prepared to accept them (Akello, Richters, & Reis, 2006). The importance of social support and sustained attachment to loved ones and other groups when responding to stressful events is evident (Hobfoll et al., 2007). Achieving resilience after facing adversity relies on the affected persons capacity to rely on positive relationships, especially families, and communities who have the capacity to help affected individuals access the necessary resources (Ungar, 2011). Similarly, family members, intimate partners and others are more likely to put the needs of the survivors first (Logan, Evans, Stevenson, & Jordan, 2005), and might not understand the effect the experience has on them. Therefore, interventions targeted towards survivors of conflict-related sexual violence, or conflict-affected communities in general must widen their focus to include the needs of family members and other individuals who care for CRSV survivors.

⁴⁹ Gulu Women’s Economic Development and Globalization is a women’s rights organization in Gulu, Uganda that was founded in 2004 as a non-profit, non-partisan, and non-governmental organization. It implements short and long-term sustainable development programs.
Limitations

A few limitations are worth noting. First, the qualitative interviews offer perspectives and insights from family members of conflict-related sexual violence in northern Uganda. Although these interviews explore potential relationships between different concepts and experiences, they do not seek to draw causal conclusions. Second, participants were recruited using purposive sampling, therefore, the themes identified from the narratives cannot be generalized to the larger population of family members of CRSV survivors. Third, this study focused on interviewing family members of CRSV survivors who were willing to be interviewed, and had a female survivor in the family. Therefore, it did not explore experiences of family members who were beyond the reach of the Women’s Advocacy Network or those who had a male CRSV survivor in the family. This approach risks overemphasizing problems of family members of female survivors only, while ignoring family members of male survivors. Further research should explore the challenges faced by family members of male CRSV survivors and former child soldiers. Fourth, this study focuses primarily on the views of family members without including the perspectives of the survivors they cared for. Fifth, the spouses who ended up being part of the study all had a somewhat successful relationship with CRSV survivors. As such, this study cannot speak to the perspectives of intimate partners who had difficult relationships with former LRA abductees. More research is needed to explore both the attributes of spouses who had difficult (failed) intimate relationships with former abductees, especially with women who came back with children. A final limitation involves the issue of collecting data from family members who were somewhat successfully connected with help groups, including WAN. As such, their concern may underrepresent the magnitude and scope of barriers facing family members that might be isolated within the community and don’t actively seek social support. Further research
with larger and more diverse sample needs to examine the impact of caring for CRSV survivors (both male and female) on family members as well as the larger community.
Summary

Bearing witness to human suffering and having to intervene in crisis can take a tremendous toll on individuals, and can be exacerbated when experienced within the context of armed conflict. Family members narratives reveal the multiple layers of challenges they faced as a result of their exposure to a loved one’s sexual assault during war. Although these experiences may aggravate problems the family faces in the post-conflict period, they might also help us understand factors that make some family members more resilient. This argues for moving beyond a narrow focus on the impact of conflict-related sexual violence on survivors, to a broader view of understanding the effect on families and communities. Having resilient individuals, families, and communities will depend on the strength of interventions to address the ripple effects of conflict-related sexual violence, increased access to counseling and other health services to families, and enhanced economic opportunities for former abductees, but particularly women and grandparents who continue to care for children born of captivity. In addition, it’s crucial that programs respond to the secondary trauma faced by family members, and improve long-term and sustainable coping mechanisms that have very little negative consequences. It must be noted that the experience of sexual violence aggravates the poverty survivors and their families face, making it difficult to meet basic needs. This is especially true when former abductees are unable to work due to physical or emotional trauma and economic losses. There is a need for economic empowerment of these women, their families, as well as sympathetic and non-judgmental support groups like WAN, where survivors and families can feel safe to share their experiences and help each other heal.
Table 5.1. Characteristics of Family Members of Women Survivors of CRSV

<table>
<thead>
<tr>
<th>Name*</th>
<th>Age</th>
<th>Relationship to CRSV survivor</th>
<th>City of residence</th>
<th>Age of survivor at abduction</th>
<th>Year of abduction</th>
<th>Length of abduction</th>
<th>Currently living with survivor</th>
<th>Number of people in the household</th>
<th>Survivor returned pregnant or with child</th>
<th>Lived together after survivor returned</th>
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<tr>
<td>Abbo</td>
<td>51</td>
<td>Mother</td>
<td>Gulu</td>
<td>12</td>
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<td>8 years</td>
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<td>10</td>
<td>Yes</td>
<td>Yes</td>
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<td>2 years</td>
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<td>1995</td>
<td>8 years</td>
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<td>4</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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<td>Gulu</td>
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<td>2004</td>
<td>1 year</td>
<td>No</td>
<td>8</td>
<td>Yes</td>
<td>Yes</td>
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<td>2004</td>
<td>1 month</td>
<td>Yes</td>
<td>8</td>
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<td>Barlonyo</td>
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<td>4 years</td>
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<td>Barlonyo</td>
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<td>2003</td>
<td>1 year</td>
<td>Yes</td>
<td>5</td>
<td>Yes</td>
<td>Yes</td>
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<td>Barlonyo</td>
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<td>2004</td>
<td>2 years</td>
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<td>7</td>
<td>Yes</td>
<td>Yes</td>
</tr>
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<td>55</td>
<td>Mother</td>
<td>Barlonyo</td>
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<td>5</td>
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<td>8</td>
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<td>Aromo</td>
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<td>Survivor is deceased</td>
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<td>Aromo</td>
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<td>8</td>
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<td>Brother</td>
<td>Aromo</td>
<td>17</td>
<td>2003</td>
<td>1 month</td>
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<td>7</td>
<td>Yes</td>
<td>Yes</td>
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<td>Aromo</td>
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<td>NA</td>
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<td>1998</td>
<td>5 years</td>
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<td>7</td>
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<tr>
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<td>6</td>
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<td>Mother</td>
<td>Acholibur</td>
<td>4</td>
<td>1990</td>
<td>15 years</td>
<td>Survivor is deceased</td>
<td>7</td>
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<td>Yes</td>
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<td>Acholibur</td>
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<td>Survivor is deceased</td>
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<td>7</td>
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*All names are pseudonyms to maintain confidentiality of participants
Not Available (NA) is used for cases where participants didn’t remember details about dates, circumstances, or asked to skip the question.
6. Conclusion and Policy Implications

The effects of conflict-related sexual violence (CRSV) on survivors, families, and communities are calamitous, and persist long after wars end. Between 1980 and 2009, there were 86 civil wars, where 18 of those conflicts involved “widespread rape”, and 35 of those conflicts included “many or numerous reports of rape” (Cohen, 2013). CRSV continues to affect men, women, and children around the world, who are often caught in the crossfires of armed-conflicts. Currently, there are at least 19 countries affected by war where verifiable information exists for the use of sexual violence as a tactic of war and terrorism (UNSC, 2018). For example, just in the past few years, extremist groups like Boko Haram in Nigeria, and the Islamic State of Iraq and the Levant (ISIS) in Iraq have abducted hundreds of girls and women who have suffered multiple forms of sexual violence in captivity (Callimachi, 2015; Otten, 2017; Sverdlov, 2017). Upon rescue, many of these girls and women are reunited with families who do not have the tools to cope with the trauma their loved ones experienced, as well as the adverse effects of the indirect exposure to sexual violence on themselves and other family members. In northern Uganda, one of Africa’s longest protracted conflicts, one in three women report having suffered at least one for of CRSV (Kinyanda et al., 2010). The aim of this dissertation was to explore the long-term impacts of CRSV on women and families living in post-conflict regions of northern Uganda. My hope is that lessons learned from the experiences of survivors and families in northern Uganda could be used to inform policy and improve programming for post-conflict communities in Uganda, as well as other countries affected by wartime sexual violence.

In the next sections, I present the key findings from the study for both survivors and family members, as well as policy, research, and programmatic oriented recommendations. Since most
of the problems survivors and family members raised overlapped and were cross-cutting and interdependent, actionable recommendations that can be taken by key stakeholders are made jointly.

Key Findings

Survivors of CRSV

I studied the long-term impacts of CRSV on women survivors in two ways. First, I explored the persisting issues survivors continue to face from their own perspectives. I was interested in understanding the enduring impact of the CRSV experience on their health, relationships, and support seeking behavior. I found that survivors in northern Uganda continue to face multiple challenges almost a decade after the war ended. These include a range of health-related issues, especially persisting untreated psychological problems such as anxiety and depression that continue to be triggered by a range of stressors, including stigma and economic hardships. Survivors relationships with family members, and intimate partners were also negatively affected because of their CRSV experience, which in turn adversely affected their support seeking behavior and overall healing process. Participants in this study faced hardships because of difficulty in accessing land and their inability to support themselves due to structural barriers including lack of access to economic opportunities. Survivors also had a great desire (but found it difficult) to support the education of children born in captivity, who also could not access land rights. This is because according to some Acholi traditions, children inherit land from fathers or through their paternal lineage. In addition, survivors encountered stigma from some family and community members due to being labeled as “former rebel” and the stigma that came with that label as well as having children born as a result of abduction by LRA rebels. Finally, although
most participants didn’t seek formal care due to personal and structural barriers—including fear of stigma, cost of services, and lack of information—survivor-led support groups were a source of strength for most survivors.

Second, I used nationally representative data on intimate partner violence (IPV) and data on conflict-events perpetrated by actors known to use sexual violence to study the patterns of IPV prevalence among women living in areas affected by the Ugandan conflict. I found that intimate partner violence was generally high in Uganda, including in conflict-affected regions, with over 65 percent of women saying they experienced at least one form of IPV, including emotional, physical or sexual violence by their partners. The most common type of violence experienced in conflict-affected areas was physical violence, followed by emotional and sexual violence. However, due to the limitations of the data (only 20 percent of the sample lived in conflict-affected regions), this result should be interpreted with caution. In addition, this was not reflected in the qualitative interviews where most women did not report experiencing violence from their intimate partners, and in cases where women did mention experiencing violence, it was mostly emotional abuse. Finally, I looked at attitudes towards wife beating for both men and women living in conflict-affected areas. I find that more men living in non-conflict affected regions found wife beating acceptable compared to men living in conflict-affected regions. This is an interesting observation that requires further investigation.

Family Members

Another important aim of this dissertation was to study the effects of CRSV on families of survivors, including intimate partners, who were indirectly exposed to the CRSV experience of loved ones. There is a dearth of research that examines possible ripple effects of CRSV, and sexual violence in general, on families of survivors. My goal was to explore how family
members of women CRSV survivors were affected by their indirect exposure to the trauma of the CRSV survivor. I wanted to understand in what ways family members were affected, including in terms of their relationship with the survivor, their health and well-being, the types of support they sought (if any), and coping mechanisms they found helpful. For most participants in the study, their relationship with the survivor became complicated as a result of the survivor’s disclosure about her CRSV experiences. In most cases, family members knew about what the survivor experienced but did not encourage further conversation. Mothers of survivors reported that the responsibility of caring for children born in captivity mainly rested on them, which at times negatively impacted their own relationship with their spouses and other family members.

In terms of the indirect effects of CRSV, I found that all family members in the study experienced symptoms of secondary traumatic stress, similar to symptoms described in the vicarious trauma literature including anger, anxiety, sadness, and withdrawal. None of the participants in the study sought formal care for their symptoms. However, they encouraged the survivor and themselves that forgetting the past and repressing the memories about what had happened was one of the best ways forward. In addition, they relied on their faith and focused on their relationship with God to deal with what they were experiencing. Unlike the survivors interviewed in this study, family members did not report having a support system where they could discuss what they were feeling and experiencing. However, they shared that they would have benefited from counseling services and other types of social support tailored to their needs.

**Implications for Policy, Research, and Practice**

The findings from this study on the enduring effects of wartime sexual violence have important implications for policy, research, and practice. Policy interventions are more likely to
be effective if that are informed by evidence, take the contextual complexities of conflict-affected communities into consideration, can be implemented within the constraints of existing resources, and incorporate the perspectives of individuals directly affected by the problem. The subsequent recommendations are made by taking these four points into careful consideration.

**Improve Access to Mental Health Services**

*Key stakeholders:* Policy makers, local organizations, donors, faith leaders, elders, researchers, program implementers, care providers, survivors, families of survivors

The World Health Organization recommends that mental health and psychosocial services for survivors of sexual violence should be integrated into general health services, and existing community support mechanisms, since specific targeting of survivors can make them susceptible to further stigma and discrimination (WHO, 2012). Therefore, interventions and support related to mental health services implemented in northern Uganda should be based on participatory principles and implemented with feedback and support of communities, including faith leaders, and elders who can dispel stigma and shame towards seeking mental health care.

Sustainable mental health services are generally inadequately resourced in Uganda, and especially in conflict-affected regions. There aren’t enough well-trained providers or community workers that can meet the mental health needs of survivors and their families. Given that leaders in self-started survivor-led groups are currently providing informal care to other survivors in the community, donors, policy makers, and program implementers should consider improving the capacity of women and men in these communities. This includes allocating funding for training community workers and survivors in case management and psychosocial support.

Group cognitive behavioral therapy (CBT), a type of psychotherapy that facilitates cognitive and emotional processing of the person’s reaction to trauma with other individuals who share
similar experiences, has been found to be effective in similar low-income conflict-affected settings (Bass et al., 2013; Bolton et al., 2014; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013). Based on the salient mental health problems identified in this study for both survivors and families, local organizations working with conflict-affected communities in northern Uganda should consider implementing similar interventions that test the efficacy of CBT among survivors and families of survivors in northern Uganda.

A concerted effort by researchers and local organizations is needed to implement more rigorous studies so we can better understand the secondary impact of CRSV on families and other individuals who care for survivors of wartime sexual violence. Researchers should consider extending the focus of secondary trauma (which is mainly focused on providers) to include families, friends and others who might be affected by the experience of sexual violence survivors. Validated psychometric tools currently used to measure secondary trauma on providers such as the Vicarious Resilience Scale (VRS) or the Secondary Traumatic Stress Scale (STSS) could be adapted and used to assess the need of family members of CRSV survivors (Killian, Hernandez-Wolfe, Engstrom, & Gangsei, 2017; Watts & Robertson, 2015). These tools can then inform the development and implementation of services for war-affected communities.

**Improve Relationships with Families, Intimate Partners, and Communities**

*Key stakeholders: Local organizations, faith leaders, elders, care providers, researchers, survivors, families of survivors*

The experience of conflict-related sexual violence can have adverse effects on the relationships between survivors and their family members, intimate partners, and communities. In Uganda, the stigma and rejection survivors of sexual violence face is deeply tied to their status as a former LRA wife, and because of societies’ views toward children born of sexual violence.
In addition, the perpetuation of stigma towards CRSV survivors is exacerbated by traditional and cultural views about women’s sexuality and gender inequalities in the society. Organizations working with survivors and families should work with faith leaders, and elders in the community who have an important voice on what is acceptable in their communities, and have the power to change how CRSV survivors and families are viewed, and challenge issues around their acceptance or rejection by members of the community.

Local organizations should continue to coordinate community dialogues that bring different perspectives and members of the community together. This includes care providers who should talk about some of the challenges former abductees face and can provide counseling to intimate partners of CRSV survivors as well as create awareness about some of the possible responses that can be helpful to their successful re-integration.

Researchers, program implementers, and local organizations need to build the evidence base on the ripple effects of CRSV on families, friends, and others in the survivor’s network (secondary survivors). When family members and friends of survivors are prepared for what to expect during and after their care for traumatized survivors, they will be better equipped to provide the care and support survivors need. In addition, they can mitigate the risk of their indirect exposure to the trauma on their emotional and mental health by using risk-reduction strategies including talking to providers about how they’re feeling or joining support groups for families of survivors.

**Provide Access to Land Rights for Women survivors and their Children**

*Key stakeholders: Policy makers, local organizations, faith leaders, elders, survivors, families of survivors*
Land is an important resource in Uganda, and over 90 percent of rural women depend on agriculture for income, and sustenance (FOWODE, 2012). The challenges women survivors face in northern Uganda is compounded by their inability to own land or provide land for their children born in captivity. In most northern Ugandan traditions, identity and belonging is tied to one’s father. Although both male and female children born in captivity are affected by their inability to access land, this problem is more pronounced among male children who need to own land in order to get married, and provide for their families. The issues around land ownership for survivors of CRSV and their children are undoubtedly affected by how people view their return and place within the community. Therefore, the involvement of community leaders, and elders is critical to activists’ and organizations’ efforts to remove the stigma towards CRSV survivors and their children.

Grassroots survivor-led organizations such as the Women’s Advocacy Network (WAN) have been actively engaged in solving the issues around land ownership for children born in captivity. In Acholi culture, knowing one’s paternal home or village is an integral part of social belonging. As such, women from WAN have mobilized to reunite some children born in captivity with their paternal families through community dialogues. Policy makers, local governments and funders should consider supporting these grassroots initiatives that have been leading a reconciliation and healing effort, and have had some success reuniting children born in captivity with their paternal families.

As the children conceived within the LRA reach adolescence, and start asking about their access to land and paternal families, their mothers might be forced to disclose their abduction and the sexual violence they experienced. This can raise a host of challenges for the children including sense of identity and belonging. Survivors should work with care providers and others
in their social network in order to receive psychosocial support as they work to devise the best ways through which they can disclose their experiences to these youth, who will undoubtedly be impacted.

**Support Survivors and Families Caring for Children Born in Captivity**

*Key stakeholders: Local organizations, donors, faith leaders, elders, program implementers, care providers, survivors, families of survivors*

When children born in captivity are rejected by intimate partners of women survivors, the burden of caring for them often falls on their mother’s family members, especially the grandmother. This puts a huge burden on families, especially those that are economically constrained. In addition, the stigma that is projected towards these children ends up affecting the family that cares for them. Local organizations and funders who support survivors of CRSV through different types of economic programming should consider extending their services to include family members of CRSV survivors who might need and benefit from support with livelihoods, family mediations, and other types of economic and psychosocial support.

Children born in captivity might also not have easy access to training and educational opportunities because of their mothers’ lack of resources, stigma in the community, and other structural barriers. These children will succeed in both the personal and public spheres only if their mothers succeed. Therefore, programs and initiatives targeted towards children born in captivity must also be inclusive of the needs of the mothers (or others) who are raising them. This might include family and community-based psycho-education, and coordinating community dialogues around specific issues affecting children, their mothers, step-parents, and others who care for them.
Increase Survivors’ Access to Economic Opportunities

Key stakeholders: Local organizations, donors, program implementers, survivors, families of survivors

One of the major barriers women survivors face is related to barriers to economic opportunities. In addition to their difficulty in accessing land, their lack of skills in specialized areas makes it difficult for them to do seek out economic opportunities outside the agriculture sector. Funders and organizations working with conflict-affected communities should consider helping women to diversify their skills through different educational and capacity training opportunities. This could include trainings on how to be involved in local leadership, adult education, community mobilization, vocational skills, health care, and community mobilization.

Survivor-led support groups for CRSV survivors and other similar grassroots movements in northern Uganda are powerful resources that should be further empowered. These organizations have the ability to bring issues faced by the most vulnerable and marginalized members of society to the attention of local governments and program implementers. They are key in creating awareness about the needs of CRSV survivors, mediating on behalf of survivors, educating the public about the stigma and discrimination faced by survivors, and bringing different stakeholders together for dialogue and sharing of experiences. Funders and donors working in Uganda should consider investing in these groups and providing both financial and educational support so that their work can be sustainable in the long-term.

Final Reflections

In this dissertation, my goal was to provide a better understanding of the enduring effects of wartime sexual violence on women survivors and families who care for them. It is my hope that through soliciting the perspectives of women and families directly, and asking them about the
problems they continue to face, I was able to present a snapshot of the most salient issues affecting these communities. The recommendations provided are suggestions for actionable steps that different stakeholders can take to address some of the challenges presented. Finally, I hope that the issues raised, solutions provided, and lessons learned will be useful in informing programming not only in northern Uganda, but other countries in sub-Saharan Africa and around the world affected by wartime sexual violence.
Appendix A: Interview Guide for Women Survivors

1. Can you tell me about your abduction experience? When were you abducted? What happened during those years?
   *Probe:* Did you experience rape, forced pregnancy?

2. Did you have children as a result of this experience? If yes, how many? Boys or girls?
   a. How old are these children now? Have you faced any challenges while raising these children in the community?
   *Probe:* (If participant is currently married) How have the children born during captivity integrated in the new family? Are there any challenges?

3. What were the most difficult things about coming home (after the abduction)?

4. How has this experience impacted your physical health? Your emotions and feelings?
   *Probe:* Did you experience sadness, depression, or any other negative thoughts?

5. How has your experience of sexual violence during abduction affected your relationship with your family? (e.g. husband, mother, father, brother, sister, children).
   a. Can you tell me more about how this relationship was before your abduction and how it changed after your experience?

6. What was your family’s response when you returned?
   *Probe:* Were there things you remember your family doing or saying that helped or hurt you?

7. Did you confide in your family? Can you tell me more about how that experience was like? Who else did you confide in?
   *Probe:* Why did you choose that person to confide in?

8. What is your current relationship with your family? How about your husband or partner (if married?)
   a. Did you (or do you still) experience any violence at home or in your current relationship?
      *Probe:* ask participant about domestic violence, inter-personal violence etc. If yes, why do you think are the reasons for this violence? How frequent is it? Do you share this with family or other people in the community?

9. How do you think being a survivor of abduction (sexual violence) has affected your family members?
   *Probe:* The way they treat you, their standing in the community, their health?
10. What kinds of social, health or justice related services have you tried to access?
   Probe: Please ask participant to list all services she accessed or wanted to access
   i. Which services did you want but were not able to get?
   ii. Can you tell me about the services that you found most useful?
   iii. What kind of health services did you frequently use before your CRSV experience, how about after?
   iv. Did you get help from different organizations after you came back, please tell us more about it?
      Probe: For example, ask participant about any transitional justice organizations she might have used.

11. What are other problems you faced in your life as a result of being a former abductee?
    Probe: What kind of challenges are you facing now?

12. Who are you currently living with? Are you working?

13. If you had the resources, what would you like to do now?

14. What would you want to share with other survivors?
Appendix B: Interview Guide for Family Members

1. Can you tell me about your [mother/ wife / sister / daughter’s] experience with sexual violence during abduction?
   a. What type of sexual violence did she experience?
   b. Do you know if she was raped during her time in captivity?

2. How did you find out about what happened (abduction or rape)? Who told you? (e.g. timing, context, other people in the family she confided in)
   *Probe: How did she tell you? Did the rest of the family know? Who else knew? How did they react?*

3. How long did you live with the survivor after she experienced the sexual violence or after she came back from abduction? When was the last time you lived with the survivor?

4. How did you react when you found out about what happened? (Reaction when you initially found out (from others/from her) and/or when she confided in you)
   *Probe: How old was she when she [the survivor] was abducted, when did she return? Ask for approximate time and year*

5. What was your relationship with the survivor before the CRSV incident, how did it change after you found out about the incident OR when she came back?
   *Probe: What were some of the problems you faced in the house after she came back? Did she come back with a child? How were things at home and in the community?*

6. How do you think her experience (e.g. abduction, rape) has affected you? How do you think it has affected other family members?
   *Probe: Can you give some specific examples of how things changed because of this experience? What were the main challenges?*

7. How do you think it has affected your health or well-being?
   *Probe: Did you face any sadness, depression or other emotional problems?*

8. Did you seek any health or other support services with the survivor, or by yourself?
   a. If yes, please describe these services
b. If no, what kind of services would you have wanted to have access to? What were the main reasons you did not access these services? What were the main challenges?

c. What do you think were the most important resources that helped the survivor cope with her experience?

9. Has the survivor continued to seek care and healing? If yes, how so?

   Probe: What kind of life is the survivor currently living? Is she married, does she have a job? How is her health and standing in the family and community?

10. Do you know if the survivor currently experiences any violence at home?

11. What would you want to share with the families of other CRSV survivors?

   Probe: Do you talk to other family members about this experience? What have you learned from others? What kind of support has been helpful?
Appendix C: Introductory Script for Survivors

Hello, my name is [insert name of study staff] and I am part of a study team at the Justice Reconciliation Project in Gulu that is conducting a study that aims to understand the health and social needs of women survivors of conflict-related sexual violence and their families in Northern Uganda. The study is called *Long-term Effects of Wartime Sexual Violence on Women and Families: The Case of Northern Uganda* and is being conducted in collaboration with Ms. Mahlet A Woldetsadik, who is leading the project and is a doctoral student at the Pardee RAND Graduate School, a university in the United States.

We would like to invite you to participate in the study because your experience as a survivor of conflict-related sexual violence can contribute much to our understanding and knowledge of the physical and health as well as social needs of survivors and their families. We will be interviewing around 20 to 30 survivors in total. You are free to decline to be interviewed and no one outside of the study team will know this.

We anticipate the interview to last between 60 to 90 minutes, and the main topics we will cover include your experience with conflict-related sexual violence, the potential effect it might have had on your physical, mental and social well-being, the types of services you sought or desired, and how you think it has affected the relationship with your family. You are free to decline to answer any question and to provide the level of detail you feel is appropriate. We will be asking to audio record interviews and we will be preparing transcripts or notes from the interviews. The audio recordings will be destroyed as soon as they are verified, usually within about two weeks after the interview. You are free to decline to be recorded if you prefer.

While writing the final results of the study, we will be reporting themes and variation in responses across the interviews. Although we may include some direct quotes, we will not be attributing them to you by name or in a way that would directly identify you. However, some people who know this field may make inferences, correctly or not, about the source of the quotes.

Responding to questions about your experience with conflict-related sexual violence may be emotionally upsetting. You can withdraw from participation at any time if the interview is upsetting you or refuse to answer any specific questions. We will ensure that counselors from Gulu Women’s Economic Development and Globalization (GWED-G) are available to meet with you to discuss your concerns and distress right after the interview or refer you to the appropriate services at a later date.

In addition, we will do everything necessary to keep your participation and the information you provide confidential by allowing you to choose the place and time of the interview and following strict data safeguarding guidelines.
Participating in the study may help you think about the physical and mental health as well as social needs of women survivors of conflict-related sexual violence and the effect this experience might have on their families. In addition, our hope is that the insights we will get from the interviews will ultimately be used to help inform programs and design better interventions that address the health and social needs of survivors and their families in northern Uganda and other conflict-affected countries in the region.

You will receive transportation reimbursement of 10,000 Ugandan Shillings for participating in the interview. You’ll receive this payment even if you don’t complete the full interview.

If you are interested and willing to participate in this project, you can tell me now or please contact me [insert number of study staff] or Mr. Oryem Nyeko, advocacy team leader at the Justice Reconciliation Project in Gulu, on [insert number] or [insert number], at your convenience.
Appendix D: Introductory Script for Family Members

Hello, my name is [insert name of study staff] and I am part of a study team at the Justice Reconciliation Project in Gulu that is conducting a study that aims to understand the health and social needs of women survivors of conflict-related sexual violence and their families in Northern Uganda. The study is called *Long-term Effects of Wartime Sexual Violence on Women and Families: The Case of Northern Uganda* and is being conducted in collaboration with Ms. Mahlet A Woldetsadik, who is leading the project and is a doctoral student at the Pardee RAND Graduate School, a university in the United States.

We would like to invite you to participate in the study because your experience as a family member of a women survivor of conflict-related sexual violence can contribute much to our understanding and knowledge of the physical and mental health as well as social needs of survivors and their families. We will be interviewing around 20 to 30 family members of survivors. You are free to decline to be interviewed and no one outside of the study team will know this.

We anticipate the interview to last between 60 to 90 minutes, and the main topics we will cover include how you think the experience of the survivor in your family has affected you, and other family members, and challenges you might have faced as a result of having a women survivor in your family.

You are free to decline to answer any question and to provide the level of detail you feel is appropriate. We will be asking to audio record interviews and we will be preparing transcripts or notes from the interviews. The audio recordings will be destroyed as soon as they are verified, usually within about two weeks after the interview. You are free to decline to be recorded if you prefer.

While writing the final results of the study, we will be reporting themes and variation in responses across the interviews. Although we may include some direct quotes, we will not be attributing them to you by name or in a way that would directly identify you. However, some people who know this field may make inferences, correctly or not, about the source of the quotes.

Responding to questions about a family member’s experience with conflict-related sexual violence may be emotionally upsetting. You can withdraw from participation at any time if the interview is upsetting you or refuse to answer any specific questions. We will ensure that counselors from Gulu Women’s Economic Development and Globalization (GWED-G) are available to meet with you to discuss your concerns and distress right after the interview or refer you to the appropriate services at a later date.
In addition, we will do everything necessary to keep your participation and the information you provide confidential by allowing you to choose the place and time of the interview and following strict data safeguarding guidelines.

Participating in the study may help you think about the physical and mental health as well as social needs of women survivors of conflict-related sexual violence and the effect this experience might have on their families who cared for them. In addition, our hope is that the insights we will get from the interviews will ultimately be used to help inform programs and design better interventions that address the health and social needs of survivors and their families in northern Uganda and other conflict-affected countries in the region.

You will receive transportation reimbursement of 10,000 Ugandan Shillings for participating in the interview. You’ll receive this payment even if you don’t complete the full interview.

If you are interested and willing to participate in this project, you can tell me now or please contact me [insert number of study staff] or Mr. Oryem Nyeko, advocacy team leader at the Justice Reconciliation Project in Gulu, on [insert number] or [insert number], at your convenience.
Appendix E: Informed Consent Information

You are being invited to take part in a project titled *Long-term Effects of Wartime Sexual Violence on Women and Families: The Case of Northern Uganda*. This project is being led by Ms. Mahlet A. Woldetsadik, who is a doctoral student at Pardee RAND Graduate School, a university in the United States.

The study explores women’s experiences with conflict-related sexual violence, and aims to understand how these experiences might affect women survivors and their family members.

Before you decide to participate, it is important for you to understand why the research is being done, and what it will involve. Please take time to read or listen to this information carefully and discuss it with your family, friends, relatives or other people in your community if you wish. Please let us know if there is anything that is not clear of if you would like further information. Take time to decide whether or not you want to take part.

**What is the purpose of the study?**
The purpose of the study is to assess the health and social needs of women survivors of conflict-related sexual violence and their families in Northern Uganda. We believe that gaining a better understanding of these needs will allow organizations to identify and provide improved services for survivors and their families.

**Why have I been chosen?**
You are being invited to take part in this study because your experience as a survivor of conflict-related sexual violence (or family member of a conflict-related sexual violence survivor) can contribute much to our understanding and knowledge of the health and social needs of survivors and their families. Our hope is that these insights will ultimately be used to help inform programs and design better interventions that address the health and social needs of survivors and their families.

**Do I have to take part?**
No, you don’t have to take part in the study if you don’t wish to. Your participation in this study is entirely voluntary. Taking part, withdrawing at any time or a decision not to take part will not affect the services or care you receive through the Women’s Advocacy Network or the Justice Reconciliation Project. You have the right to withdraw from the study at any time.

**Who is organizing the research?**
The study is being organized by the Justice Reconciliation Project in conjunction with Ms. Mahlet A. Woldetsadik, who is a doctoral student at the Pardee RAND Graduate School, a university in the United States. The Human Subjects Protection Committee at the RAND Corporation (Ms. Woldetsadik’s institution) and the Ugandan National Council for Science and Technology in Uganda has reviewed this study and approved it for your protection.
What will it involve?
If you agree to participate, you will be asked to give an oral consent to show that you have agreed to take part. A research assistance who works at the Justice Reconciliation Project will arrange a convenient time with you and either a JRP staff member of Ms. Woldetsadik will conduct a one-on-one interview that will last between 60 to 90 minutes. The interview will be conducted in English, or Luo.

With your permission, we would like to audio-record the interview to ensure that we are able to accurately capture your views and experiences. To protect confidentiality, individual names will not be collected during the interview. If you are not comfortable with the interview being recorded, you can still participate but we would like to have a second interviewer be present to take notes.

Will my taking part in this study be kept confidential?
There is a risk that your information might be accidentally disclosed but we have taken several steps to make this unlikely. First, in order to ensure confidentiality, we will not be recording your name. Instead, we will use a number system that will help us identify your interview and other personal details you may share with us such as your age, or the city where you live. Second, the recordings, and interview transcripts will be stored in a secure space and no one outside of the research team will have access to that information. The recordings will be erased as soon as a written copy has been typed up and translated to English for purposes of analysis by the study team. Third, although quotes from what you say may be used when findings of this study are discussed or published, no information that could identify or be prescribed to you will be used with the quotes.

What happens to the results of the research study?
We will use the interviews in which you participate to write up reports about the effects of conflict-related sexual violence on women survivors and their family members. Nothing you say will be identified as coming from you.

Potential risks and discomforts
Responding to questions about your experiences with conflict-related sexual violence (a family member’s experience with conflict-related sexual violence) may be emotionally upsetting. You can withdraw from participation at any time if the interview is upsetting you or refuse to answer any specific questions. We will ensure that counselors from Gulu Women’s Economic Development are available to meet with you to discuss your concerns and distress right after the interview or refer you to the appropriate services at a later date.

In addition, we will do everything necessary to keep your participation and the information you provide confidential by allowing you to choose the place and time of the interview and following strict data safeguarding guidelines as described above.

Potential benefits to participants and/or society
Participating in the study may help you think about the health and other needs of women survivors of conflict-related sexual violence and the effect this experience might have on their
families. The information you provide will be used by JRP and other organizations providing health services to improve service provision to survivors and their families.

What kind of compensation will I get?
You will receive transportation reimbursement of 10,000 Ugandan Shillings for participating in the interview. You’ll receive this payment even if you don’t complete the full interview.

Who can I contact?
If you would like to talk to someone about the study, or get more information, please contact Ms. Mahlet Woldetsadik at [insert e-mail address], Mr. Oryem Nyeko, advocacy team leader at the Justice Reconciliation Project in Gulu, on [insert number] or Human Subjects Administrator at the Ugandan National Council for Science and Technology on 0414705513/21. In addition, you can reach the Chairperson of IRB at Makerere University at 0393 29 13 97.

Interviewer: This information was read to the participant, or the participant was given enough time to read this consent form and ask questions.

Interviewer Signature: …………… Date: ………………………

Participant: I have read or the information on this consent form was read to me. I was given the chance to ask questions, and my full rights were explained to me. By signing this form, I give full informed consent to participate in an interview.

Participant Signature: …………… OR Participant Thumb Print: ………………………
## Appendix F: Demographic Questionnaire

### A. SURVIVOR

<table>
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<tr>
<th>S1</th>
<th>Participant ID</th>
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<tbody>
<tr>
<td>S2</td>
<td>Participant Current Age</td>
<td>“How old are you?”</td>
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<tr>
<td>S3</td>
<td>Participant Age when the first CRSV was experienced</td>
<td>“How old were you when you were abducted?”</td>
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<td>S4</td>
<td>Education</td>
<td>“What is the highest level of education you attended?”</td>
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<td>Degree or higher = 5</td>
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<td>Relationship Status</td>
<td>“What is your relationship status?”</td>
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<td></td>
<td>Single (never married) = 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In a relationship = 2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Legally Married = 3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Separated or divorced = 4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Widowed = 5</td>
<td></td>
</tr>
<tr>
<td>S6</td>
<td>Current City</td>
<td>“Which district do you currently live in?”</td>
</tr>
<tr>
<td></td>
<td>Gulu = 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lira = 2 (Barlonyo, Aromo)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pader = 3 (Acholibur)</td>
<td></td>
</tr>
<tr>
<td>S7</td>
<td>What is your current household composition (who do you live with)?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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## B. FAMILY MEMBER OF SURVIVOR

<table>
<thead>
<tr>
<th>F1</th>
<th>Participant ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>F2</td>
<td>Participant Current Age</td>
</tr>
<tr>
<td></td>
<td>“How old are you?”</td>
</tr>
<tr>
<td>F3</td>
<td>Participant Gender</td>
</tr>
<tr>
<td></td>
<td>Male = 1</td>
</tr>
<tr>
<td></td>
<td>Female = 2</td>
</tr>
<tr>
<td>F4</td>
<td>Member of family who is a CRSV survivor</td>
</tr>
<tr>
<td></td>
<td>“What is your relationship to the woman in your household who is a CRSV survivor”</td>
</tr>
<tr>
<td></td>
<td>Mother = 1</td>
</tr>
<tr>
<td></td>
<td>Sister = 2</td>
</tr>
<tr>
<td></td>
<td>Daughter = 3</td>
</tr>
<tr>
<td></td>
<td>Wife/Fiancé/Partner = 4</td>
</tr>
<tr>
<td></td>
<td>Cousin = 5</td>
</tr>
<tr>
<td></td>
<td>Other close relative = 6</td>
</tr>
<tr>
<td></td>
<td>*Mark all that apply</td>
</tr>
<tr>
<td>F5</td>
<td>Education</td>
</tr>
<tr>
<td></td>
<td>“What is the highest level of education you completed?”</td>
</tr>
<tr>
<td></td>
<td>None = 1</td>
</tr>
<tr>
<td></td>
<td>Attended primary = 2</td>
</tr>
<tr>
<td></td>
<td>Attended secondary = 3</td>
</tr>
<tr>
<td></td>
<td>Diploma = 4</td>
</tr>
<tr>
<td></td>
<td>Degree or higher = 5</td>
</tr>
<tr>
<td>F6</td>
<td>Relationship Status</td>
</tr>
<tr>
<td></td>
<td>“What is your relationship status?”</td>
</tr>
<tr>
<td></td>
<td>Single (never married) = 1</td>
</tr>
<tr>
<td></td>
<td>In a relationship = 2</td>
</tr>
<tr>
<td></td>
<td>Legally Married = 3</td>
</tr>
<tr>
<td></td>
<td>Separated or divorced = 4</td>
</tr>
<tr>
<td></td>
<td>Widowed = 5</td>
</tr>
<tr>
<td>F7</td>
<td>Current City</td>
</tr>
<tr>
<td></td>
<td>“Which district do you currently live in?”</td>
</tr>
<tr>
<td></td>
<td>Gulu = 1</td>
</tr>
<tr>
<td></td>
<td>Lira = 2 (Barlonyo, Aromo)</td>
</tr>
<tr>
<td></td>
<td>Pader= 3 (Acholibur)</td>
</tr>
<tr>
<td>F8</td>
<td>What is your current household composition (who do you live with)?</td>
</tr>
</tbody>
</table>
Appendix G: Data Safeguarding Plan (DSP)

Ms. Woldetsadik will have overall responsibility for data safeguarding. The main contact at the Justice Reconciliation Project in Uganda (Mr. Oryem Nyeko) and Ms. Woldetsadik will provide the guidelines for data safeguarding to other research staff, monitor the process and implement the procedures for handling data in Uganda and at Pardee RAND Graduate School.

To protect confidentiality and safety of all participants and the data they have provided, no names will be collected, and all interviewees’ details will be kept confidential and firewalled through a simple coding/numbering system based on the type and numerical sequence of the interview as shown in Table 1:

<table>
<thead>
<tr>
<th>Table 1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Survivor of CRSV</strong></td>
</tr>
<tr>
<td><strong>ID</strong> = Unique ID for participant depending on the # sequence the participant was interviewed</td>
</tr>
<tr>
<td><strong>L</strong> = Location of recruitment</td>
</tr>
<tr>
<td>Gulu= L1</td>
</tr>
<tr>
<td>Barlonyo= L2</td>
</tr>
<tr>
<td>Aromo= L3</td>
</tr>
<tr>
<td>Acholibur = L4</td>
</tr>
<tr>
<td><strong>S</strong> = Survivor</td>
</tr>
<tr>
<td><strong>F_F</strong> = Female Family Member; <strong>M_F</strong> = Male Family Member</td>
</tr>
<tr>
<td><strong>E.g. 01L1_S</strong></td>
</tr>
<tr>
<td>The first interview, at location 1, with a survivor</td>
</tr>
<tr>
<td><strong>E.g. 07L3F_F</strong></td>
</tr>
<tr>
<td>The 7th interview, at location 3, with a female family member</td>
</tr>
</tbody>
</table>

Thus, **01L1S** would indicate the first survivor interviewed from Location 1, and **07L3F_F** would indicate the seventh female family member interviewed from location 3.

All interviews will be recorded using the Olympus DS-3500 Professional Dictation Digital Voice Recorders, which are equipped with password protection and file encryption options. Each recording will be encrypted immediately after an interview is complete. At the end of each day or within 24 hours after interviewing (estimated # of interviews per day is 3– 4 per interviewer), the recordings will be uploaded to the study computer and Ms. Woldetsadik’s laptop and saved under an encrypted folder. Once the file has been uploaded to the computers, the file on the recording devise will be immediately deleted. The interviewer will create a verbatim transcript of each recording within 7 days after the interview. After all transcripts have been translated to English, and verified by an outside translator, the recordings will be deleted from Ms.
Woldetsadik’s computer. Audio and transcript files will not contain any identifying information and will be saved according to the numbering system shown in table 1.

The numbered transcripts will be shared with a professional translation service to be translated to English. The final transcripts (in English) will be stored on a separate and encrypted file on Ms. Woldetsadik’s RAND Computer only. If participants decline to be recorded, the notes from those interviews will be taken using the same numbering system described above, and typed and saved into the study computer within 24 hours. Paper copies of notes will be stored in a locked cabinet at JRP’s office and destroyed at the conclusion of the study.

During the writing process, and when a particular quote is used, it will be done in such a manner as to ensure anonymity and firewalling. Thus, no real names will be used and if a reference is made to a quote it might be “a survivor in Location x stated” or a pseudonym will be used. At no point will an individual’s details be referenced in the report or anything derived from it.


Champion-de-Crespigny, J. S. (1996). *The experience of couples in intimate relationships when the woman is a survivor of child sexual abuse: A phenomenological study*. (Doctoral dissertation, University of Ottawa (Canada)).


FOWODE (Forum for Women and Democracy) (2012). Gender Policy Brief for Uganda’s Agriculture Sector. FOWODE, with support from the United Nations Joint Programme on Gender Equality.


McCoy, S., & Mazurana, D. E. (2004). Where are the girls? Girls in fighting forces in Northern Uganda, Sierra Leone and Mozambique: Their lives during and after war.


———. 2018. Uganda Demographic and Health Survey 2016. Kampala, Uganda and Rockville, Maryland, USA: UBOS and ICF.


Verhey, B. (2004). *Save the Children, UK, and CARE, IFESH and IRC*. 152


