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Implications for Health Care Practice and Improved Policies for Victims of Sexual Violence in the Democratic Republic of Congo

By Haleigh Hanlon[1]

Abstract

As violent conflict ravages the Democratic Republic of Congo, thousands of women and girls are victims of sexual violence. Unfortunately, there are few services available to this population. While the exact number of victims is uncertain, the available data indicate the large scale of women and girls affected by sexual violence, and the urgent need for aid, services, and better policies to improve care. This humanitarian crisis is slowly gaining Western attention, but the current demand for humanitarian action and improved policies is greatest in the following three categories which will be addressed in the body of the work below: (1) an increase in humanitarian aid, (2) medical assistance, and (3) social support.

Introduction[2]

As violent conflict ravages the Democratic Republic of Congo (DRC), thousands of women and girls are victims of sexual violence. In fact since the DRC was first colonized civil war, along with political and social turmoil has scathed the region (Haskin, 2005). As a result of consistent fighting, which has escalated at several points within the past ten years, a massive humanitarian crisis leaves many in need of medical assistance, specifically victims of sexual violence. While the overall humanitarian crisis in the DRC is urgent as tens of thousands die monthly and millions are displaced, the brutalities and suffering associated with rape inflicted upon thousands of women and girls deserves special attention because of the specific needs of this population (Global Policy Forum, 2005).

Many consider the humanitarian crisis in the DRC the worst since World War II (Egeland, 2006). A handful of international organizations, including Human Rights Watch, Amnesty International, and Doctors Without Borders have documented countless human rights violations. Despite the abundance of victims in the DRC, the brutalities inflicted upon women and girls warrant special attention because of the overwhelming number of victims, the horrific extent of their injuries, and the lack of medical care and support. At minimum there are "tens of thousands" of rape victims and only several hospitals to treat them (Pratt and Werchick, 2004). This humanitarian nightmare is slowly gaining Western attention, but the current demand for humanitarian action and improved policies is greatest in the following three categories which will be addressed in the body of the work below: (1) an increase in humanitarian aid, (2) medical assistance, and (3) social support.

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The Problem: Sexual Violence

Sexual violence in DRC is complex; rape is often used as a weapon against women, girls, families and communities (Pratt and Werchick, 2004). Rozée (203) identifies a host of rape motivations, including punitive (rape as a punishment), status (rape enforced to lower the victim's status and elevate the rapist's status), theft (rape victims kept as sex slaves), ceremonial rape (rape is part of a tradition), exchange (sex is used as a means to obtain goods) and survival rape (sex is traded for necessities needed for survival) (as cited by Pratt and Werchick, 2004). Qualitative reports document that women and girls in the DRC are targeted for every motivation identified by Rozée (2003), but the data suggests that the primary motivations behind the current epidemic are punitive, status, and theft. In the DRC, rape in all forms, is designed to destroy individuals, families and community structure. Mills and Nachega (2006) suggest that rape is even used as a weapon used to infect victims with HIV/AIDS. Gieseke (2007) states that the reasons offered by the victimizers as to why women and girls are raped are they are seen as beautiful or because they are considered ugly, or because of alleged political sympathies, or because of ethnicity and nationality, or because their husbands are educated, or simply because "they are female".

According to Amnesty International (2004) "all of the armed forces involved in the DRC conflict have committed rape and sexual violence, including government armed forces of the DRC, Rwanda, Burundi, and Uganda. These groups include, but are not limited to, the Mai Mai, the Congolese Assembly for Democracy (RCD- subdivided into several smaller militias throughout the Eastern DRC), the Movement for the Liberation of the Congolese (MLC), Forces for the Democratization and Liberation of Rwanda (FDLR), Forces for the Defense of Democracy (FDD- Burundian), and the Interahamwe (meaning those who attack together") of Rwanda (Amnesty International, 2004). According to Mekwege, one of the region's few gynecologists, "each armed group has a trademark manner of violating" (Nolen, 2005). Burundian groups rape men and women, the Mai Mai rape with foreign objects and mutilate women, while Rwandan militias gang-rape (Nolen, 2005).

Equally disturbing is that these attacks take place despite the presence of the largest United Nations Peacekeeping force, MONUC (United Nations Organization Mission in the Democratic Republic of Congo), which currently consists of 17,000 troops. Dually problematic are substantiated allegations of the direct involvement of MONUC troops in the sexual exploitation of women and young girls (Van Woudenberg, 2004). Women and girls in the DRC, simply, are not safe, not even from those sent to protect them. Brutality against women and girls is an accepted norm in the DRC.

It should be noted that the Rwandan genocide prompted a subsequent influx of Hutu refugees into the DRC (Haskin, 2005). Many Hutu extremists, involved in the atrocities committed against Tutsis and Hutu-moderates, entered the DRC following the Rwandan Genocide, which played a major role in the Second Congo War. Interestingly, the spike in reported rapes and other gruesome tactics used against women in the DRC, first noticed in 1996, bear striking similarity to both the frequency and brutality of crimes committed against women also documented during the Rwandan genocide (Pratt and Werchick, 2004). Many experts note that that sexual violence in both Rwanda and the DRC is unique because of the extent its brutality.

In fact, the epidemic is horrifying. Data collected throughout the Eastern DRC reports that the youngest rape victim was an infant of only four months of age, and the oldest victim an elderly woman of 84 years of age (Pratt and Werchick, 2004). In an account from one village only the youngest girls were gang-raped (Human Rights Watch, 2004). These girls were about three years old.

> "They [soldiers] pushed open the door of my house and asked for money. I didn't have any, so they threw me to the ground and one soldier started to rape me. My 10 year-old daughter was present, looking on. When they saw her, two soldiers took hold of her to rape her. I tired to stop them, but they shot me. I did all I could to stop them, to protect her, but they raped my little girl all the same".
>
> -Survivor (Amnesty International, 2004)

Gang-rapes are not uncommon, nor is it uncommon for women to be taken as sexual slaves and held by militias for months or even years at a time. Forced incest is also a frequent practice, as many women are forced to have intercourse with their brothers, fathers, and sons, or else the men are murdered. It is common for women to suffer vaginal stabbings and even gunshot wounds in the vaginal track following attacks. Not surprisingly, these violent sexual assaults demand extensive treatment, more specifically gynecological, non-gynecological and psychological care.

The Data: Challenges

Measuring the population affected by rape is difficult. Experts struggle with the following variables: (1) many rapes are not reported, (2) many of the women and girls able to reach clinics might be counted more than once, (3) many victims are raped on more than one occasion and, (4) many women and girls are victimized by more than one offender (Gieseke, 2007 and Pratt and Werchick, 2004). In addition, much of the available data comes from the eastern DRC since rape is allegedly highest in this region (World Health Organization, 2005). This is not surprising since the eastern part of the DRC is so close in proximity to other conflict regions such as Rwanda, Uganda, Burundi and Sudan. As such, the proximity to these violent zones play a major role in the ongoing violence and subsequent sexual violence targeted at women (Gieseke, 2007). Nonetheless, these numbers should be considered in terms of health services because they provide quantitative insight into sexual assault trends, and the current quantity of need.

Many experts believe the actual number of rapes is higher than the reported rates (World Health Organization, 2005). The World Health Organization (2005) suggests that women may not report rape because of the social stigmas associated with rape, while Gieseke (2007) suggests that women might not report out of fear of further attacks by offenders. Nonetheless, these numbers indicate the large scale of women and girls affected by sexual violence, and the urgent need for aid, services, and better policies to improve care.

While it is difficult to determine whether rapes are increasing or whether reporting and access to services are increasing, the data suggest that sexual violence is not decreasing. Between 1998 and 2005, 41,225 acts of sexual assaults against women were reported in South Kivu, Maniema, Goma, and Kalemie (World Health Ogranization,

2005). Notably, most of these rapes, 25,000, occurred in South Kivu which is on the western border of Rwanda and Burundi (World Health Organization, 2006). The following year the United Nations reports 27,000 rapes occurred in just the providence of South Kivu— an increase of 2,000 (United Nations, 2007). While these numbers suggest an increase in reported rapes, many experts believe that they are still only a fraction of actual figures. Christine Schuler-Deschryver suggests that these numbers are underrated by about 75% and estimates that in 2004, at least 100,000 women and girls were raped in South Kivu (Gieseke, 2007).

According to Rodriguez (2007), 40 women are raped daily in South Kivu. Of these victims, 13% are under the age of 14 years old. Additionally, 3% of victims die from their injuries, and between 10-13% contract HIV/AIDS. According to Mukwege, 10 new victims, both women and girls, enter the Panzi Hospital of Bukanvu daily for treatment, and have been "so sadistically attacked from the inside out, butchered by bayonets and assaulted with chunks of wood, that their reproductive and digestive systems are beyond repair" (African Research Bulletin, 2007).

Health Care Implications

Because of the violent nature of sexual assault, subsequent physical traumas require extensive medical services. Rape is among the biggest health threats, if not the biggest threat, to women and girls in this region (World Health Organization, 2005). Amnesty International notes that the "most pressing need" among victims is "access to adequate health care…[as] there is a clear lack of trained doctors and other medical personnel" (Amnesty International, 2004). The World Health Organization reports that as of 2004, there were only 5,827 doctors in the entire Democratic Republic of Congo, and only 28,879 nurses to aid a population of over 57.5 million (World Health Organization, 2005).

In addition, many women suffer extreme psychological trauma as a result of their rape experiences. Unfortunately, many victims do not have access to psychological services. Statistics related to social support services are not reported, but qualitative evidence suggests an urgent demand for psychosocial services as well as psychosocial education programs that address community attitudes towards victims of sexual assaults.

Gynecological Health Outcomes

Many rape victims suffer from traumatic gynecological fistulas, abnormal tears in the reproductive tract, which cause most who experience them incontinence (Acquire Project, 2005). These medical complications are usually the result of violent rape, rape by more than one offender, and/or the insertion of foreign objects such as gun barrels and broken bottles into the vaginal track (Acquire Project, 2005). Fistulas cause a host of physical pain and health complications and thus have negative outcomes for physical health, particularly if untreated. These injuries, in some cases, are life threatening (Gieseke, 2007).

In addition to long-term health problems caused by fistulas, many women suffer psychological pain. For example, because traumatic gynecological fistulas cause incontinence, women are often divorced by husbands and shunned from communities, adding to their humiliation and grief. Besides exacerbating psychological trauma, shunning women has negative economic ramifications. When women are displaced from

their economic support systems, particularly with children to care for, and they are unable to work because of injuries, they often rely on charities for survival (Malteser International, 2007). Women, already psychologically traumatized by violent rape, are forced to manage additional stressors resulting from poverty and homelessness once they are removed from their former socioeconomic support system. This introduces a new set of complications that in part, contribute to psychological stress (Pinel and Bosire, 2007).

Extreme gynecological injuries are not limited to vesico-vaginal and recto-vaginal fistulas. In some cases, rape victims suffer from prolapsed uteruses. In these cases, the uterus is displaced into the pelvic cavity, and in rare cases outside of the vagina (Gieseke, 2007). Prolapsed uteruses are repairable through extensive surgeries and time consuming recoveries, but like fistulas, are extremely painful and debilitating (Amnesty International, 2004).

There is also plenty of documentation that reports victims who are shot by their rapists in their vaginas, which requires vaginal surgery, though repairing these kinds of wounds is not always possible. In addition many women's pelvises are shattered during rape due to force, and many others contract sexually transmitted diseases and HIV/AIDS during sexual assaults that require treatment. The chances that victims acquire sexually transmitted diseases, including HIV, greatly increases because of the "destruction of the genital tissue…associated with rape or gang rape" (Amnesty International, 2004).

It is imperative that women are treated for STDs and HIV/AIDS. One of the most vital services, especially in a region where HIV/AIDS rates are high, is acquisition of Post Exposure Prophylaxis (PEP). PEP anti-viral drugs are proven to reduce the rates of HIV transmission. However, effectively providing PEP to victims is problematic. To begin, PEP drugs must be administered within 72 hours of viral exposure. Since there are only a few hospitals that provide such treatment, and many rapes occur in isolated regions, accessing these hospitals within 72 hours of an assault is an unlikely possibility for many.

Non-Gynecological Physical Health Outcomes

Needed medical treatment is not limited to gynecological care. According to Human Rights Watch, Amnesty International, and Doctors Without Borders, many women are beaten before, during, and following sexual assaults. Plenty of reports detail brutal beatings that require extensive care for women to properly heal. In one report published by Amnesty International, several women describe beatings, which they endured daily at the camps of militias (Amnesty International, 2004). In addition, many women are shot in the limbs while trying to resist their rapists. In many incidents, these injuries result in amputations, and many women suffer without the use of prosthetics that also renders them unable to work (Amnesty International, 2004).

Psychological Health Outcomes

Not surprisingly, psychological needs among this population are great. The World Health Organization reports that psychological symptoms among this population might include: nervousness, depression, social withdrawal, sexual dysfunction, post-traumatic stress disorder, and suicide (World Health Organization, 2005). In fact, about half of raped women meet criteria for PTSD, and the rate increases when sexual assaults are combined with other physical atrocities (World Health Organization, 2005).

Qualitative reports suggest that sexual and physical injuries among this population might be the norm.

In addition, social stigmas exacerbate victims' psychological symptoms. Husbands, families and communities commonly shun rape victims, and social rejection intensifies negative psychological outcomes Amnesty International, 2004). Sadly, rape victims not only report dismissals from families and communities, but report taunting by peers due to their victimization. In some cases victims give birth as a result of rape. As if this experience is not traumatic enough, the victims' families and communities often reject these children as well. Although sexual violence has tortured this population for over a decade, society has not adjusted from traditional thinking to understanding the traumatic psychosocial needs of victims.

Policy Recommendations

The need for health care services among this population cannot be stressed enough. Improvements to health care services for victims of sexual violence in the DRC require immediate action, specifically a significant increase in aid to provide additional and improved services. Psychosocial supports as well as community education programs must also be strengthened. While there are additional policy implications that the international community should address to achieve peace in the DRC, recommendations here are limited to improving the physical, psychological, and social functioning of victims of sexual violence.

Implications for Health Practice and Improved Services

There is a desperate need to increase foreign aid, namely health and population aid, as a means to increase the budget for medical services. The Organization for Economic Co-Operation and Development reports that between 2005 and 2006, only 2.5% of foreign aid to the DRC was designated to health and population, despite the demand for greater assistance (Organization for Economic and Co-Operation Development, 2006). Many women wait for emergency care, or do not receive care because health care services are scarce (Nolen, 2006). Some women suffer injuries, bleeding daily for years, until they acquire medical care (Nolen, 2006). In addition, the scarcity of services contributes to women's inability to timely access PEP anti-viral drugs to prevent HIV/AIDS. This region is desperate for more health care workers and hospitals, and increasing foreign aid earmarked for health care would alleviate the scarcity of health care services.

In addition, NGO policies should address terrorism committed against aid workers, so that the little care that exists in the DRC is not threatened. In 2005, two MSF (Doctors Without Borders) employees were kidnapped in Bunia and tortured for 10 days. Following their release, MSF withdrew teams from this region leaving 100,000 people without care (Medecins Sans Frontiers, 2005). Arguably, violence committed against aid workers is an effort to force withdrawal, so subsequent withdrawal in turn encourages future violence against workers. While challenging, future policies should address the best means to combat aid worker terrorism without compromising community health. Perhaps collaborating with peacekeepers to increase travel safety is one way to handle this dilemma.

In addition, future policies should address increasing and improving psychological care because of its potentially important role in rehabilitating victims of sexual violence. Only 15% of foreign aid went to social services (Organization for Economic and Co-Operation Development, 2006). Equally as problematic, is that a program evaluation revealed that many of the existing psychosocial services were counter effective. According to Rodriguez (2007) a 2005 OCHA supervised service evaluation determined that several counseling centers contributed to victims' grief and were subsequently closed.

Despite the lack of adequate psychological services, this does not mean that culturally sensitive psychological services would not benefit victims. Clearly, the trauma experienced by this population results in negative psychological outcomes, and requires appropriate psychological care. The demand for psychiatrists, psychologists, and social workers, familiar with the Congolese culture that can provide appropriate care to victims should not be understated. This population is severely traumatized and needs psychological treatment in order to heal mentally. However, it is vital that hospitals, community centers, and NGOs provide services by properly trained medical professionals to ensure that psychological services do not inflict further psychological trauma on victims. Future policies should address the need to increase aid for social services, namely social sector relief, and also stress the importance of implicating culturally sensitive practices through extensive relevant training.

Lastly, policies should address improving and increasing community education. Community health workers, international organizations, and NGOs should work with local populations, including local men, to educate in all of the aforementioned arenas. Educating men is imperative to reconstruct this society's attitude towards rape victims, and consequently to elevate victims' status within this community. Despite the commonality of sexual violence, cultural norms have not adapted to the interests of victims; and in fact, further victimize already assaulted women. While victimization is widespread, societal understanding is not, and victims are continually discriminated against by various societal infrastructures.

Community education should also address educating perpetrators, both from armed groups as well as civilians. Because rape is an accepted norm in this society, it is likely that some perpetrators do not fully understand the extent of the injuries they inflict on victims. Thus, if possible, this group should not be excluded from community education practices.

Model: Malteser International

Malteser International is an international NGO relieving humanitarian suffering in about 30 countries throughout the world (Malteser International, 2007). Currently, this NGO operates ten projects in the Democratic Republic of Congo. Of these humanitarian relief efforts, several projects specifically serve the medical, psychological and social needs of victims of sexual assault. One program in provides training and counseling for local health workers. Services are provided to victims, perpetrators, and entire communities.

Malteser International recognizes the importance of both adequate medical and psychosocial services that victims of sexual violence require. As such, this organization works hard to provide in all areas of need among rape victims. In addition, Malteser

International educates communities, including men, to expand awareness in an effort to advocate acceptance of victims into communities that would otherwise ostracize them. This includes educating men about the needs of victims of sexual violence, and the adverse consequences of rejecting victims from families and communities.

These types of programs are imperative in order to improve the quality of life among victims. Malteser International treats the physical, psychological, and social needs of victims, giving them the best chance of healing. Thus, future policies need to address all of these arenas, as all of these areas have important implications for improved health of victims of sexual violence.

Conclusion

There is no doubt that additional hospitals, medical workers, and educational programs are needed to address these dilemmas. Foreign aid policies should address these needs in order to better serve this population. It is vital that future fiscal policies address the need for services in this region, as the tragic state of the victims of sexual violence is urgent.

The overwhelming needs of this population should be a priority on the international community's agenda. A host of documentation implicates that sexual violence is a phenomenon over a decade old in this region. It is time for the international community to take the necessary measures to aid victims of this humanitarian nightmare. If the international community and NGOs follow some of the recommendations outlined in this article, there are reasons to be hopeful that victims of sexual violence can be successfully treated.

References

Acquire Project. (2006). "Traumatic Gynecologic Fistula: A Consequence of Sexual Violence in Conflict Settings". A report of a meeting held in Addis Ababa, Ethiopia, September 6-8 2005."

African Research Bulletin. (2007). Democratic Republic of Congo: Epidemic of rape. *Political and Social Cultural Series, 44*(10).

Amnesty International. (2005). Democratic Republic of Congo: Mass rape- time for remedies. Available at http://www.amnesty.org/en/library/info/AFR62/018/2004.

Gieseke, S. (2007). Rape as a tool of war in the Eastern Democratic Republic of the Congo. Submitted to the Center on Rights Development.

Global Policy Forum. (2005). UN says Congo death toll among World's Worst; Urges Congo and Rwanda to work to restore peace. Retrieved November 20, 2007, from http://www.globalpolicy.org/security/issues/congo/2005/0107volatile.htm.

Human Rights Watch. (2004) Democratic Republic of Congo: War crimes in Bukavu. Available at http://www.hrw.org/english/docs/2004/06/11/congo8803.htm.

Human Rights Watch. (2006). Sexual Violence in the Congo War: A Continuing Crime. Available at www.hwr.org.

Mills, E., & Nachega, J. (2006). HIV infection as a weapon of war. *Lancet, 6*(1).

Medecins Sans Frontiers. (2006). Democratic Republic of Congo: Rape as a Weapon in North Kivu. Available at http://www.doctorswithoutborders.org/news/2006/07-19-2006.cfm.

Medecins Sans Frontiers. (2005). Nothing new in Ituri, the violence continues. *MSF Reports*. Available at www.msf.org.

Nolan, S. (2005). Not women anymore: The Congo's rape survivors face pain, shame, and AIDS. *Forced Migration Review.*

Organization for Economic Co-Operation and Development. (2006). Aid Recipients Chart, Democratic Republic of Congo. Available at www.oecd.org.

Pinel, A., & Bosire, L. (2007). Traumatic fistulas: The care for reparations. *Forced Migration Review, 27.*

Pratt, M. & Werchick, L. (2004) Sexual terrorism: Rape as a weapon of war in Eastern Democratic Republic of Congo. USAID/DCHA Assessment Report.

Rodriguez, C. (2007). Sexual violence in South Kivu, Congo. *Forced Migration Review, 27*.

United Nations. (2007). Security Council deeply concerned about pervasive sexual-based violence. Security Council, Department of Public Information, available www.un.org.

Van Woudenderg, A. (2004). MONUC: A Case for Peacekeeping Reform. Testimony of Anneke Van Woudenberg before the U.S. House Committee on International Relations, Subcommittee on Africa, Global Human Rights and International Operations. Retrieved February 29, 2008, from http://www.hrw.org/english/docs/2005/03/01/congo10222.htm.World Health Organization. (2005). Coping with Sexual and Gender-Based Violence in the DRC. Available at http://www.who.int/hac/crises/cod/sexual violence/SEXUAL.