

Sexual and Gender-Based Violence Among Refugees and Internally Displaced Persons in the Democratic Republic of the Congo: Post-Conflict Scenario

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Abstract: The ongoing humanitarian crisis in the Democratic Republic of the Congo has triggered sexual and gender-based violence, including rape, sexual slavery, trafficking, intimate partner violence, and sexual exploitation. Gender inequalities and abuse of power experienced by women and young girls at refugee settings further exacerbate their vulnerability to different forms of violence. This study aimed to offer an evidence-based approach to developing strategies in tackling the complex problem of sexual and gender-based violence among refugees and internally displaced persons in the Congo. We conducted a narrative review of all the relevant papers known to the authors to explore the origins of the problem, its implications on public health, and its impact on equity. The study revealed that sexual assault survivors face physical and psychological sufferings, excruciating emotions, and profound disruption of their social well-being since they are often stigmatized and ostracized by society. The analysis of current government policies revealed a lack of programs to address survivors' specific concerns and policy enforcement problems. This study suggested strategic objectives and policy implementation steps. The proposed strategies address women empowerment and gender stigma, provision of effective health services, and adequate response action.

Keywords: SGBV, evacuees, post-conflict, policy, DRC

Background

I took refuge in a camp for displaced people where three armed men raped me. . . . physical and psychological pain was immense. . . . distressed that I felt I could not look after my children after the attack. I felt like my family and community completely abandoned me.

– Gisèle, the mother of three.¹

The Democratic Republic of the Congo (DRC) is one of the largest countries in Sub-Saharan Africa and home to over 86 million people as of 2019.^{2,3} Presently, safe drinking water is provided for 43% of the country's households (69% in cities and 23% in the countryside). Sanitation is available to a mere 20% of the households. The fertility rate in DRC is 6.1 children per woman, which is higher than the average of 4.8 children per woman in Sub-Saharan Africa. The DRC has one of the highest early childbearing rates, with 125.24 births per 1000 adolescent girls aged

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between 15 and 19 years of age.² Despite some progress in reducing extreme poverty over the last twenty years, the DRC still ranks as one of the poorest nations globally. In 2018, 72% of its population, especially in the north-western and central-southern regions, survived on less than US\$ 1.90 a day.²

The DRC was colonized by Belgium in 1885 and granted its independence seventy-five years later in 1960. However, the legacy of colonization and current global post-colonial policies have underlain the government's present failures to address the suffering of the Congolese people. The highest rates of poverty in the world, recurring conflicts, and the growing inequity has profoundly affected public health.³ The cost of colonization was the depopulation of an estimated ten million people under King Leopold II of Belgium. During this period, people faced enormous discrimination and severe ill-treatment from the colonizers.⁴ In the 20th century, the country achieved significant improvements, including advances in administration, economic development, and the healthcare services provision.^{5,6}

Nevertheless, the Congolese faced difficulties in their endeavor with governing the country independently after the colonial rule. The predetermining factors included dependence on the colonizers' guidance and technical expertise, loss of pre-colonial survival skills necessary for a balanced co-existence with the environment, and the years of suppression of human dignity and identity.^{5,7,8} The public health system developed by the Belgians, principally focused on maintaining the workforce's productivity and gradually degraded after the DRC's independence with the departure of most of their medical experts.^{5,9,10}

Moreover, the cascading dynamics of civil conflicts and wars in the eastern DRC following the independence, was fueled mainly by neo-liberal politics in the pursuit of the country's resources and resulted in the economic breakdown, massive forced migration, unprecedented violence, and deaths of thousands of people.^{11–13} Ultimately, the public health situation dramatically deteriorated with a significant increase in inequalities in health.^{14–18} The problem is especially alarming considering the 5.4 million refugees and internally displaced persons (IDPs) in the DRC, and over 800,000 Congolese refugees who fled outside the country.¹⁹ In the places where armed conflicts have come to an end, the process of rehabilitation at refugee settings should adequately address all population groups' fundamental health rights to avoid the growth of inequalities in health.^{20,21}

Martials and Methods

A review of literature concerning sexual and gender-based violence (SGBV) was conducted using PubMed, PsychINFO, Pre-CINAHL and Google Scholar. Terms used in each database search included the following: (exploitation, abuse OR violence) AND (refugee OR displaced person) AND Congo. Specific names of the policies and regulating documents were also searched. Scanning the references of found papers was also conducted. The following inclusion criteria were used: the article was written in the English language, the study focused on SGBV among refugees or IDPs in DRC. Exclusion criteria were set as studies on SGBV amongst the non-refugee populations. Information related to strategies identify, prevent, and respond to SGBV was extracted from the identified articles. The data gathered primarily focused on the prevalence and origins of SGBV, public health and equity implications, analysis of current policies, and policy evaluation. The three authors independently examined each of the articles. Any controversies were resolved by the authors through reaching a consensus in discussion.

Results

Sexual and Gender-Based Violence at Refugee Settings

Definition of the Problem

SGBV refers to acts inflicting mental, physical, or sexual suffering perpetrated against a person's will and based on gender differences.²² In the DRC, the high levels of SGBV have affected women since the beginning of the conflict in 1998. It was recorded that 1000 women had been raped daily, whereas young girls below 18 years accounted for 65% of the victims.^{23–26} Rape is used as a weapon of war, but it plays an essential role in post-conflict societies when the intensity of a conflict is diminished significantly.^{27–30}

At refugee settings, the Congolese women are often separated from other family members due to the disruption of social structures by armed conflict, making them more vulnerable to SGBV.^{31–33} Thus, the following types of SGBV occur at refugee and IDP camps: sexual attack or coercion, including by persons in authority; domestic violence; sexual assault while searching for essential needs for domestic purposes; survival sex or forced prostitution; and sexual exploitation in return for securing legal status or access to resources in asylum country.^{34,35} Furthermore, sexual abuse of young women and adolescent girls is an area of concern in the DRC.^{36–38} Girls in refugee camps

are often forced to engage in sex in exchange for clothing and sanitary products, and teachers force female students to exchange sex for money or school exam grades.^{33,39,40}

The Implications of the Problem for Public Health

In the DRC, the acts of SGBV are often perpetrated at the extreme level of brutality and tortures, such as gang rape, genital mutilation, forced abortion, etc.^{38,41} Survivors of SGBV face physical injuries, sexual and reproductive health (SRH) concerns, including HIV and other sexually-transmitted diseases, sterility and fistula, psychological and emotional sufferings, such as depression, anxiety, and post-traumatic stress disorder, and often cannot address them adequately due to a lack of access to (or inappropriate quality of) health care services.^{42–44} The acts of SGBV may result in long-term disabilities and even death and the social impacts of SGBV cannot be underestimated.^{41,45,46} Ultimately, there is a lack of knowledge about healing and recovery after SGBV, including the impact of sociocultural environment on healing processes and cultural nuances of healing goals following it.⁴⁷

The USAID reported that HIV prevalence among women who survived SGBV in conflict and post-conflict areas in the DRC was much higher than among women in the general population (25.6% against 1.6%, respectively).⁴⁸ A case-control study in Kinshasa found that SGBV was significantly associated with HIV infection and its behavioural risk factors, such as alcohol consumption and polygamy.⁴⁹ Additionally, a mathematical model revealed that gang rapes in the DRC, Sudan, Burundi, Rwanda, Sierra Leone, Somalia, southern Sudan, and Uganda could have resulted in a 6–7% median increase in HIV incidence among girls and women aged 5 to 49 years.⁵⁰ Besides, the prevalence of HIV infection among women in the IDP camps was significantly higher and more strongly associated with the history of SGBV than among women in the host population of the DRC and other conflict-prone African countries.^{51–53} Nevertheless, some researchers have argued that the data supporting the association between conflict-driven SGBV and the HIV prevalence and incidence rates at the population level is inconclusive.^{54–56}

The Origins of the Problem and Impact on Equity

Globally, gender inequalities have a strong relationship with sexual violence.^{57–61} The vulnerability of women in refugee and IDP camps to SGBV is predetermined by pre-existing cultural gender inequalities and domestic violence and deterioration of traditional gender roles in society due to the

destruction of households as a result of war and deaths of family members.^{34,62–67} Peacekeepers and aid workers have engaged in hegemonic masculinity practices that encourage sexual exploitation and abuse of the most marginalized in the communities – women and children.^{68,69} The harm suffered by survivors has hardly been addressed by any of the agencies, including the United Nations.⁷⁰

Moreover, SGBV initiated by militants has been adopted by the civilians in refugee camps.^{31,71–73} The close relationship between sexual violence and masculinity implies “rape myths”⁷⁴ based on beliefs of denial of sexual offenses and men’s dominance.^{75–78} Besides, most survivors or victims do not report their experiences due to the stigma associated with sexual violence in the DRC based on cultural perceptions. They fear being abandoned by husbands, primarily if (gang) rape resulted in pregnancy.^{71,79} Thus, social isolation and ostracism of rape victims by community members could harm women more so than the assault itself.^{33,80,81} Additionally, women’s social and economic marginalization in refugee settings implies growing inequities in health, such as SGBV, food insecurity, and a lack of access to health services.^{74,82,83} Finally, there is a lack of appropriate SRH services to address SGBV and high rates of maternal deaths, HIV, and illegal abortions among women in refugee camps, especially young women and adolescents.^{84–86}

The conceptualization of SGBV in both scholarly and policy research is far from incorporating the complexity of the underlying causes of SGBV among refugees.⁸⁷ Firstly, existing literature focuses mainly on women as victims and rarely addresses the experiences of other at-risk groups, such as men, the disabled, and LGBTI.^{88,89} Secondly, most of the studies highlight various aspects of physical violence and its context, and there is a lack of research on the causes and impacts of structural violence, including health, economic, cultural, political, and racial disparities.^{90,91} Thirdly, SGBV experiences are likely to differ dramatically across the continuum of conflict, refugee exile, and resettlement.⁸⁷ There is little examination of SGBV in the context of resettlement.⁹²

Building a Strategy Analysis of Current Policies

The existing policies tailored to respond to SGBV provide only short-term relief for survivors and rarely offer comprehensive preventive interventions.⁹³ National efforts to tackle the problem of SGBV in the DRC implied legislative criminalization of sexual violence and the government’s dedication to dealing with this problem.⁹⁴ Additionally,

the government adopted the 2009 UN Action on Sexual Violence in Conflict comprehensive strategy for the DRC.^{95,96} The plan focuses on strengthening national authorities' capacities to prosecute SGBV crimes, especially those committed by militants. However, there is a lack of enforcement of the policy, and survivors often obtain justice through community mediation rather than the legal system.⁹⁷ Other aspects of the program cover prevention and protection, assistance to survivors, security sector reform, and data mapping.⁹⁸ Noteworthy, there is a lack of government programs to address specific concerns of SGBV among refugees and IDPs.^{37,38,99,100} UNHCR developed guidelines for SGBV prevention and response among these vulnerable groups.³⁴ The work of the agency, in close cooperation with other humanitarian organizations, has contributed to achievements in the handling of SGBV cases, for example, through assistance in creating community centers for SGBV cases identification and referring support services, and training focal points among refugees and IDPs.¹⁰¹ On the contrary, the World Bank initiatives to prevent SGBV by investing money in the education sector of the DRC have not accounted for inequities in access to education.^{102–105} Arguably, global markets supported by neoliberal politics are linked to state-corporate crimes that induce sexual violence in the DRC.^{106–108}

Therefore, the government's insufficient commitment and the "collapse of public health services" have challenged the overall progress of the strategy.⁹⁹ Noteworthy, the policy of provider-initiated HIV testing and counseling (PITC) has been proven to be highly successful in the DRC¹⁰⁹ and could help address SGBV among displaced populations. However, its implementation is problematic because it depends on international support and resources, which are scarce and often earmarked due to political instability.^{24,110} Focus of international organizations has mainly been in response to SGBV rather than on prevention from its occurring.^{111–114}

Strategic Objectives and Policy Implementation Steps

The guiding principles in tackling the complex problem of SGBV among displaced people include community engagement in behavioral change, a multi-sectoral approach by all actors, highlighting the issues of equity, and ensuring the equal participation of all community members (specifically, young women and adolescents), in planning, implementing, monitoring and evaluating processes.²² Economic and food security of displaced women is an essential determinant of social cohesion and women empowerment; in particular, it

may prevent women from engaging in survival sex.¹¹⁵ Communication activities have proven to be effective in raising the solidarity of women.^{116,117} Engaging men and boys in SGBV prevention is another perspective approach to change male gender beliefs.^{118–120} Additionally, security reform in displaced settings is one of the crucial components of SGBV prevention.^{95,96}

Implementation of comprehensive primary health care will address the needs of displaced populations by ensuring the equity and sustainability of the outcomes.^{121–125} Decentralizing SRH services and making them equally accessible for all population groups, including adolescents and young women, should be emphasized.^{126–129} Training of healthcare personnel to be sensitive to the needs of displaced women (including SGBV survivors),^{130,131} and creating adolescent-friendly environments,¹²⁶ are essential components of prevention. The multi-sectoral approach will help address a broader spectrum of social determinants of health that lead to (gender) inequities.^{132,133}

The actions should be based on the fundamental human rights and priority of women's health and well-being as postulated in the Sustainable Development Goals (SDGs), in particular SDG 3 (good health and well-being) and SDG 5 (gender equality), SDG 4 (quality education) and SDG 10 (reduced inequality).¹³⁴ Therefore, effective prevention and a response strategy should include engagement with communities and civic society, strong support from the government, and durable and coordinated international participation (Table 1).

Expected Outcomes and Performance Measurement

Monitoring and reporting progress is crucial in ensuring that the prevalence of SGBV in refugee settings is decreasing.^{101,135} Evaluations will measure progress toward achieving a sustained reduction in SGBV by 2024. Specific indicators for critical interventions are listed below.

Indicators for the Interventions Addressing Women Empowerment, Gender Stigma, and Rebuilding Community Structure

- The number of women groups that meet regularly
- The number of women involved in micro-enterprise development
- The number of initiated educational programs and a percent of those successfully implemented
- A percentage of people with a changed attitude towards SGBV (regular surveys)

Table I Combating Sexual and Gender-Based Violence at Refugee Settings in the DRC During the Post-Conflict Scenario: Plan for Action by 2024

Strategic Objectives	Policy Implementation Steps		
	Local Level	National Level	Global Level
Women empowerment and changing gender stigma; rebuilding community and family structure	Provision of environments, ensuring safe access of women to essential energy and resources	Combating poverty and investing in the economic and social development of women	Practicing increased political pressure to stabilize the political situation and end conflicts in the DRC
	Targeted micro-crediting programs for displaced women	Promotion of gender equality in education and other aspects of life	Provision of financial support to rebuild the country's economy and combat extreme levels of poverty
	Group conversations and debates on human rights, gender, culture, the stigma associated with rape, etc.	Ensuring security and safety in refugee and IDP settings	Developing evidence-based general principles to address awareness regarding SGBV
	Health education initiatives to engage men and boys in SGBV prevention	Promotion of national support to community outreach activities to confront SGBV in displaced settings	
	Encouraging husbands to participate in maternal and childcare services		
Provision of adequate health services and facilities, focusing on the issues of equity	Training of health workers to be sensitive to SRH needs among young women and adolescents	Integration of sector-wide approaches (SWAPs) into health systems	Support of system-wide initiatives of the DRC government to strengthen its health systems, including the SRH sector
	Creating adolescent-friendly environments	Decentralizing SRH services	Focusing on equity in international human resource development and distribution in the health sector
	Integration of family-centered PITC services into refugee and IDP camps	Applying a multi-sectoral approach to health management	Developing cost-effective mechanisms to address gender health inequities
	Use of gender-sensitive health promotion materials		
	Direct involvement of young women and adolescents in addressing their SRH needs		
Adequate response action	Establishing referral, reporting, monitoring, and evaluation mechanisms for appropriate identification of risks	Law enforcement to combat impunity for acts of SGBV against refugees and IDPs	Developing evidence-based general principles to address the promotion of legal reforms for a comprehensive response to SGBV
	Establishing a means of response to survivors' medical and psychosocial needs	Developing national mechanisms to work with perpetrators	Enhancing the international legal norms, instruments, and settings in addressing the acts of SGBV

- The number and percentage of women distributing food, water, and fuel among other women
- Types and quality of information materials
- The number of boys and men involved in health educational programs addressing SGBV

Indicators for the Interventions Addressing the Provision of Equitable Health Services

- The number and types of SRH services available, a percentage of adolescent friendly SRH services
- The percentage of health workers trained to respond to SGBV
- The number and type of psychosocial support services

Indicators for the Interventions Addressing Adequate Response Action

- The number of incidences reported through informal and formal channels
- The number of offenders prosecuted
- The number of legal actions taken to protect the survivors

Limitations on Policy Implementation

Various internal and external forces may influence policy implementation. Time lags between adopting the policy and its practical application depend on the DRC's government commitment, cooperative action of international partners, and activism of civil society. The proposed approach is designed with a long-term view; therefore, there is a risk that the stakeholders will be demotivated to invest resources without observing immediate effects following the implementation.¹³⁶

In a conflict-affected setting of the DRC, the implementation of SGBV policy may be affected by lack of infrastructure, including little or no police coverage, which creates barriers for reporting SGBV cases. Other limitations include poor funding allocations, poor multi-sectoral coordination, dominance of customary law, discriminatory gender stereotypes and socio-cultural norms.^{137,138}

Besides, the policy's implementation may be influenced by external forces, such as globalization, characterized by the deterioration of social systems and problems for the government to invest in public health due to the focus on privatization.¹³⁶ This may lead to more unpredictable and uncontrollable outcomes.

Conclusion

While in exile at refugee settings in the DRC, thousands of people suffer from the widespread SGBV. Women and young girls are the most vulnerable due to cultural gender inequalities aggravated by on-going conflicts, which have resulted in the destruction of family and community structures, deterioration of gender roles in society, and increase of impunity among militants and persons in authority. Public health implications of SGBV include physical and socio-psychological sufferings, which often cannot be adequately addressed due to the scarcity of relevant healthcare facilities. Current policies to address SGBV have failed due to the government's insufficient commitment and a lack of political will and cooperation of the global players to support comprehensive prevention programs rather than focusing on targeted interventions in response to SGBV acts. The proposed strategic objectives in tackling SGBV at refugee settings focus on community and civic society engagement, government support, and international participation.

Recommendation

The proposed plan for action to combat SGBV against refugees in the DRC during the post-conflict scenario by 2024 includes strategies to address women empowerment, changing gender stigma, and rebuilding community structure; provision of effective health services focusing on equity; and adequate response action. Policy implementation steps are outlined at local, national, and global levels. Expected outcomes are based on the indicators of critical interventions.

Article Highlights

- Sexual and gender-based violence has a profound physical, psychological, and social impact on women and young girls in the DRC.
- Implementing current policies that address SGBV is problematic due to the government's insufficient commitment and dependence on international support and resources.
- Most international organizations have focused on the response to SGBV rather than on prevention from its occurring.
- The proposed strategies and policy implementation steps at local, national, and international levels are offered.
- The proposed plan for action by 2024 addresses women empowerment and gender stigma, the provision of effective health services, and adequate response action.

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