MEDECINS SANS FRONTIERES

SEXUAL VIOLENCE IN THE DEMOCRATIC REPUBLIC OF CONGO

THE CRITICAL NEED FOR A COMPREHENSIVE RESPONSE TO ADDRESS THE NEEDS OF SURVIVORS

MSF FIELD REPORT | JULY 2021

We wish to acknowledge first and foremost the thousands of sexual violence survivors in the Democratic Republic of Congo, and the institutions, organisations, individuals, and members of civil society supporting the sexual violence response.

COVER:
2018, Salamabila, in the province of Maniema
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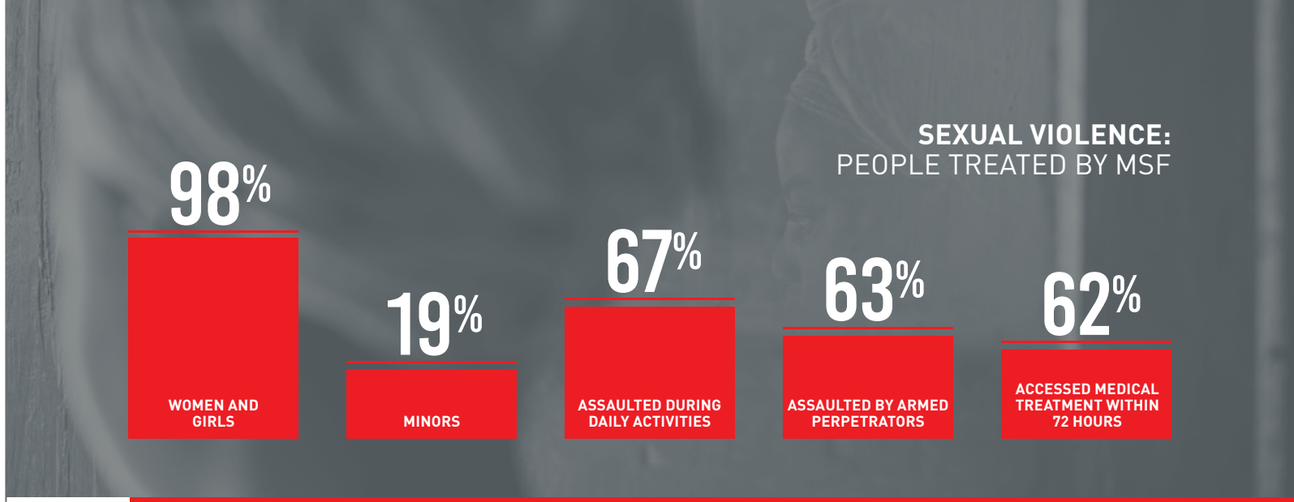
DSI CONCEPTION

This report was produced by MSF teams in DRC based on quantitative and qualitative data collected in its field projects.

MSF 2021

TABLE OF CONTENTS

PROVINCE	PROJECT AREA	NUMBER OF SURVIVORS WHO ACCESSED MSF SUPPORTED CARE IN 2020
KASAI-CENTRAL	KANANGA	3,278
NORTH-KIVU	MASISI	817
	MWESO	1,046
	WALIKALE	52
	GOMA	124
	RUTSHURU	169
	BAMBU	109
	BIRAMBIZO	135
	KIBIRIZI	1,722
ITURI	ANGUMU	11
	DRODRO	3
	NIZI	247
	MAMBASA	423
SOUTH-KIVU	BUNYAKIRI	662
	KATASOMWA (BUNYAKIRI)	229
	MULUNGU	420
	ITOMBWE-MINEMBWE	1,026
	KIMBI-LULENGE	160
	BARAKA	43
MANIEMA	SALAMABILA	77
UPPER KATANGA	LUBUMBASHI	57
TOTAL		**10,810**



SUMMARY

Year after year, Médecins Sans Frontières (MSF) teams are first-hand witnesses of the scale and impact of sexual violence in the Democratic Republic of Congo (DRC).

In 2020, 10,810 survivors[1] of sexual violence received medical and/or psychological care in MSF-supported medical facilities throughout the country.

While movements of armed actors and fighting clearly increase the risk and number of sexual assaults, such violence persists outside the context of weapon bearers, including family and partner violence.

Sexual violence is a medical emergency that requires immediate medical and psychological care to limit the consequences for survivors.

In addition to the immediate[2] physical and psychological impacts, the people treated by MSF emphasise that this violence has long-term consequences – sometimes for a lifetime – due in particular to the social stigmatisation, exclusion and loss of livelihood experienced by many survivors.

Unfortunately, emergency and long-term care for survivors of sexual violence remains largely unavailable in DRC.

Given the magnitude of the problem and its consequences, MSF believes that emergency and long term support programmes must be put in place as soon as possible, with significant and continuous funding, to accompany survivors until they have made a full medical, psychological and socioeconomic recovery.

[1]This report uses the terms 'victims' and 'survivors' of sexual violence interchangeably, although these terms have different meanings, particularly in relation to the temporality of the assault. The term 'victim' emphasises that a criminal act and a human rights violation have taken place. It is used in official documents such as medical certificates following the sexual assault. The term 'survivor', on the other hand, emphasises the person's capacity for action and resilience to cope and recover.

[2]In addition to mental health issues, survivors face physical injuries such as violent trauma, broken bones, haemorrhaging, vaginal fistulas, anal lacerations etc. Survivors are also at risk of sexually transmitted infections (including HIV) and unwanted pregnancies, which if managed non-medically, can have an impact on reproductive health and even result in death. See Whitehouse, K and Sieber, S., LUXOR Literature Review, Sexual Violence in DRC, Brussels, Luxembourg, March 2020.

RECOMMENDATIONS

1. PROGRAMMES THAT FOCUS ON SURVIVORS AND THEIR NEEDS MUST BE AVAILABLE AND ADEQUATELY FUNDED TO ENSURE THEY ARE OF HIGH QUALITY AND CAN BE ACCESSED FREELY. APPROPRIATE SUPERVISION AND MONITORING OF THESE PROGRAMMES SHOULD BE AN INTEGRAL PART OF THE PLANNING PROCESS.

To respond to the medical emergency of sexual violence, MSF calls on all actors – donors, authorities and non-governmental organisations (NGOs) – to put in place free, quality support services that include comprehensive medical and psychological care which are accessible to all.

This emergency and long-term support is essential, regardless of the causes of the violence and whether or not it is linked to armed clashes.

All measures must be taken at national, provincial and local levels to ensure the availability of **comprehensive post-rape kits** that include post-exposure prophylaxis (PEP) to prevent HIV transmission, essential vaccines, emergency contraception, and tests and medication for sexually transmitted infections (STIs). Access to prevention and treatment should be available and free of charge to all survivors of sexual violence, and available at the service delivery point (last mile delivery). These measures should include:

- setting up training on ordering and using post-rape kits, at every level;
- monitoring stocks at local and zonal levels in collaboration with civil society, as well as responding to stockout alerts, so that sufficient numbers of complete post-rape kits are available at all times;
- ensuring sufficient funding.

In order to provide quality care, it is essential that donors and other actors invest in the **training of staff in health centres**. In all primary care settings, personnel should be trained on how to provide medical and psychological care of survivors: medical protocols, confidentiality, patient circuits, informed consent, guaranteeing gratuity of care, respect and compassion, and the provision of necessary documents to enable legal follow-up.

Programmes focusing on **emergency and long-term psychosocial support** must be integrated as an essential part of the care package for all survivors. These programmes should be adapted to the needs of each patient and to the local context, and linked to initiatives that cover other needs, such as protection, socioeconomic support and legal support.

As sexual violence can lead to unwanted pregnancies, it is essential that **safe abortion care** for all is included in the care package, especially to avoid unsafe abortions and maternal deaths. Clinical training on medical abortion and family planning should be provided and commodities made available in health facilities.

In areas where access to health facilities is difficult for geographical or security reasons, **decentralised and/or community-based approaches** should be developed and adapted to the local context and to the specific needs of survivors. Such approaches require the training of focal points capable of raising awareness among communities and survivors, providing essential and confidential medical care and psychological first aid. **Particular attention should be paid to conflict-affected areas**, where access to health facilities can be particularly difficult.

In order to ensure access to medical care, it is essential that treatment of **sexual violence is free** (consultation and medication). All national and international organisations involved in the response, including donors, must ensure adequate funding to guarantee access to and effective monitoring of free and comprehensive quality care.

2. EFFORTS SHOULD BE MADE TO STRENGTHEN THE COORDINATION OF THE RESPONSE TO SEXUAL VIOLENCE BETWEEN DIFFERENT SECTORS AND LEVELS OF IMPLEMENTATION (NATIONAL, PROVINCIAL AND ZONAL). THIS WORK SHOULD BE CARRIED OUT BY ALL THOSE INVOLVED: NATIONAL, PROVINCIAL AND LOCAL AUTHORITIES AND STAKEHOLDERS; INTERNATIONAL ACTORS AND DONORS; CIVIL SOCIETY.

The response to sexual violence should be seen as a multisectoral response, with structured **coordination and information-sharing mechanisms** to better address needs.

Referral circuits between the various actors must be defined in a clear, transparent and effective manner, particularly by **identifying the responsibilities**

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of each. The gap between the intentions for action and the initiatives actually carried out on the ground must be bridged by strengthening the operational commitment of those involved in the response.

3. WHILE EMERGENCY MEDICAL INTERVENTION REMAINS THE PRIORITY, IT IS ESSENTIAL ALSO TO STRENGTHEN PREVENTION ACTIVITIES, INCLUDING THOSE ADDRESSING INTIMIDATION AND THE RISK OF REPRISALS AGAINST SURVIVORS. ACCESS TO PROTECTION AND/OR LEGAL SERVICES (LEGAL COUNSELLING AND SUPPORT) SHOULD BE PART OF A COMPREHENSIVE CARE PACKAGE.

Effective protection programmes are essential **for all survivors**, both minors and adults, and must take into account the specific needs of each community.

Prevention programmes must first and foremost **address the root causes of sexual violence**, whether or not they are linked to armed conflict. They must be **developed with communities,** and their implementation must be backed by long-term funding.

Protection from threats, intimidation and exposure to further violence must be guaranteed for all survivors, including those seeking medical and/or psychological care.

4. EFFECTIVE AND SUSTAINABLE SOCIOECONOMIC SUPPORT AND SOCIAL REINTEGRATION ACTIVITIES SHOULD BE INTEGRATED INTO THE STANDARD CARE PACKAGE. THESE ACTIVITIES SUPPORT SURVIVORS WHO FACE SOCIAL EXCLUSION OR FINANCIAL DIFFICULTIES AS A RESULT OF BEING SEXUALLY ASSAULTED.

The systematic inclusion of survivors of sexual violence in sustainable, locally adapted and needs-based **socioeconomic support programmes** should be seen as an essential and integral part of the care package.

Access to initiatives that provide money, food, shelter and support for socioeconomic reintegration (vocational training, micro-credit etc.) must be guaranteed to all survivors in need of such support, regardless of the nature of the referral, until full medical, psychological and social recovery is achieved.

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INTRODUCTION

During 2020, the humanitarian situation continued to deteriorate in DRC, particularly in the East of the country, following the resurgence of armed conflict and criminality in several areas. Civilians, particularly in North-Kivu, South-Kivu and Ituri, were severely affected by violence, leading to regular displacement, with serious consequences for their physical and mental health. Targeted and opportunistic violence also affected NGOs, hampering humanitarian access to the population.

According to the UN's Office for the Coordination of Humanitarian Affairs (OCHA),[3] cases of conflict-related sexual violence in North and South-Kivu, Ituri and Maniema provinces have increased in proportion to the fighting and movements of state and non-state armed actors.

But sexual violence in DRC is not only linked to armed conflict. Every day, women, girls, men and boys are sexually assaulted by individuals that are not directly taking part in hostilities, including inside conflict zones, and this remains an important and often overlooked component of the problem of sexual violence.

In 2020, MSF teams witnessed a very high level of sexual violence both in provinces affected by active clashes and in those considered more stable, such as Kasai-Central.

EVERY DAY, WOMEN, GIRLS, MEN AND BOYS ARE SEXUALLY ASSAULTED BY INDIVIDUALS THAT ARE NOT DIRECTLY TAKING PART IN HOSTILITIES, INCLUDING INSIDE CONFLICT ZONES.

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Despite efforts by humanitarian and development organisations, civil society and authorities to prevent violence and provide support to survivors, many patients state that their immediate and long-term needs remain largely unmet.

This report aims to show this reality by presenting medical data collected by MSF teams in 2020, and testimonies of field workers providing medical and psychological support to survivors of sexual violence.

[3] OCHA (2020). Overview of humanitarian needs, Democratic Republic of Congo, https://reliefweb.int/node/3701749.

METHODOLOGY

This report is based on medical data collected by MSF during 2020 in health structures and in communities where its teams, including staff from the Ministry of Health, provide care (medical and/or psychological) to survivors of sexual violence. These facilities are located in the provinces of Kasai-Central, North-Kivu, South-Kivu, Ituri, Maniema and Haut Katanga.

The quantitative data was cleaned, analysed and integrated with semi-structured interviews with MSF staff to analyse and understand the main trends. As a protection measure for the teams and the survivors, we have chosen not to include names or job titles of people quoted or locations where interviews were carried out.

Given that only data on survivors who managed to reach an MSF-supported facility (or who received first aid from MSF-supported community health workers) were analysed, the results should be considered indicative rather than statistically representative.

This report uses the term 'sexual violence' because the vast majority of cases treated in MSF-supported facilities were sexual assaults, although teams also provided support for a small number of cases of intimate partner violence (IPV) which did not necessarily always or exclusively involve sexual assault.

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SINCE MAY 2017, MSF PROVIDES FREE MEDICAL CARE AND PSYCHOLOGICAL SUPPORT TO SURVIVORS OF SEXUAL VIOLENCE

SEXUAL VIOLENCE : A DAILY HORROR FOR THOUSANDS IN DRC

In 2014, an MSF report highlighted the extreme level of needs and barriers to care related to violence in DRC, particularly sexual violence, including physical and psychological trauma, stigmatisation of survivors, and lack of access to care.[4] Since then, sexual violence has unfortunately remained widespread in the country and MSF teams have witnessed this reality on a daily basis.

In 2020, MSF teams supported the medical and/or psychological care of 10,810 victims of sexual violence – an average of nearly 30 people per day – in medical facilities or via community health teams in the health zones of Kananga, Bobozo (Kasai-Central province); Angumu, Drodro, Mambasa, Nizi (Ituri province); Masisi, Mweso, Rutshuru, Kibirizi, Bambu, Birambizo, Walikale, Kibua, Itebero, Goma (North-Kivu province); Baraka, Bunyakiri, Kimbi-Lulenge, Mulungu, Itombwe and Minembwe, (South-Kivu province); Salamabila (Maniema province); Lubumbashi (Haut-Katanga province).[5]

Women and girls remain by far the most affected group. In 2020, they represented 98% of the survivors treated with MSF support.

While the phenomenon of sexual violence committed against **men and boys** remains largely unexplored, men (194 male patients in 2020) state that they were sometimes forced by armed perpetrators to rape women and sometimes sexually assaulted by women. As in many other countries, the stigma of sexual violence seems to be particularly pronounced when it affects men, to the extent that it is often taboo to talk about "rape" in these cases. This affects access to care for male victims.

"Men feel ashamed, they feel they have lost their masculinity, their power. The patients we see come to seek medical help for sexually transmitted infections."

Minors are significantly impacted by sexual assault: in 2020, nearly one in five (19%) victims treated by MSF were under the age of 18. There are significant variations between the different areas where MSF works, including the average age of child survivors. In Walikale territory, in North-Kivu, the average age of child survivors was 13.

[4]MSF (2014). Everyday Emergency: Silent Suffering in Democratic Republic of Congo, https://www.msf.org/msf-releases-report-shocking-humanitarian-situation-eastern-democratic-republic-congo

[5]These figures reflect the locations of health facilities, and not necessarily the place of the aggression and / or the area of origin of the survivors. In some health facility locations, a significant number of survivors from other health zones receive care.

MINORS IN MSF CARE[6]	NUMBER	%
ANGUMU	34	65
BAMBU	10	6
BARAKA	93	22
BIRAMBIZO	10	23
DRODRO	36	29
GOMA	27	4
BUNYAKIRI	38	35
KANANGA	641	20
KIBIRIZI	8	10
KIMBI	116	51
MAMBASA	289	68
MASISI	147	18
MWESO	274	26
NIZI	61	36
RUTSHURU	134	13
SALAMABILA	81	5
WALIKALE	88	36

Providing care for child victims is particularly sensitive, as children are very vulnerable and in the process of forming their identities. If their case is not managed appropriately, the violence they have suffered can scar them for life.

"A nine-year-old girl was taken to the health centre [...] She was found to have a fistula related to a sexual assault [...] [The injury] had not been discovered for some time because the girl had probably been afraid to tell anyone. This will have a long-term physical and psychological impact."

In MSF projects in Angumu, Drodro and Nizi (Ituri), 19% of new patients attending psychological consultations were minors who had been sexually assaulted. In Kananga (Kasai-Central), 641 children received treatment for sexual violence in an MSF-supported facility in 2020.

It is not always easy for families to identify when there has been sexual abuse of children. Very young survivors may be unable to articulate exactly what happened to them, and many also receive threats from their abuser(s) to remain silent. In some cases, child patients are brought in by parents concerned about changes in the child's behaviour in the weeks or months following an undisclosed sexual assault.

"Many of the children we receive come one or two months after the abuse. They come because they start to develop behavioural changes. When we talk to the children, they tell us what happened, and they say that the abuser told them they would kill them if they spoke."

The feelings of shame that haunt many patients seem to be particularly pronounced among young girls.

"Sometimes we see little girls coming to the health facilities because of a general malaise. Through the medical consultation we realise that they have been raped but were afraid to tell their parents. This is especially true when the perpetrator is a family member or someone close to the family."

The shame and fear of **being stigmatised** experienced by girls who have been sexually abused can sometimes affect the whole family. In some areas, such as Walikale (North-Kivu), MSF teams have observed that 'amicable' solutions, such as forced marriages, are employed by some families in order to preserve honour and guarantee a place in society for young survivors.

[6]Divided by health zone and by territory for Walikale.


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"Amicable solutions are an additional aggression for survivors [...] There is shame, but there is also the need for parents to ensure that their daughters have the opportunity to marry, because if it is known that they have been raped, they will not be able to marry."

While MSF teams were able to support the care of nearly 11,000 survivors in 2020, it is clear that this is only the tip of the iceberg, as under-reporting is known to be common and access to care is still hampered by multiple barriers.

Survivors share on a daily basis the **obstacles they face accessing care**, such as: considerable distances between the place of assault and the first health centre offering quality treatment, extortion of money during the journey, the poor state of the roads, lack of money to pay for transport, and lack of awareness that sexual violence is a medical emergency for which there are services available. In Masisi health zone in North-Kivu, during the second half of 2020, approximately one in ten patients who did not arrive at the health facilities within 72 hours of being sexually assaulted indicated that the delay was due to the fact that they had been kidnapped or detained, and were therefore unable to access care.[7]

"Many survivors who come from far away have no money to pay for transport to go home."

Shame and guilt also play a role in the decision-making of many victims.

"Sometimes we see women isolating themselves [after being sexually assaulted]: they stop meeting friends, they stop going to the market. They are afraid that if the community finds out what happened to them, they will be laughed at."

Stigma, fear of social exclusion and **fear of being abandoned by their relatives** are factors that survivors take into account when deciding to seek treatment. For example, husbands often abandon wives who have been assaulted.

"We see patients who have been sexually assaulted multiple times. They tell us that they know other women who have been assaulted but who do not come for consultation for fear of being rejected by their husbands. They suffer at home, in silence."

[7]12% in Q3; 10% in Q4 2020.

In addition, survivors of sexual violence say they fear being attacked again on the way to medical facilities and that their attacker will take revenge if they seek help. They report feeling threatened, afraid of further violence or of being killed.

"We have received reports that survivors are threatened with physical harm, such as having their breasts cut off, if they seek medical care."

Sexual assaults are often accompanied by **other types of violence**. Many victims report being kidnapped, beaten, subjected to ill-treatment[8], witnessing their homes or villages being looted, and even having their relatives killed while they were raped.

In some areas, extreme violence sometimes takes the form of **gang rapes** committed by up to 15 perpetrators at a time. Tragically, such situations of extreme violence are common. In 2020, MSF provided medical and/or psychological care to 2,628 survivors of gang rape in the health zones of Kananga, Masisi, Mweso and Walikale.[9]

ASSOCIATED VIOLENCE[10]

KANANGA	
Being hit or beaten	**10%**
Destruction or theft of property	**35%**
Killing of family members	**9%**
Death threats	**23%**
MASISI	
Being hit or beaten	**36%**
Destruction or theft of property	**24%**
MWESO	
Being hit or beaten	**17%**
Destruction or theft of property	**10%**
Ill-treatment	**1%**
Forced labour	**1%**
Kidnapping	**13%**
SALAMABILA	
Being hit or beaten	**15%**
Destruction or theft of property	**68%**
Killing of family members	**3%**
WALIKALE TERRITORY	
Armed attack on house or village	**32%**


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"We received a woman who had been assaulted in Kasai by armed men. They forced her husband to sleep with their daughter. After this tragedy, the husband decided not to stay with his family, saying: 'How can I still look my daughter in the eye?' [...] Later, the daughter passed away. Before she died, she kept saying: 'The day dad comes, will I have the courage to look him in the eye? Will he still be considered my dad?' According to her mother, she died because of this."

Human rights associations who raise awareness about sexual violence and community health workers who assist survivors are also subject to threats

[8]In this report, the term "ill-treatment" is used to refer to cases of torture and cruel, inhuman or degrading treatment.

[9]More specifically, 69% of patients treated in MSF-supported facilities in Masisi health zone, 57% in Kananga health zone, 24% in Walikale territory and 11% in Mweso health zone were attacked by multiple aggressors.

[10]Distributed by health zone and by territory for Walikale.


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and harassment. At the same time, the **deteriorating security situation** in the East of the country and the increase in attacks on humanitarian organisations have hampered their access, including in areas where there is significant need. According to the International NGO Safety Organisation, NGO fatalities in DRC tripled in 2020, and the number of abducted staff increased by 35% compared to the previous year, a situation linked to the spike in opportunistic banditry[11] and the resurgence of armed conflict in the eastern regions. MSF has not been spared by this wave of violence and is regularly forced to reduce its areas of intervention, with an impact on its ability to reach vulnerable populations[12].

Due to the many obstacles and risks faced by patients, as well as to reduced **humanitarian space**, **access to care within 72 hours**[13] of an assault, in order to prevent HIV transmission, is a challenge for many victims of sexual violence. In 2020, only 62% of survivors who came to MSF-supported health facilities were able to access medical treatment within 72 hours. This proportion is lower in some regions, such as Kananga[14] (Kasai-Central) and Walikale territory (North-Kivu), where respectively 28% and 38% of patients received treatment within 72 hours[15].

Barriers to healthcare not only reduce access to quality care **immediately after a sexual assault, but also reduce access to medical and psychological follow-up**.

In contexts where access to health facilities is difficult, **community-based and decentralised approaches** have proven to be very effective in providing survivors with care. This is particularly the case in Maniema province, where MSF supports a network of reproductive health workers who support the identification, care and referral of victims[16].

[11]INSO (2021). Despite Coronavirus restrictions, 2020 saw only a marginal reduction in incidents impacting NGOs, reports INSO https://www.ngosafety.org/news/2020_NGO_incidents.

[12]In 2020, MSF faced four critical incidents in the Kivus. Throughout the year, movements were reduced or suspended. In December 2020, MSF had to make the difficult decision to end most of its support to health structures in Kimbi and Baraka in Fizi territory, South-Kivu Province.

[13]Receiving medical care within 72 hours of a sexual assault is crucial to prevent HIV, and in order toto provide better preventative care for unwanted pregnancies and sexually transmitted infections. This is also the period when survivors are most in need of medical care and psychosocial support. However, different types of medical and psychosocial support can still be provided beyond this period.

[14]The reasons given by the patients to explain the delay included: lack of knowledge of the existence of treatment; distance; shame, being a minor (associated fear).

[15]Seeking care remains crucial after the 72 hours; many treatment and care options remain available.

[16]This community-based programme registered 1,722 victims of sexual violence in 2020, or about five per day. Of the approximately 150 patients registered on a monthly basis, only approximately 50 presented themselves at MSF-supported health facilities, demonstrating the key role that these community focal points can play in increasing victims' access to care

PROLONGED CRISIS FUELS SEXUAL VIOLENCE

The instability in DRC, which deteriorated further during 2020, fuels an environment conducive to sexual violence and other human rights violations[17].

Forced displacement, which is particularly common in DRC, increases vulnerability to sexual violence, especially for women and girls. In many health facilities supported by MSF, a high proportion of survivors of sexual violence identify themselves as being displaced. In North-Kivu, this was the case for 39% of victims treated in the Kibirizi health zone, and 36% in the Mweso health zone. Some are attacked in places where they should be protected from violence, such as in camps for internally displaced people (IDPs). Others are attacked while travelling to find food for their families.

The data collected by MSF shows that the majority (67%) of survivors of sexual violence were assaulted in the course of their daily activities: in the fields (the main source of subsistence for a large part of the population); while collecting wood or at home.

Armed conflict and the proliferation of weapons are among the main factors contributing to the scale of sexual violence in DRC. In 2020, more than 60% of survivors treated by MSF were attacked by aggressors bearing weapons, often identified by the survivors as being a party to the conflict. During the year, our teams also observed that in areas where the security situation had deteriorated, the proportion of patients attacked by people with weapons was higher than elsewhere. This was the case in the territories of Masisi and Rutshuru (North-Kivu), but also in Salamabila (Maniema), where respectively 75%, 84% and 70% of survivors declared that their attackers were armed.

It was also observed that the proportion of sexual assaults by armed perpetrators increases in parallel with movements and combat between parties to the conflict. This trend was clearly illustrated in MSF-supported facilities in the health zones of Masisi and Walikale territory in North-Kivu. In the Masisi health zone, MSF staff found that the proportion of sexual assaults perpetrated by armed attackers rose from 60% in the first quarter of the year to 89% in the fourth quarter, in parallel with the worsening insecurity in places where the assaults took place. Similarly, in Walikale territory, the proportion rose from 23% in the first quarter to 64% in the fourth quarter of 2020.

MSF teams observed that military movements and changes in control of territories often lead to an increase in sexual violence. In the second quarter of 2020, this situation occurred on the Mugunga-Sake-Parc des Virunga axis, where 85% of aggressions took place among survivors treated in MSF-supported facilities in Goma. Here, the number of victims who received medical treatment tripled over the course of the year, from 142 patients (from January to June) to 520 (from July to December).

[17]See Human Rights Watch (2021). World Report 2021, https://www.hrw.org/world-report/2021/country-chapters/democratic-republic-congo.

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Despite the clear link between armed violence, conflict and sexual violence, it is important to note that **many survivors are assaulted by individuals who are not directly taking part in hostilities**. In 2020, 30% of patients receiving care for sexual violence reported having been sexually assaulted by someone without a weapon. Domestic violence, intimate partner violence[18] or, more generally, sexual violence as a non-conflict-related criminal act persists even in areas of intense fighting.

"Intimate partner violence is something we see frequently. We receive women who tell us that they are beaten by their husbands and forced to have children."

Unfortunately, MSF notes that, in its areas of operation, **immediate and long-term support programmes for survivors of non-conflict-related sexual violence are largely insufficient**, and that the narrative of "rape as a weapon of war" remains predominant.

"I remember one case where some survivors were kidnapped with their young daughters. They were beaten and raped. [When they arrived], they were very scared and even the sound of a door closing startled them."

The **psychological, social and economic impact** of sexual violence is often long-lasting and affects survivors' ability to resume a normal life. Anxiety, fear, isolation, shame and avoidance strategies are among the main problems observed in psychological counselling.

"Survivors are often afraid to return to the place where they were assaulted. Many cannot go back to the fields where they were abused, even if it is their only source of livelihood. They just can't go back."

It is also common for survivors to feel guilt and believe that they could have prevented the incident. Many experience nightmares and disturbing flashbacks. They may feel that they have lost control of their lives and are no longer able to carry out everyday tasks.

"Many of our patients have lost the meaning of life. The impact of sexual violence on psychosocial well-being is enormous."

These feelings are often accompanied by clinical consequences such as post-traumatic stress disorder, depression and anxiety.

"Many victims who come for treatment say that since the attack they have had difficulty sleeping, taking care of themselves, have nightmares, feel that they have become crazy."

[18]Intimate partner violence (IPV) is violence perpetrated by a partner (such as a spouse), including physical, sexual and emotional violence. It is the most common form of gender-based violence.

ARE WE DOING ENOUGH ?

Despite an international and national outcry against sexual violence in DRC, and despite efforts to support survivors, it is clear that their needs are far from being met.

This situation was confirmed in November 2020 by the Humanitarian Coordinator of the United Nations in DRC, who emphasised the current weakness in the provision of care for survivors of gender-based violence (GBV).

The figures speak for themselves: in the first half of 2020, it is estimated that barely one in four victims in DRC received medical care, 5% received psychosocial assistance, 15% received legal assistance and only 0.5% benefited from socioeconomic[19] reintegration.

Funding for holistic care of survivors of sexual violence in DRC remains far below the needs. In 2020, the Humanitarian Response Plan (HRP) aimed to cover 36% of humanitarian health needs and 32% of humanitarian protection needs – including barely 8% of the needs of the 10.9 million victims of GBV[20]. In the end, less than 6% of the sum requested by the Health Cluster and 18% of the sum requested by the Protection Cluster were funded.

The proportion of annual financing needs covered by international donors continues to decline in DRC. This trend seems to have continued in 2021. In April 2021, only 3% of the funds needed for the Health Cluster and less than 2% of the funds needed for the Protection Cluster were allocated[21].

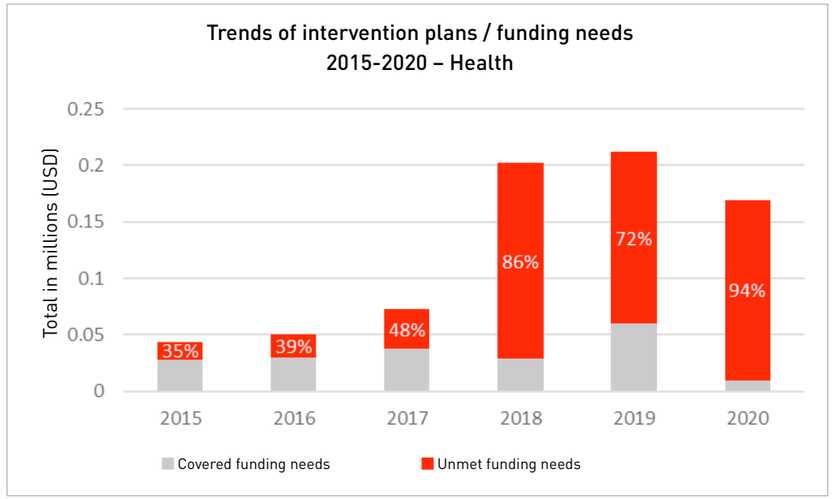
On the medical side, MSF notes that, in its areas of intervention, there are **too few health facilities capable of providing survivors of sexual violence with comprehensive care**.

Even when there is a health facility in the area that offers care for survivors of sexual violence, often medical staff lack training, and stocks of post-rape kits are either inadequate or close to their expiry date. Due to the **lack of medical stock**, emergency contraception and essential vaccinations such as tetanus and hepatitis B are often not provided.

[19]United Nations, DRC (2020). «Humanitarian Coordinator calls for continued efforts to end gender-based violence», https://drcongo.un.org/fr/102653-le-coordonnateur-humanitaire-appelle-poursuivre-les-efforts-pour-mettre-fin-aux-violence.

[20]OCHA (2020). Revised Humanitarian Response Plan - Democratic Republic of Congo, https://reliefweb.int/report/democratic-republic-congo/r-publique-d-mocratique-du-congo-plan-de-r-ponse-humanitaire-2020-1.

[21]OCHA (2021). Democratic Republic of Congo. Follow-up to 2021 funding - Humanitarian Response Plan (HRP) as of 21 April 2021 https://reliefweb.int/report/democratic-republic-congo/r-publique-d-mocratique-du-congo-suivi-des-financements-2021-plan.



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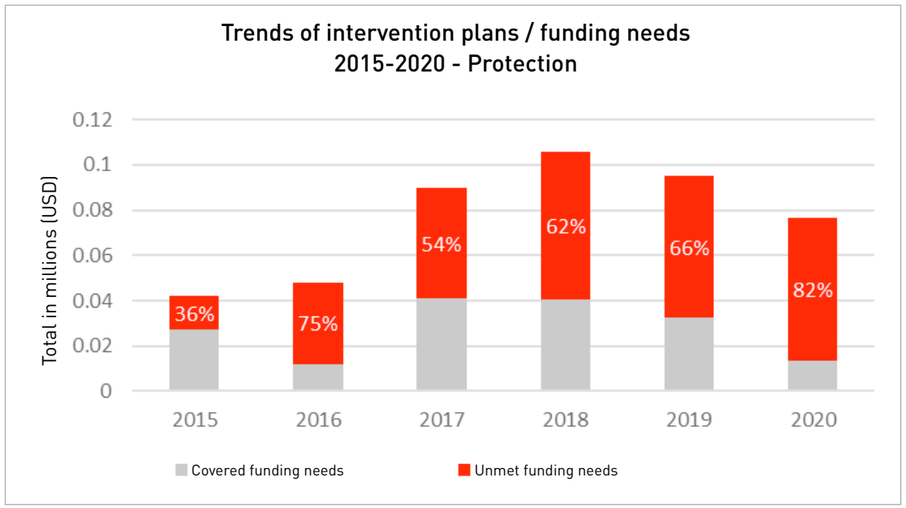
Lack of confidentiality in health facilities is also an issue highlighted by many patients, who sometimes travel long distances to receive care away from home, where they feel more anonymous.

"Some survivors say they don't feel comfortable going to health centres because the person who attacked them is known in the community, and they feel ashamed."

Direct medical costs (such as the purchase of medicines or the payment of formal and informal fees) **and indirect costs** (such as payment for transportation) further hamper access to care.

"One of our patients lives on the Bukavu axis. She is currently staying with a host family. She will have to go home soon, but she asked us if we



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2017, KANANGA PROVINCIAL HOSPITAL

could give her some money to pay for transport. Many survivors of sexual violence who come from far away have no money to return home."

MSF also notes serious gaps in long-term support for survivors, both in terms of protection and socioeconomic reintegration. In the areas where MSF works, the greatest needs include: protection programmes that address both immediate and long-term needs; strengthening the prevention of sexual violence in order to ensure safety and deter intimidation or reprisals; and facilitating access to justice.

"We see women who have been raped and who still endure violence and stigmatisation. That's what really bothers me. It is not the survivor's fault; it is the aggressor's fault. We need more protection actors here. Women often don't have the means to access justice and are exposed to additional risks."

The lack of security and protection has a considerable impact on survivors' access to medical care.

LACK OF ACCESS TO SUPPORT PROGRAMMES SOMETIMES LEADS VICTIMS TO 'NORMALISE' WHAT HAPPENED TO THEM.

"A patient who had been sexually assaulted in Katsiru had to wait and wait and wait… because she was afraid that her assailant was free [not in custody] or that he would find out that she was seeking medical care. She decided to come here on foot [10 km from her home]. When she arrived, we found that she had not eaten or slept since the attack and needed protection."

Impunity and gaps in protection mechanisms expose survivors (and sometimes their families) to further violence and threats. In 2020, none of the patients treated by MSF in Goma asked to receive a medical certificate proving that they had been raped, because the high level of impunity has made them lose confidence in the judicial system. Lack of access to support programmes sometimes leads survivors to **'normalise' what happened to them,** which is the only coping mechanism available to them after surviving such a traumatic experience.

2018, SALAMABILA, SALAMABILA, IN THE PROVINCE OF MANIEMA

2017, KANANGA PROVINCIAL HOSPITAL

"Perpetrators can be arrested, but they are often released after a few days. This creates a lot of insecurity for survivors. They and their families are often threatened and left unprotected."

The economic consequences of sexual violence are often severe, including social exclusion, abandonment by the survivors' family or inability to work due to physical and psychological trauma, resulting in loss of income. In addition, extreme poverty and lack of sources of livelihood increase the suffering of survivors. In Salamabila health zone (Maniema), 95% of those who received psychosocial support from MSF reported having socioeconomic worries.

In 2020 in Kananga (Kasai-Central), MSF teams identified 1,980 survivors whose needs remained unmet, due to certain referral criteria and insufficient coordination and collaboration between the actors involved.

"We sometimes see survivors of sexual violence whose clothes are torn, who do not even have soap. These practical problems further affect survivors' well-being. […] Some are too afraid to go back to the fields [because this is where they were attacked], and we try to find solutions together. But sometimes there is no real solution because there are no other actors to whom we can refer them. These survivors are hungry, we know that, but we are limited."

There is **a need for more effective, long-term socioeconomic support focused on survivors' needs** to help them recover and cope with adversity, social exclusion and family abandonment. Such support is essential in the most affected areas of DRC, including the health zones of Salamabila, Kananga, Masisi, Walikale, Goma, Mweso, Kimbi and Baraka.

CONCLUSIONS

In 2020, 10,810 survivors of sexual violence – an average of 30 per day – received medical and/or psychological care in MSF-supported medical facilities and through the provision of community-based care.

Despite the clear link between armed violence, conflict and sexual assault, MSF has observed that domestic violence, intimate partner violence or, more generally, sexual violence as a criminal act unrelated to conflict, persists even in areas of intense active fighting.

While women and girls are most vulnerable to sexual violence, boys and men are not spared.

The impact of sexual violence goes beyond the initial shock and often affects survivors' ability to resume a normal life. Avoidance strategies, anxiety, fear, isolation and shame are some of the main problems we see in therapy sessions with victims of sexual violence. Sexual violence is a medical emergency, but it also leaves invisible scars that can last a lifetime for survivors, including stigmatisation and the loss of their livelihood. However, access to quality, holistic survivor-centered care and support services can assist survivors through their healing process toward full recovery.

It is therefore essential that support programmes are designed and funded at two levels: emergency response on the one hand; and ongoing support until survivors have made a full recovery – medically, psychologically and socially – on the other.

THIS LACK OF SUPPORT SIGNIFICANTLY INCREASES THE SUFFERING OF SURVIVORS. IT IS ESSENTIAL THAT FUNDING IS INCREASED TO MEET BOTH THEIR IMMEDIATE AND LONG-TERM NEEDS.

Given the multiple barriers that survivors face to access support services, it is reasonable to assume that the number of cases of sexual violence witnessed by MSF and other actors is only the tip of the iceberg. Despite this, there is still no adequate response to the phenomenon.

Systemic underfunding and inadequate coverage of quality programmes –a lack of trained staff, a lack of medicines and other supplies, and a lack of guarantees of gratuity– exacerbate barriers to medical and psychological care. Survivors also face inadequate coverage of emergency and long-term socioeconomic support, prevention and protection programmes.

This lack of support significantly increases the suffering of survivors. It is essential that funding is increased to meet both their immediate and long-term needs.

The government of DRC, the international community and civil society must act to improve the quality and quantity of programmes focusing on the needs of survivors of sexual violence, who must no longer be left to suffer in silence.

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