Rape without remedy: Congolese refugees in South Africa

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Theresa Alfaro-Velcamp1,2,3* and Robert H. McLaughlin1

Abstract: Refugees Without Remedy describes how anti-foreign sentiments map to the rape of Congolese refugee women, and how they lack a meaningful way to seek recourse in South Africa. The trauma caused by rape—especially when combined with forced migration, loss of a family member, and xenophobia—persists in their everyday lives. Rape has become normalised across contexts in which migrants are repeatedly raped in their home countries, in transit, and again in their host countries. This paper elevates narratives of rape alongside the framing of refugee status in human rights discourse, describing this multi-faceted problem with attention to immigration and health laws that derive from commitments to human dignity and justice in the South African Constitution (Sections 7 and 10). Although South African law grants access to health care to everyone, existing health and legal systems fail—as they do in many jurisdictions and for varied reasons—to bring meaningful remedy to refugee women who are survivors of rape. The paper is informed by more than 80 interviews and draws on selected cases that are illustrative of the trauma of rape and its implications for a lack of refugee protections.

Subjects: Terrorism & Political Violence; Mental Health; Violence and Abuse; Trauma

Keywords: rape; refugee women; health and human rights; South Africa; the Democratic Republic of Congo (DRC)

ABOUT THE AUTHOR
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PUBLIC INTEREST STATEMENT
Refugees are subjected to gender-based violence and specifically rape in their home countries, during transit, and in the host country. The horrific accounts of pervasive rapes in the Democratic Republic of Congo (DRC) have been documented. Here, the authors examine how the lack of international human rights protections for refugees who have fled the DRC has had an enduring and dangerous impact for those in South Africa. The normalisation of rape among refugees in South Africa has created a context in which raped refugee women are not getting access to needed health care. To the extent that rape is accepted as an inherent part of the refugee experience, local, state, and international actors are challenged to make effective, remedial interventions. The article is based on over 80 interviews and draws on selected cases.
1. Introduction

“What’s so terrible about rape? You don’t die from it”, a humanitarian colleague commented to Roberta Cohen, a former UN consultant and U.S. delegate to the UNHCR (United Nations High Commissioner for Refugees) (Cohen, 2000, p. 74). Cohen lamented that “it was the acceptance of rape as a regrettable but unavoidable part of refugee life” (Cohen, 2000, p. 74). This acceptance of rape by humanitarian aid workers and UN staff is often coupled with how immigrant women feel that their perpetrators do not see them as human beings. The ubiquity of rape among refugees in South Africa can be linked to the broader normalisation of rape within South African culture. A compelling theory of this normalisation is the legal and social construction that some people are “unrapeable”—meaning certain individuals (men, women, and transgender people) do not count when harmed, and that, in turn, South African society responds or fails to respond to their needs on this basis (Gquola, 2016; Helman, 2018). In this context, refugee and immigrant discussions have often been framed by the persistence of xenophobia in post-apartheid South Africa, yet few have pushed inquiries into the specifics of how anti-foreign sentiments map to the rape of refugee women. This paper elevates narratives of rape alongside the framing of refugee status in human rights discourse, describing this multi-faceted problem with attention to immigration and health laws that derive from commitments to human dignity and justice in the South African Constitution (Sections 7 and 10). Although South African law grants access to health care to everyone, existing health and legal systems fail—as they do in many jurisdictions and for varied reasons—to bring meaningful remedy to refugee women who are survivors of rape.

The paper is motivated by the research question of whether and how the normalisation of rape contributes to the inadequacy of refugee protections and access to health care. It begins with a discussion of the research methodology, followed by a description of the intersection of refugee and health rights in South Africa. A subsequent section discusses the Democratic Republic of Congo (DRC) and the enduring trauma experienced by refugee women in Cape Town. The paper then offers a set of illustrative cases, narratives about rape and survival. The narratives highlight how a context of xenophobia and inadequate implementation of human rights have left these survivors of rape without remedies in health and law. Through these narratives, a pattern is apparent in which women have been gang-raped in their home villages in the DRC. In fleeing their homes, the women become internally displaced. Insecurity within their home countries then prompts these women to flee further, to another country, and they may be raped while transit. Often, those who seek refuge in South Africa have thus been doubly assaulted, at least, and arrive only to face new, continuous threats (Ross-Sheriff, 2013, p. 1). Through their astounding journeys, these women survived—whereas many did not—and they want to share their stories and be heard.

The South African Migration Programme (SAMP) has monitored attitudes toward migrants and refugees for nearly 20 years and found “unequivocal evidence of deep-rooted and pervasive hostility and animosity towards migrants and refugees” (Crush & Ramachandran, 2014, p. 3). According to SAMP research, 11 percent of South Africans sampled said they would use violence against foreign migrants (Crush & Ramachandran, 2014, p. 19). Of this same sample, only 31 percent felt that refugees always had a right to legal protection, and 36 percent felt that refugees always had the right of protection by police (Crush & Ramachandran, 2014, p. 18). These views exhibit the tensions in South African society about international human rights, including obligations to care for the local population, and doing so with limited resources. They stand in contrast to South African constitutional protections.

Although xenophobia has been debated and well documented throughout Africa, the escalation of anti-foreign criminal activities such as rape is rarely explicit as a health concern with meaningful remedies—especially in light of progressive realisation, the legal and constitutional notion that the obligations of the state extend only to what the state can pay for and pragmatically achieve (Onoma, 2013). In South Africa, rape has been and remains heavily discussed and analysed, including efforts to attend to and account for the perpetrators of rape. More than 25 percent of
South African men admit to forcing a woman to have sex (Jewkes, Sikweyiya, Morrell, & Dunkle, 2010). The South African Police Service (SAPS) reported in 2018/2019 that there were 41,583 rapes; though difficult to substantiate and verify, the number implies an average of 114 rapes per day were recorded by the police (Africa Africa Check, 2019, pp. 3–4).

Helen Moffett situates sexual violence as part of the post-apartheid, democratic South Africa in which it has become a “socially endorsed punitive project for maintaining patriarchal order. Men use rape to inscribe subordinate status onto an intimately known ‘Other’—women” (Moffett, 2006, p. 129). Moffett explains that the current narratives of “normalisation” surrounding sexual violence in developing countries can be layered and often do not take into account the historical context of extreme ethnic and racial conflict (Moffett, 2006, p. 131). This analysis depends on the principles of “othering” that subordinate women to an inferior position in an established patriarchy. According to a 2004 study of 3,500 participants, one in three South African women can expect to be raped in her lifetime; and one in four women will be beaten by her domestic partner (Moffett, 2006, p. 129). Moffett ultimately argues that many men rape “not because they want to or are ‘tempted’, but because society tells them they can (and in some cases, should) do so with impunity” (Moffett, 2006, p. 140). It is within this cultural context that refugee women arrive bearing past experiences of sexual violence and continued vulnerability, especially to rape.

2. Methods
To describe rape among refugee women, this study involved more than 80 interviews and presents selected cases that are illustrative of the trauma of repeated rape and its implications for refugee health protections. The paper is based on an ethnographic research methodology and participant observation. Open-ended interviews in Cape Town, South Africa, were conducted between April and November 2015 and in October 2016. In addition, a Congolese community leader organised two focus groups in October and November 2015 during which approximately 12 people attended and 6 women shared their stories with each other and the authors. The interviews were conducted in English with the Congolese community leader translating from Lingala to English when the refugees preferred to use their native language. The research was designed to protect their anonymity, including the use of pseudonyms in data collection. A list of questions was developed before the project began, refined as the interviews were undertaken, and approved by ethics review committee of the Faculty of Law at the University of Cape Town (UCT Faculty of Law Research Ethics Committee, 7 April 2015 [L2-2015]).

The research team involved had begun to investigate the topic of asylum seeker and refugee documents and decided to interview immigrants with whom team members had developed trust over several meetings. As that project unfolded, participants were motivated to speak in the hope that exposing corruption might stop abuse. This project and its focus on rape emerged from participant interests. In the interviews that followed, new participants came forward wanting to tell their stories of rape because the rapes have profoundly shaped their lives. Their courage in doing so drives the effort here to present narratives with authenticity in voice and word choice, and dignity in presentation (Liebling, 2018).

The women who came forward described meeting with South African Refugee Status Determination Officers (RSDOs), UNHCR officials, and the Trauma Centre counselors. The Trauma Centre offers psychological support. In some cases, Trauma Centre counselors can make referrals to UNHCR for possible resettlement. In particular, the women feared the SAPS, felt unsafe in South Africa, and were interested in resettling to another country.

In full recognition that the study could afford no assistance to its vulnerable participants, the methodology was conservative (McLaughlin & Alfaro-Velcamp, 2015). Participants were engaged in good faith with the understanding that they would be honest and truthful in sharing information, and would also be reserved and partial in their responses where appropriate to protect their private interests. The authors strove to maintain equipoise through a commitment to verifiable
detail in the migration narratives. The participants shared devastating stories of deliberate rapes and of having been targeted as members of groups, some eligible for refugee protection, others less so. The suffering they endured and the inability to get redress highlight the limits of human rights laws and progressive realisation in South Africa.

This study is also informed by experience preparing intake interview notes for refugee clients of the University of Cape Town Refugee Rights Clinic. One of the authors volunteered at the clinic to help prepare letters to the South African Refugee Appeal Board. Most of the clients were men and many were from the DRC. Five women and one man were explicit about their experiences of rape and family loss. One woman who recounted being gang-raped displayed burns on her back from the perpetrators. A South African RSDO rejected this 24-year-old woman from South Kivu as not being a refugee because the officer did not perceive her to be fleeing persecution. Speaking through a Swahili translator, the woman recalled her single mother’s failed effort to retain the family farm against village men. These men killed the woman’s mother, ruining the woman’s life. Yet her story did not convince the officer to rule in her favor. In 2007, 10 village men had come to the farm and the woman hid in the bush. She witnessed her mother getting gang raped, stabbed in the vagina, and killed. Three days later, the same 10 men gang raped the woman and impregnated her, resulting in the birth of her then six-year-old son, who joined her at the clinic. After the rape, her family had called her a prostitute and banished her from the family house. After drafting an appeal letter and arranging for a follow-up appointment for her, the woman disappeared, and the author does not know the fate of her appeal.

The male client reported that “neighbors had been raped and getting HIV”. Several other clients reported that they had missing relatives and were haunted by children who had disappeared. They wondered whether their children were dead or alive. Although it was rarely mentioned, it was implied that rapes had occurred. Others reported having to witness the rape or killing of loved ones and then barely escaping themselves. Many relied on translators, and many details were lost in the communications. In some instances, translation services were not available and for immigrants not conversant in English, the most effective language in South Africa for immigration matters. This became an acute problem, adding to the difficult of articulating these life stories.

3. Context

3.1. Status and the intersection of refugee rights and access to health care in South Africa

The sequence associated with adjusting legal status in South Africa confuses almost everyone—the asylum seekers, immigrants, police, officials in detention centers, and the general public. Compared to other African countries that have refugee populations, South Africa currently allows foreigners to more fully integrate into South African society. The closing of the Cape Town Refugee Reception Office to new asylum seekers in 2012, however, led to an unknown number of immigrants surreptitiously entering and residing in South Africa’s Western Cape Province. A March 2015 court ruling held that individuals needed to go to one of four Refugee Reception Offices (RRO)—in Musina, Durban, Pretoria, and Port Elizabeth—to receive a Section 22 (asylum seeker) permit in South Africa. This ruling was later declared unlawful by the Supreme Court of Appeal on 29 September 2017. (Scalabrini Centre, Cape Town v The Minister of Home Affairs (1107/2016) [2017] ZASCA 126 (29 September 2017). The Director General of the South African Department of Home Affairs (DHA) was directed to reopen the Cape Town RRO by 31 March 2018; the reopening has since been postponed until January 2020 (Palm, 2019). The years of uncertainty escalated in late 2019 when 600 refugees and immigrants participated in a sit-in protest near the offices of the UNHCR in Cape Town. Beginning on 8 October, the sit-in was broken up on 14 November. This was protest was coordinated with a similar protest in Pretoria. (Evan, 2019). At the time of writing, video footage showed dramatic images of foreign nationals being dragged into trucks.
Under the **South African Refugee Act 130** of 1998, Section 3, a Section 22 permit allows an individual to remain in South Africa legally and move about the country freely until a hearing to determine whether her/his situation fits the definition of a refugee fleeing persecution due to race, tribe, religion, nationality, political opinion, social group, external aggression, and/or disturbing public order. (This refugee definition is drawn from the 1951 Refugee Convention.) After the first hearing, the asylum seeker can be granted refugee status (Section 24) or deemed unfounded (a determination subject to appeal) or manifestly unfounded. If the individual is found to have a manifestly unfounded, fraudulent claim, then he or she needs to leave the country within 30 days or face deportation. At this moment, the individual becomes “illegal”. RSDOs at the DHA often make swift adjudications of refugee applications, and the officers reject 89 percent of individuals who come before them (Department of Home Affairs [DHA], 2014, pp. 6–8). The number of refugees and asylum seeker cases in South Africa in 2015 was estimated to be the second largest multiyear backlog of unsettled asylum cases in the world (Stupart, 2016/2018; UNHCR, 2016).

There are three main laws and immigration regulations that guide South Africans on questions relating to refugees’ and migrants’ access to health and emergency care. These are the **National Health Act**, the **Refugee Act** of 2008, and **Immigration Act 13** of 2002. The laws, however, are not consistent and create contradictory and confusing situations for patients and medical practitioners. With respect to protections, the **National Health Act 61** of 2003, Chapter 1 (2)(c), commits the government to “protecting, respecting, promoting and fulfilling the rights of: the people of South Africa to progressive realisation of the constitutional right of access to health care services [...] (iv) vulnerable groups such as women, children, older persons and persons with disabilities” (Immigration Act 13 of 2002 [Immigration Regulations, 26 May 2014]).

Despite South African constitutional and legal protections for refugees, there is little to no enforceability. The intentions of international parties—such as the signatories to the United Nations Convention Relating to the Status of Refugees; Refugee Convention; and the International Covenant on Economic, Social, and Cultural Rights—and regional instruments such as the African Charter on Human and Peoples’ Rights fail to protect these refugees who have been raped.

Scholars have linked the limitations of these instruments to embedded assumptions about gender relations. The notion of universal humanism often conflates tradition and culture with respect to gender relations and humanitarian interventions (Palmary, 2007, p. 125, UNHCR, 2002). The problematic nature of these gender categories has created a lacuna for men and boy survivors of sexual abuse. The experiences of the Congolese women described in this paper thus relate to broader humanitarian needs. Despite attempts to quantify and find survivors of rape, data are “fundamentally incomplete” because of the “shaky foundation for humanitarian programming” which is rooted on a continuum of gender-based violence of women and girls and men and boys (Dolan, 2016, p. 632). Chris Nolan argues from his, “extensive practical experience working directly with refugee women, men, and LGBTI survivors of sexual violence ... that accessing appropriate support services which work for all survivors regardless of gender is a struggle that is particular acute for the latter categories” (Dolan, 2016, p. 629). This gender hierarchy has limited how to approach the needs of rape survivors in refugee contexts, especially outside of refugee camps.

### 3.2. The DRC and enduring trauma

Many of the refugees who live in South Africa today are from the DRC, having fled the lingering conflicts of the recent wars and the refusal of former president Joseph Kabila to step down. After much strife in January 2019, Félix Tshisekedi of the Union for Democracy and Social Progress party was inaugurated as president. The history of the DRC has led to a lack of institutions that serve and protect its people. The country, known as the Belgian Congo, was ruled and exploited by Belgium from 1885 until it gained independence in 1960, which ushered in a period of coups d’etat, internal warfare, and migration that continue today. Two wars devastated the country. The First Congo War (1996–1997) involved Congolese Tutsi who lived primarily in the eastern part of the country. Tutsi-led
Rwandans invaded the country, adding to political instability. Long-term military dictator and President Mobutu Sese Seko was forced out of office. The Second Congo War (1998–2003) involved nine African countries and about 20 armed groups. Approximately 5.4 million people died (Coghlan et al., 2007) and estimates are that more than 1.4 million Congolese refugees fled, with more than 70,000 emigrating to South Africa (Flahaux & Schoumaker, 2016, p. 6).

The populations in the DRC continue to be vulnerable to violence, especially rape. Political instability has created an ongoing stream of refugees for nearly three decades, redirecting refugee communities throughout Africa. The Lancet reported, “… health workers say male relatives are often forced at gunpoint to rape their own daughters, mothers, or sisters; and that frequently, women are shot or stabbed in their genital organs after they are raped. Sometimes broken bottles or corn cobs are shoved into the women’s genitalia after the rape” (Wakabi, 2008, p. 2). Similar stories are heard from Congolese refugee women who have settled in Cape Town. The trauma they have experienced is “… neither meaningless nor unimaginable, although it might be experienced as if it were. More significantly, its elusive traces are manifest in the failure of imagining, remembering, and narration to integrate the self in a cohesive fashion” (Field, 2012, p. 134). These refugees sought to remember, share themselves, heal and seek justice by telling their stories.

Racial and gendered constructions combined with xenophobia complicate the examination of rape in South Africa. The notion of unrapeability implies that some women cannot be harmed by the sexual violations enacted upon them (Helman, 2018, p. 10). This concept plays on the 2006 Jacob Zuma (South African President 2009–2018) rape trial in which Advocate Kemp said that Fezekile Ntsukela Kuzwayo (Zuma’s accuser) was sexually promiscuous and therefore unrapeable. The extension of this notion to foreign-born women, such as the Congolese in Parow, a suburb of Cape Town, resonates with xenophobic attitudes and how refugee women are often deemed illegal and stateless. Refugees, though vulnerable to sexual violence, can be deemed unrapeable on the basis of the precariousness of their legal status alone. As Lisa Vetten theorises about rape more broadly, it is “not only the consequence of individual failings, but the outcome of a whole series of inactions and collusion on the part of others. In this way, it can be said to illustrate how oppression is sustained more collectively” (Vetten, 2011, p. 270). Post-apartheid South Africa maps this oppression to refugees, and specifically to women like those who shared their stories in this research.

To heal, survivors of rape not only need an infrastructure of support, but they also need to feel safe in their surroundings. The healing includes telling their story of trauma and coming to terms with their traumatic past. As psychiatrist Judith Herman writes, “[T]he most common trauma of women remains confined to the sphere of the private life, without formal recognition or restitution from the community. There is no public monument for rape survivors” (Herman, 2001, p. 73). Herman also asserts that for healing it is important to create a future for survivors of rape, whereby “the response of the community has a powerful influence on the ultimate resolution of the trauma” (Herman, 2001 pp. 70, 197). The South African context of xenophobia and the normalisation of rape does not allow survivors to heal. It is the “hegemonic definitions of trauma … [that] are not scientifically neutral but culturally specific and … [they] … have to be revised and modified if they are to adequately account for—rather than to (re)colonize—the psychological pain inflicted on the downtrodden” (Craps, 2013, p. 21). The experiences of these Congolese refugees need to be described in cultural, social, and legal contexts. The inherent vulnerabilities ascribed to them have left them unprotected in their home countries, during their migration, and upon arrival in a host country.

4. Results

4.1. Gloria and Lucia

Of the six women at the first meeting, all had experienced rape personally, as had many of their daughters. All had lost a family member—a husband, parent, or child. Gloria, the first woman to
speak was 47 years old, and her husband had been a supporter of Mobutu Sese Seko. When Mobutu lost power, her husband fled. People unfamiliar to the woman arrived at her home and raped her. She and her six children left. They first went to Angola for a year, then to Namibia, and arrived in South Africa in 2000. Gloria was upset about the resettlement process and believed that she was soon to be emigrating to the United States. During the authors’ second visit to see Gloria, she mentioned that her two daughters had been gang raped in the DRC. One of the daughters had a child in 1999 and lives with her.

Lucia, a 59-year-old grandmother seemed distrusting of the authors, but she opened up on her second visit. Her husband and son-in-law were Mobutu supporters. One night, Kabila soldiers came to their house, attacked them, and beat her so badly that they knocked her teeth out. Her daughter was pregnant at the time. Lucia and her daughter fled to Lubumbashi and then to Zambia. They went to Johannesburg and arrived in Cape Town in 2009. When her daughter went to a hospital for a prenatal check-up, the doctor called Lucia and explained that her daughter was dying and needed a Cesarean section. Twin girls were born as their mother died. Lucia said that people had “tried to kidnap the girls”, but it was not clear who these people were. Lucia also said that “they killed her daughter” at the hospital. She had been to the Trauma Centre in Cape Town, but they would not refer her to UNHCR. At the time of research, the Trauma Centre had a Protection Needs Referral Form in which a refugee would describe her difficulties in her country of origin or asylum in the hopes of getting a referral to UNHCR to be resettled out of South Africa. Lucia said that she wanted the girls to live in a safer place.

4.2. Rosine
Rosine, another 59-year-old grandmother, recalled that after the 2006 election, pro-Kabila forces broke into her house because her son was a member of the Movement for the Liberation of Congo, led by Jean-Pierre Bemba. Rosine also did propaganda work for her son and a progressive political party in the DRC. She left because her husband and two children were killed. Rosine added that she had been raped in front of her children and then the Kabila soldiers killed two of her children in front of her.

Rosine had been rejected for refugee status and subsequently appealed for reconsideration. One of her children had been beaten in 2008 during the xenophobic attacks and suffered brain damage. During the 2008 attacks, an estimated 20,000 non-nationals were internally displaced by xenophobic violence. (Cohen, 2013, p. 63; Gonzales, 2012). She brought her 32-year-old son with an expired asylum seeker permit to the second meeting with the authors. Rosine also mentioned at the second meeting that her daughter, born in 1999, had recently been beaten by a South African boy at school. The daughter had reported the boy to a teacher for a school infraction, but school authorities told the woman and her daughter that they must not say anything. If they reported the incident to the police, the school authorities would “chase” the girl away. After sharing this, Rosine said that because of the lack of time at the first meeting, she did not mention that her two daughters (born in 1980 and 1987) were gang raped and beaten in 2006 in the DRC. The daughters came to South Africa and received their refugee status, but they are not well. One daughter has a child from the gang rape, and all seven of them live in one house.

4.3. Victoria
Victoria came to the first meeting, and she had an asylum seeker permit. Her husband had been a journalist for Mobutu, and when Kabila came to power in 2006, she and five children (two children and three grandchildren) fled to Brazzaville in 2006–2007. Her daughter was born in 1972 and her son in 1976. When Kabila said it was safe to return, they did so in 2010 and were living near the airport. One day in June 2010, they heard gunshots, and the Kabila soldiers took her husband and shot and killed him in front of her. They raped her and then stabbed her in the chest.

Victoria fled with her children to a Catholic Church and asked the priest for help. She then took a truck to Lubumbashi and eventually got to Johannesburg. In Johannesburg, she went to another
Catholic Church and they gave her money to go to Cape Town. In July or August 2015, her son went missing in Johannesburg, and she wanted to take custody of his two sons—ages 15 and 9. Her daughter-in-law was planning to bring the boys to Cape Town; however, the daughter-in-law became ill and was in hospital. Victoria described how once the daughter-in-law got better, she and the grandsons would come to Cape Town. Victoria's son remains missing, illustrating how fragile these refugees' lives remain in the host country.

4.4. Ruth

Unlike the other women, Ruth came from Eastern Congo and spoke in English during the first meeting. She was soft-spoken and seemed confident about her story compared to the other women present. Her father was a supporter of Mobutu and kept things (presumably food and arms) in their family home. One day in 2003, Kabila soldiers came and said they needed everything, and the father said, “not everything”. The soldiers then beat him and the family and “did things” like “putting things in women’s vaginas”.

According to Ruth, after the beatings and rapes, they started walking to Rwanda and arrived in Goma, where they slept outside. Other groups also started arriving. She decided to take a boat to Uvira with the other groups and left her family behind in Goma. Ruth never explained to the authors why she left her family. From Uvira, she went to Tanzania, then to Johannesburg, and took a big car to Cape Town.

Ruth was told in Johannesburg that it would be easier to get work in Cape Town because ladies will help you “plait hair”. She was working in Gugulethu, a township nine miles outside of Cape Town. While in Gugulethu, she has been robbed seven times. During one robbery, two "black South Africans" took her purse and phone at gunpoint. She left for a while but returned to work in Gugulethu in a second-hand cargo shipping container, plaiting hair with other foreign women. All the women employed in the container were foreign.

Coinciding with the 2008 xenophobic violence in Gugulethu, robbers broke into the container where Ruth was plaiting hair and stole hair dryers and everything else they could take. While trying to escape, Ruth fell and broke her knee. She had to wear a cast for six months. She was stressed going to work and tried to work only on Saturdays. She also had high blood pressure. Ruth said she wanted to leave South Africa.

At the second meeting, Ruth did not want to speak in English and asked for a translator. She said that her nephew had been killed in Johannesburg during the week of 16 November 2015, while getting a haircut. He was in the barbershop and someone stabbed him. Ruth brought her three-year-old grandson and pictures of herself in a cast from the beating she had described at the first meeting. Although Ruth had refugee status, she felt unsafe.

4.5. Tina

Tina, the sixth woman to speak at the first meeting was the youngest. At 31, she had worked as a security guard in Cape Town. Her father had been a general secretary under Mobutu in 1991–1992. She had been sent to a boarding school while her father went into exile in Brazzaville. He was killed in 1997, and her mother now lives in the United States. It was not clear when Tina entered South Africa and obtained her asylum seeker permit.

In 2006, while Tina was working as a security guard, the manager in charge asked to see her, but he kept her waiting for four hours. Eventually, he asked other men to make sure that no one was around, locked the door to the room, and put the key in his pocket. He began to slap her, calling her kwerekwere (foreigner) and kicking her. There were three men in the room. One of the authors asked if the men wanted her sexually or just to beat her. Tina said she did not know why they beat her, and she avoided a direct answer to the question about rape. She had tried to escape through a window and failed. Finally, a man downstairs heard her screaming and started knocking on the...
door; the beating stopped. The man from downstairs demanded they all go to the police station, and the police did not ask her any questions and let the manager go. Tina was visibly upset while describing her experience in South Africa, suffered stress, and reported having high blood pressure. At the second meeting, Tina brought her asylum seeker permit and her Trauma Centre card that had been filled up, attesting to her counselling sessions. She said that she had not been feeling well.

4.6. Marie

During the second meeting with the Congolese families, the attendees were about to all say goodbye when one of the women said she needed to speak to one of the authors. Marie looked to be in her 20s or 30s and was distraught. She began by saying Xhosa-speaking South African men had kidnapped, held, and raped her in 2014 in Parow. When asked how long she was held, Marie said that she did not know. She explained that while she was walking home from church on a Sunday, a car chased her. Apparently, the men in the car had tried to catch her before, but she had escaped to a Somali spaza store (a small convenience store). Marie said she recognised the driver and reported this to the police, but they had not followed up.

Marie pulled out her asylum seeker permit, her police report with a case number, and her Trauma Centre letter that referred her to UNHCR. Marie’s needs assessment by a counselor at the Trauma Centre said, “the whole family has experienced torture both in DRC and in South Africa as well. They are trying very hard to integrate in South Africa but it is impossible … they face daily trauma with the continuous social crime and they are victims in their community (Copy given to author).” Accordingly, the counselor said the family would like the UNHCR to determine whether they are suitable candidates for resettlement because they are not finding any security or peace in South Africa. All of this seemed like the other interviews with the other women until Marie displayed a photograph from the police showing deep wounds on her back and her eyes rolled back. Asked whether she had a family to care for her, Marie responded that she had a husband and a son. Her husband, however, had not been the same since the kidnapping.

4.7. Rafael

Rafael (a pseudonym that she selected for this research), the “strong woman from Congo” as her CSO colleagues described her, presented herself as a survivor and framed her experiences working with refugees as empowering. Rafael has had an asylum seeker permit that has been renewed 16 times. During a two-hour interview with Rafael in 2015, she revealed the details of her life. Rafael was born in Lubumbashi in 1976 and trained as a nurse. With her father’s help, she started a rural clinic in Kasunjeji, near Dompweto in the Katanga Province, where Mai Mai soldiers were known to terrorise the area (Gettleman, 2008).

One day in 2006, three or four soldiers came to the village and raped her cousin. Nine days later, her cousin died and the soldiers came after Rafael. They looted her store, restaurant, and pharmacy, and they raped her. She wanted the rape to be a secret. She and a client from her former restaurant then decided to go to Swaziland. Although Rafael thought she was going to Swaziland, after three days in a truck, she ended up in Cape Town. Upon arrival, she and others went to the DHA in Foreshore and a minibus picked them up. She had no idea what was going on because she did not speak English, and she felt very disoriented. They were taken to a women’s shelter.

Sometime during her first few days in Cape Town, a man named Jeremy (a pseudonym) picked her up along with other refugees in a kombi (a mini white bus) and took her to a refugee civil society organisation (CSO). With her inability to speak English, she did not understand what was going on. The following day, Jeremy came to take her to the DHA to get an asylum seeker permit. On the way, he took her to his house and kept speaking English, which she did not understand. He took her to a room and raped her. It was 5 November 2006, and she was 35 years old. Rafael repeated this date as if to remind herself of how far she had come. She recalled that when he finished the rape, she thought to herself, “I don’t know what to say because I was leaving my
country because of this” (referring to the gang rape in the DRC). Jeremy told her that if anyone asked her anything, to pretend like she was getting small bags of food that were being given out. Rafael then began retelling parts of the rape and said, “he doesn’t even know my name … I wasn’t talking because I don’t know how to talk”. Although the recollection was made in English nine years later, Rafael expressed her profound, enduring sense of isolation, confusion, and depression in not being able to communicate with anyone around her.

In 2008 when the xenophobic violence broke out, Rafael described how foreigners were afraid to walk around Cape Town. Her brother went out to buy airtime for his cell phone and he never came back. To this day, Rafael does not know what happened to him. At the end of the interview, Rafael said, “I want to share with other people; there’s a reason why I’m alive”. She wanted to inspire and help other refugee women.

5. Discussion
Although the participants had obtained asylum seeker permits and refugee status, they were and remain vulnerable to xenophobic attacks and abuse by South Africans. Moreover, there is evidence that bona-fide refugees, asylum seekers, and immigrants are compelled to purchase papers to allow them to reside in South Africa (Alfaro-Velcamp, McLaughlin, Shaw, Skade, & Brogneri, 2017). To survive in South Africa has meant enduring violence and abuse without recourse through local, state and international actors. The story of Rafael echoes much of what the women shared—gang rapes in the DRC followed by traumatising rapes in South Africa.

As noted earlier, the Cape Town Trauma Centre often provides a Protection Needs Referral Form to refer refugees to the UNHCR for possible resettlement to another host country. The same counselor from the Trauma Centre mentioned above also described another Congolese family whose mother had been raped, “[W]hen they arrived in Cape Town they thought that they would be safe. However, they have not experienced safety since they arrived. They have had to flee from one community to the next to escape the xenophobic violence” (On file with authors 2015). The form indicates that, “the family is sharing a house with other refugees and South Africans. In August of 2014(?) the youngest member of the family was burnt with boiling water by the South African woman who shared a house with them. A case was made against her but she has not been found by the police”. The Trauma Centre provides counselling and support for survivors of trauma, torture and offers clinics. There is also the Rape Crisis Cape Town Trust that has a 24-hour hotline, counseling, and legal support. (For Rape Crisis Cape Town’s historical overview with its founding in 1976 and near closure in 2012, see Vetten, 2016, p. 293, 302.) The extent to which these women used the counselling services of either organisation was unclear to the authors.

The repetitive violation and insecurity described by the refugees who participated in this study has caused them immense trauma and likely post-traumatic stress disorder; they experience difficulty describing events in a linear sequence and speaking with specificity to service providers (Trenholm, Olsson, Blomqvist, & Ahlberg, 2016, p. 495). They did not appear to be getting adequate mental health care to address their own personal experiences of trauma. To place their difficulties in context, in a research study evaluating 20,517 female rape survivors from 2005–2007 in the eastern part of the DRC whose demographic profile is similar to refugees in Cape Town, investigators found “the majority of rape survivors have remained unidentified. For fear of social stigmatisation by the family, socioeconomic exclusion at the community level, and/or repercussions by perpetrators, many women resist to reveal the incident” (Steiner et al., 2009, p. 5). Of those who came forward, “about half of female rape survivors develop clinical symptoms of Post-Traumatic Stress Disorder (PTSD) at some point in their lives. Other psychological manifestations include anorexia/bulimia nervosa, depression, and anxiety” (Steiner et al., 2009, p. 2–3).

The Congolese women’s narratives further illuminate the difficulty for South African society to absorb the refugee population and provide necessary support systems while lacking sufficient infrastructure to do so. Nevertheless, it is increasingly recognised that immigrants are repeatedly raped in
their home countries, in transit, and then again in their host countries. In Casualties of Care, Miriam Ticktin describes how some French immigrant rights groups suggest that “immigrant women are disproportionately affected by violence because they are made more vulnerable by state violence—these organizations have dubbed this predicament a ‘double violence’” (Ticktin, 2011, p. 132). But for these Congolese women, it is “triple violence”. The first violation occurs at home, the second in transit, and the third is in South Africa. The refugee women are often reticent to speak of these rapes unless they believe it can help them to resettle to a safer place. The rapes that happen during migration are underrepresented; nevertheless, an April 2009 report estimated that 75 percent of immigrants crossing the South African–Zimbabwean border were raped (Doctors Without Borders, 2009, p. 14). Whether this study is representative for other border crossings is not known, however, female migrants who cross borders irregularly are known to be more vulnerable to exploitation and abuse.

What is also disconcerting is that “the refugee no longer shares in the sovereignty of country where he is persecuted, and yet does not share in that of his country of arrival, from which he hopes for protection” (Fassin & Rechtman, 2009, p. 254). And as in the SAMP study mentioned earlier, South Africans do not fully deliver human rights protections for refugees at least in part because of a scarcity of resources for native South Africans themselves. This scarcity extends to accessing health care as provided in South African law (Alfaro-Velcamp, 2017).

6. Conclusion and recommendations

How can these refugee women be helped when human rights and domestic laws do not meaningfully protect them in either their home and/or host countries? The narratives illustrate how refugee resettlement and the framework of international health and human rights law have yet to fully acknowledge the special needs of refugees who have suffered rape and/or other forms of sexual and gender-based violence (SGBV). The ubiquity of rape among refugees in South Africa can be linked to both the normalisation of rape and the notion that many refugees are unrapeable. Refugees from the DRC who have been raped encounter RSDOs among whom there exists a persistent “insinuation that it is something normal. The RSDOs clearly disregarded the experiences of applicants, rejecting the possibility that rape... could be the basis of a legitimate asylum claim” (Middleton, 2010, p. 79). Normalisation is facilitated by the ambiguous nature of rape in asylum and refugee law. Although South Africa can offer protection from a perpetrator in another country, “…it cannot guarantee adequate protection, or even an appropriate response by the police or legal system, should she become a victim of gender-related violence in South Africa” (Middleton, 2010, p. 70). There appears to be acquiescence by domestic and international actors to the widespread SGBV—especially and specifically rape—that affects those who are migrating between jurisdictions.

Unprotected Congolese refugee women living in South Africa continue to seek a remedy for themselves and their families. Due to home country traumas, language barriers, post-apartheid South African culture, and sexual predators in CSOs (such as Rafael describes), immigrant and refugee women need extraordinary protections. As reported in the Journal of American Medical Association (JAMA) in 2010 about eastern DRC, “1.31 million women and 0.76 million men are survivors of sexual violence”, and health services specific to sexual violence “should be prioritized in these areas” (Johnson et al., 2010, p. 561).

Sexual violence stems from societal violence and these norms need to change (Jewkes, Sikweyiya, & Jama-Shai, 2014, p. 2040). Not only is “coerced sexual intercourse at some stage in a South African woman’s life … certainly the norm …” (Jewkes & Abrahams, 2002, p. 1240), but it is rooted in a historical context of state-sponsored violence of apartheid and colonialism whereby “violence has become for many people a first line strategy to resolve conflict … or gain ascendancy” (Jewkes & Abrahams, 2002, p. 1239). Consistent with Jewkes’ call for a shift in norms, the refugee narratives presented here indicate that efforts can be made to improve policies and better implement domestic and international laws. The narratives further suggest a need to expand the criteria of eligibility for refugee status and access to social support and health care services. Sexualised acts of humiliation, violence, and punishment must be
actionable in law and medicine to serve the dignity of those who are wronged. This begins with enhancing the care for survivors.

The guiding principle in these recommendations is that South African policy makers can better align laws to comport with the South African Constitution and its commitment to human dignity. Countless other destination countries face a comparable challenge at and within their borders and globally, though they may lack a constitutional framework like South Africa’s in which to do better. In addition, “women’s vulnerability to sexual violence as a form of persecution must be recognized and addressed, as opposed to fatalistically accepted” (Valji, de la Hunt, & Moffett, 2003, p. 65). Justice can come in the form of acknowledging the crime of rape, prosecuting the aggressors, offering reparations, and ultimately providing survivors with the necessary support to heal from the trauma.

Following the research reported here, in June 2017, a CSO service provider emailed the authors to share that a 43-year-old woman, a grandmother with HIV, had visited the provider’s CSO facility in Cape Town. The woman had been raped by two men in Congo, and they threw acid in her eyes. She could hardly see. Her one living daughter was also raped at age 14 and became pregnant. Another daughter was gang raped, gave birth, and then died from complications of childbirth. The woman, her daughter, and grandchildren escaped to South Africa in 2015. The woman, who could not speak English, had been denied help at a health clinic because her asylum seeker permit had expired five months earlier. (Since the Cape Town Refugee Reception Office closed in 2012, the woman had not been able to afford the trip to Durban to renew the permit.) With no income and no food assistance, she was destitute. As the CSO provider wrote: “It’s a whole family ravaged by rape”. Women continue to be raped without remedy.

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Notes
1. The UN officials are sometimes the actual perpetrators of sexual violence. For instance, in 2016, more than 108 cases of children being sexually abused were reported in the Central African Republic by UN peacekeepers (Murphy, 2016). These abuses have continued with 612 cases of sex abuse by UN peacekeepers reported in 2018 (Johnston, 2018).
2. All of the women have been given pseudonyms.

Cover Image
Source: Author.

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The authors declare no competing interest.

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