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Surviving Sexual Violence in Eastern Democratic Republic of Congo[1]

By Susan Bartels[2], Jennifer Scott[3], Jennifer Leaning[4], Denis Mukwege[5], Robert Lipton[6], Michael VanRooyen[7]

Abstract

Since 1996 a deadly conflict has been ongoing in the Democratic Republic of Congo (DRC). Within this conflict, sexual violence has been inflicted upon women as a

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[1] This study was approved by the Institutional Review Board at the Harvard School of Public Health and by Dr. Denis Mukwege, the medical director of Panzi Hospital.

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strategic weapon of war. Given the challenges of working in this setting, this sexual violence epidemic has not been well studied. The current work is a retrospective chart review of women presenting to Panzi Hospital in 2006 requesting post-sexual violence care. The goals were to describe the demographics of sexual violence survivors and to define the physical and psychosocial consequences of sexual violence in Eastern DRC. A total of 1021 patient medical records were reviewed. The mean age was 36 years with an age range of 3.5 years to 80 years. Approximately 90% of sexual violence survivors were either illiterate or had attended only primary school. There were significant delays between the incidents of sexual violence and presentation to Panzi hospital (mean = 16 months, median = 11 months). Physical consequences reported following sexual violence included pelvic pain (22% of women), lumbar pain (11%), abdominal pain (7%) and pregnancy (6%). Thirty six percent of women reported being concerned about their health and sexually transmitted infections (STIs) plus HIV/AIDS were the most commonly singled out health concerns. Six percent of women reported that their husbands had abandoned them after the rape and abandonment was more common after gang rape or if the sexual violence resulted in pregnancy. Treatment programs for survivors of sexual violence must specifically address the economic hardships faced by victims must meet their time-sensitive medical needs and must provide them with psychological care.

Keywords: Democratic Republic of Congo, rape, sexual violence

Introduction

In the Eastern Democratic Republic of Congo (DRC), conflict has displaced 3 million people(1) and claimed an estimated 5.4 million lives(2), more than any conflict since World War II. The conflict began in the aftermath of the Rwandan genocide and despite international peace agreements in 2003, the violence and insecurity continue in Eastern DRC, where numerous armed militias continue to terrorize local populations and to rob the region of its mineral wealth.

Rape, sexual slavery and violent attacks on women have emerged as a prominent modus operandii of many of the militia groups operating in Eastern DRC. The true extent of the sexual violence is not known. However, the International Rescue Committee reportedly assisted over 40,000 Congolese rape survivors between 2003 and 2007(3) and in the province of South Kivu alone, the UN reported 27,000 sexual assaults for the year 2006.(3) Since rape is often underreported, it is likely that these numbers underestimate the true incidence of sexual assault. Human rights organizations have described the extraordinary brutality of sexual violence in DRC, which includes gang rape, instrumentation, kidnapping, forced "marriages" and genital mutilation.(4-8) Anneke Van Woudenberg, the Human Rights Watch (HRW) specialist for Congo, believes that rape is so widespread that "it [rape] has become a defining characteristic" of the war in DRC.(9)

Rape as a weapon of war has been employed by warring parties and occupying armies since early historical times.(10) Sexual violence is now recognized as a crime against humanity as declared in the Fourth Geneva Convention,(11) the Criminal Tribunals of Yugoslavia (http://www.icty.org/) and Rwanda (http://www.ictr.org/) and the Rome Statue of the International Criminal Court.(12)

Yet despite the progression of international norms, sexual violence in intrastate conflicts continues. In many modern conflicts, sexual violence has become ever more prevalent and destructive. Mass rape campaigns have been documented in Sierra Leone,(13-18) Rwanda,(19-23) Liberia,(24-26) the Balkans,(27-29) Uganda,(30) Sudan,(31-35) and DRC.(3-8, 36-38).

Use of sexual violence as a weapon of war is often strategic and systematic. Rape is used to terrorize civilian populations, causing people to flee and leave their homes, their belongings and their fields.(33) In other conflict settings, mass rape is used during cultural and ethnic cleansing as a means of polluting bloodlines and forcibly impregnating women to produce "ethnically-cleansed" children.(33, 37) Finally, rape is strategically used to inflict shame, suffering and humiliation. Because the stigmatization and humiliation can last for decades, widespread infliction of sexual violence may effectively destroy the cultural and social bonds of entire communities.(39)

There are many unanswered questions regarding the rape epidemic in Eastern DRC. For instance, what is the actual extent of sexual violence in the region? What are the patterns of violence and how might knowledge of these patterns be used to protect women and girls? What are the consequences of sexual violence in this context and how should resources be allocated to aid survivors? To help address these questions, researchers from the Harvard Humanitarian Initiative performed a retrospective chart review of all sexual violence victims presenting to Panzi Hospital in 2006. Panzi Hospital is located in Bukavu, the capital of South Kivu Province, and serves as a major referral hospital, providing gynecologic care to women with pelvic trauma and rape–related injuries. Specifically, this study focuses on: 1) the demographics of sexual violence survivors presenting to Panzi Hospital; and 2) the physical, psychological and social consequences of rape in South Kivu Province.

Methods

This is a retrospective chart review conducted at Panzi Hospital. Using a non-systematic convenience sample, Panzi Hospital nurses conducted interviews on sexual violence survivors as they presented to hospital in 2006. Individual women were chosen for interview based on staff availability and the perceived severity of physical / psychological trauma at time of triage. Trained female nurses conducted interviews in private using a two-paged, semi-structured questionnaire. The questionnaire asked basic demographic information and then allowed the patient to describe her sexual violence experience in an open, self-reporting narrative.

In 2006, a total of 1,021 women were interviewed under Panzi Hospital's *Victims of Sexual Violence Program.* In the same time period, another 1,851 women accessed post-sexual violence services at Panzi Hospital but because of staffing limitations these women did not undergo the detailed interview described above and data on these sexual assaults are not captured in this analysis.

For each questionnaire, a single sexual violence experience was recorded and this was the most recent sexual assault prompting the woman to seek medical attention. An individual woman may have had a prior rape experience but the details of that prior rape were not included in this analysis. Thus, there are 1,021 sexual violence experiences in this dataset.

Questionnaires for all 1,021 sexual violence survivors interviewed at Panzi

Hospital in 2006 were reviewed between November 2007 and March 2008 (S.B. and J.S.). Data were translated from French to English and entered into an electronic spreadsheet (S.B. and J.S.). Analysis was performed using SAS Version 9.2, (The SAS Institute) (R.L.). This study was approved by the Institutional Review Board at the Harvard School of Public Health and by the medical director of Panzi Hospital.

For the purposes of this study, we defined "gang rape" as an incident of sexual violence committed by two or more assailants. We defined "sexual slavery" as being held in captivity by the assailants for more than 24 hours. "Rape not otherwise specified" (rape NOS) was taken to be sexual violence committed by a single assailant and not involving sexual slavery. Rape NOS was also used to describe sexual violence in which the survivor simply stated that she was raped without providing any further details.

Results

Demographics

In 2006, a total of 1,851 women presented to Panzi Hospital requesting post-sexual violence care. Resources permitted detailed interviews to be conducted with 1,021 of these women and all 1,021 interviews were analyzed in the current study. Table 1 contains details of the population demographics. The mean age of women presenting for post-sexual violence care was 36 years and the median age was 35 years, with an age range of 3.5 years to 80 years. Four percent of sexual violence survivors were less than 16 years old and being less than 16 years of age was protective against gang rape (OR = 0.26, 95% CI = 0.14 – 0.49).

Almost half the women reported that they were married. The 22.8 % of women who reported widowhood included both women who husbands were known to be deceased and also women whose husbands were missing and presumed to be deceased. The average number of children per woman was 3.5 with a range of no children to 12 children. The vast majority of survivors was either illiterate (65%) or had only some primary education (26%). Almost 77% of women reported agriculture as their source of livelihood.

The Bashi tribe represented the largest ethnic group and over 90% of the women self-identified with one of the following five ethnicities: Bashi, Barega, Bahavu, Batembo, or Bafulero. Self-identification with the Bafulero tribe was protective from sexual slavery (OR = 0.25, 95% CI = 0.08 – 0.80). The rates of gang rape and rape NOS did not differ among ethnic groups.

Table 2 highlights details of accessing care at Panzi Hospital. Forty-six percent of women arrived at the hospital alone and very few (0.9%) were accompanied by their spouses. The average time interval from the incident of sexual violence to presentation at Panzi Hospital was 16 months with a median of 11 months. The range of time intervals varied from less than a month to over 10 years.

Consequences

Physical symptoms were commonly reported following sexual violence. These symptoms included pelvic pain (22% of women), lumbar pain (11%) and abdominal pain (7%). Six percent of the women reported that they became pregnant as a result of the rape.

Psychological complaints were also common with 26% of women reporting that they continue to experience anxiety about the sexual violence that they had endured. Women who reported sexual slavery or gang rape were 1.6 times more likely to report psychological symptoms than were women who reported rape NOS (OR = 1.6, 95% CI = 1.2 – 1.9). In comparison to those women without psychological trauma, those women with a severe degree of psychological trauma were almost four times as likely to have been victims of sexual slavery (OR = 3.9, 95% CI 1.7 – 8.9).

The percentage of women reporting psychological symptoms increased significantly as the number of perpetrators increased. For instance, women who reported sexual violence by 4-5 assailants were twice as likely to report psychological signs as women who reported only 1 assailant (Chi square 6.1, OR = 1.9, 95% CI 1.1 – 3.4). Women who reported more than 5 assailants were three times as likely to report psychological signs as women who reported only 1 assailant (Chi square 6.6, OR = 3.0, 95% CI 1.3– 7.7).

Women who became pregnant as a result of the sexual violence were 2.6 times more likely to report mild psychological trauma (OR = 2.6, 95% CI 1.4 – 5.5) and 8.4 times more likely to report moderate psychological trauma (OR = 8.4, 95% CI 3.4 – 21.5) in comparison to those women who did not become pregnant as a result of the sexual violence.

Thirty-six percent of women reported anxiety about their health following the rape. Sexually transmitted infections were most commonly singled out as a health concern (12.2%) and just over 8% of women specifically mentioned that they were concerned about HIV/ AIDS. Another 10% were concerned about their heath generally. Women who reported gang rape were 1.7 times more likely to report health concerns (OR =1.7, 95% CI 1.2 – 2.3) than were women who reported other types of sexual violence.

Social consequences of sexual violence typically involved the loss of material items or family members. Twenty-three percent reported loss of the family's valuables (most commonly cash, food, clothing, or livestock) secondary to pillaging by the assailants. Occasionally, the family home was burned or destroyed in the attack. Eleven percent of survivors reported loss of a child or loss of their spouse (including deaths and disappearances). Most of these deaths were allegedly at the hands of the sexual violence perpetrators. The disappearances most commonly involved abduction of the survivors' spouse or child/children by the sexual violence perpetrators at the time of attack. Women who reported rape NOS were less likely to report losses than were women who reported other types of sexual violence (OR = 0.49, 95% CI 0.30 – 0.82).

The other commonly reported social consequence was spousal abandonment, which was noted by 6% of women in this dataset. Other women may have suffered spousal abandonment for this reason but not volunteered the information. Overall, almost 17% of women reported their marital status as divorced, abandoned or separated. While rape NOS was actually protective from spousal abandonment (OR =0.37 with 95% CI = 0.15 – 0.87), women reporting gang rape were 2.8 times more likely to be abandoned by their husbands (OR = 2.8, 95% CI 1.4 – 5.8). Women who become pregnant as a result of the rape were 2.6 times more likely to be abandoned by their husbands than were women who did not report a resultant pregnancy (OR = 2.6, 95% CI 1.2 -5.7).

Discussion

In the current study, girls and women of all ages were found to be directly affected by sexual violence in South Kivu. These findings are similar to those reported by HRW who interviewed more than 50 rape survivors in North and South Kivu and described rape victims ranging in age from 5 years to 80 years.(6) In the dataset analyzed here, 4.5% of subjects were less than 16 years of age. This figure is somewhat lower than statistics provided by local health centers in South Kivu, which reported that 13% of all rape victims were under the age of 14.(40) The current analysis found that girls under the age of 16 were protected from gang rape. This is believed to result from the fact that sexual slavery is more often targeted towards young girls (personal communication Dr. Denis Mukwege, Panzi Hospital, January 2009). Because girls are more likely to be taken as "wives" by individual armed combatants, they are less likely to be gang raped.

Women in the current sample had a literacy rate of about 35%, somewhat less than the 54% literacy rate reported for Congolese women overall.(41) We believe this difference is because our sample was derived from the rural regions of the country. Furthermore, all the women in this sample were living in Eastern DRC, where infrastructure including that of the education system, has been disrupted by long-standing conditions of conflict and forced migration. Seventy-seven percent of women reported that agriculture was their source of livelihood and another 10% reported that they were unemployed. Overall, the data represent the high vulnerability of women presenting to Panzi hospital. They are largely uneducated and rely on subsistence farming for their survival and for the survival of their families.

The vast majority of women belonged to the Bashi, Barega, Bahavu, Batembo or Bafulero tribes. Women belonging to these five tribes were at higher risk of rape NOS and at higher risk of gang rape (compared to other tribes in South Kivu such as Babembe and Bavira). Interestingly, self-identification with the Bafulero tribe was protective from sexual slavery. The Bafulero tribe lives predominantly along the Rwanda and Burundi borders, in areas that are not heavily forested. Since women are often abducted in the forest and / or taken to the forest to be sex slaves, we speculate that lack of proximity to forested areas protects the Bafulero tribe from sexual slavery.

There were notable delays before women presented to medical attention and these delays have important implications. Ideally, post-sexual violence care should be provided within the first 72 hours such that HIV post-exposure prophylaxis (PEP), prophylactic antibiotics for sexually transmitted infections (STIs) and post-coital contraceptives can be given. At Panzi Hospital, routine care includes only prophylactic antibiotics, STI testing and HIV testing. Women present so late that post-coital contraceptives and HIV PEP are unlikely to be effective. There is an urgent need for village outreach and for community education campaigns designed to help sexual violence survivors understand the importance of early post-sexual violence care.

Many women reported physical symptoms following the sexual violence with pelvic, lumbar and abdominal pain being the most common. A 2005 study by Réseau des Femmes found that 85% of sexual violence survivors reported vaginal discharge and 79% reported lower abdominal pain.(37) These figures are higher than those currently reported and this is believed to be secondary to methodological differences between the two studies. Symptoms in the current study were recorded only if they were volunteered by the victim in an open narrative. Direct questions were asked only for details of patient

demographics. In the Réseau des Femmes study, victims were directly asked about the health consequences of rape. In our study, failure to mention a symptom in the narrative does not imply that the symptom was absent. Therefore, we expect that our figures are gross underestimates of the true prevalence of various physical symptoms.

Six percent of women stated in their narrative that they became pregnant as a result of the sexual violence. Again this is probably an underestimate since it is likely that not all impregnated women would have voluntarily reported such pregnancies. Management of pregnancy resulting from rape is always challenging even in western countries with advanced health care systems. However, in DRC, pregnancy, labor and delivery can be significantly detrimental to a women's health. Some experts estimate the maternal mortality ratio (MMR) in Eastern DRC to be 3,000 deaths per 100,000 live births,(1) more than three times the MMR for Sub-Saharan Africa overall (920 deaths per 100,000 live births).(42)

A common concern among sexual violence survivors was the contraction of STIs and HIV/AIDS. Estimates for the prevalence of HIV/AIDS in DRC vary considerably. The World Health Organization (WHO) estimates HIV prevalence in DRC to be 6% among military, soldiers and police.(43) Amnesty International estimates the HIV prevalence to be 20 – 30% among those presenting to clinics in eastern DRC.(4) Regardless of the true prevalence of HIV/AIDS, the risk of transmission is a legitimate concern during any unprotected sexual encounter. The risk of HIV transmission is further increased in the setting of wartime rape because gang rape is common, and because vaginal tears and lacerations, which often result from the violent nature of wartime rape, further increase the risk of transmission.(44)

The psychosocial consequences of rape are also severe for many women. About one quarter of women report experiencing anxiety about the sexual violence and this anxiety was higher for those who had experienced gang rape or sexual slavery. In the Réseau des Femmes study, fear and shame were reported by 91% of victims and 77% of all women reported insomnia and nightmares.(37) This discrepancy in psychological outcomes is believed to result from the different methodologies. Our study reports only psychosocial consequences that were offered spontaneously in an open narrative. In contrast, the Réseau des Femmes study used a semi-structured questionnaire that asked specific questions regarding consequences of rape.(37)

Social consequences included loss of personal valuables or the family home, loss of family members, and spousal abandonment. Loss of the family's valuables or home can be devastating in any circumstance but particularly so in Eastern DRC, where poverty is both extreme and widespread. A significant portion of the women reported that a child or their husbands had been killed in the attack. The emotional distress caused by losing a child or spouse is extraordinary, especially when rape survivors were forced to watch their family members being tortured and killed. Women were also very distressed by spousal abandonment. Those who reported gang rape and those who reported becoming pregnant during rape were both more likely to be abandoned. In DRC, policy and socio-cultural customs continue to discriminate against women, effectively preventing their economic advancement and independence. Without the economic support and protection traditionally provided by men, abandoned women become exceptionally vulnerable.

This study has several limitations. First, because it is retrospective in nature the original information and the manner in which it was collected cannot be verified or

validated. The retrospective nature also prevents clarification of documentation inconsistencies and has resulted in missing data. Furthermore, it is impossible to make causal claims from the data. For instance, a sexual violence victim with specific symptoms may have had these symptoms before the sexual violence. Second, the study is also limited by the fact that not all sexual violence survivors presenting to Panzi Hospital in 2006 could be interviewed due to inadequate resources. Third, much of the data was collected in an open narrative format. Without asking specific questions regarding consequences of rape, our study undoubtedly underestimates specific outcomes. Failure to mention a specific symptom or outcome does not imply its absence. And finally, all data was collected in French and required translation to English, introducing the potential for translation and interpretation error. Future work will address several of these limitations. Next steps include a prospective study that will ask more specific questions of sexual violence survivors. These questions will seek to better characterize the patterns of attack and will focus on the physical, psychological and social consequences of being raped. It will also investigate traumatic fistulas, which this study was not designed to address.

Conclusions

In South Kivu, sexual violence is pervasive, affecting women of all ages, ethnicities and marital statuses. Survivors of sexual violence are largely uneducated and illiterate, making them highly vulnerable. Pregnancy resulting from rape and spousal abandonment were two of the most distressing consequences following sexual violence and both of these outcomes likely exacerbate survivors' vulnerability. Although women were concerned about their health overall and about STIs and HIV/AIDS in particular, there were significant delays between the sexual violence and presentation to medical care. These delays are thought to derive from a lack of awareness that prompt medical attention can prevent STIs, pregnancy and HIV infection and from a lack of resources to travel to Panzi Hospital. Ongoing stigma surrounding sexual violence and the desire to prevent one's family and community members from knowing about the sexual violence are also believed to contribute to delays in seeking care. To protect survivors from the medical complications of sexual violence, the medical community must educate women about the importance of seeking early care. Community outreach programs are also needed to raise awareness and to reduce stigma surrounding sexual violence. And finally, for those women who lack the means to travel to hospital, aid organizations should focus on establishing efficient referral mechanisms and providing transportation services.

The rape epidemic in Eastern DRC is likely to continue unless the environment of impunity is reversed. The UN Security Council has taken an important first step with its recent adoption of Resolution 1820, which is intended to hold warring parties accountable for sexual atrocities and to intervene with security measures that will protect civilians from rape. Meanwhile treatment programs for survivors of sexual violence must meet their time-sensitive medical needs and must provide them with culturally appropriate psychological care. Aid programs must also specifically address the economic hardships that survivors face as a result of having their valuables pillaged and as a result of spousal abandonment.

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Demographic	Number	Percentage
Age:		
≤ 15	44	4.3
16 – 35	444	43.5
36 -55	400	39.2
≥ 55	66	6.5
Not Specified	67	6.6
Total	1021	100
Marital Status:		
Single & never married	125	12.2
Currently married	488	47.8
Widowed	233	22.8
Separated / divorced / abandoned	170	16.7
Not Specified	5	0.5
Total	1021	100
Highest Level of Education		
Achieved:	665	65.1
Illiterate	269	26.3
Primary School	77	7.5
Secondary School	1	0.1
Post – Secondary School	9	0.9
Not Specified	1021	100
Total		
Occupation:		
Agriculture	782	76.6
Student	49	4.8
Trader / Seller	53	5.2
Laborer	7	0.7
Teacher	2	0.2
Unemployed	102	10.0
Other	8	0.8
Not Specified	18	1.8
Total	1021	100
Ethnicity:		
Bashi	635	62.2

Barega	107	10.5
Bahavu	39	3.8
Batembo	99	9.7
Bafulero	66	6.5
Other	63	6.2
Not Specified	12	1.2
Total	1021	100

Table 1. Demographics for sexual violence survivors presenting to Panzi Hospital in 2006.

	Number	**Percentage**
Accompanied to Panzi Hospital by:		
Alone	472	46.2
Spouse	9	0.9
Family Member	29	2.8
Child / Children	28	2.7
Aid Worker	109	10.7
Friend	46	4.5
Other	56	5.5
Not Specified	272	26.6
Total	1021	100
Mode of travel to Panzi Hospital:		
Vehicle	720	70.5
Walked	206	20.2
Boat	12	1.2
Flight	8	0.8
Physically carried	1	0.1
Not Specified	80	7.8
Total	1027*	100.6*
Time Interval Between Sexual Violence and Presentation to Panzi Hospital:		
< 1 month	110	10.8
2 - 12 months	421	41.2
13- 24 months	202	19.8
25 – 36 months	148	14.5
> 36 months	100	9.8
Not Specified	40	3.9
Total	1021	100

Table 2. Access to Panzi Hospital services by sexual violence survivors presenting to Panzi Hospital in 2006. *Several women used more than one mode of transportation to reach Panzi Hospital.

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