Note on Sexual and Gender Based Violence
Democratic Republic of Congo

This note is intending to provide a brief overview of the context of Sexual and Gender Based Violence (SGBV) in the Democratic Republic of Congo (DRC), of the institutional systems in place to address it and of Sida’s humanitarian contributions aiming at mitigating its consequences.

1. Patterns of Sexual and Gender Based Violence in DRC

DRC was named and shamed in the New York Times¹ as “the rape capital of the world”… Rape is used as a weapon of war in DRC². Armed groups rape to terrorize and control women and communities and to humiliate families. It’s calculated and it’s brutal. Tens of thousands of women and girls have suffered attacks, leaving them physically damaged and emotionally terrorized. In some areas three-quarters of women have been raped. An average of 1,100 rape cases are reported each month, according to the United Nations Population Fund (UNFPA). According to the Red Cross³, 98 percent of the survivors are female. Nearly all (99.7 percent) of reported perpetrators are male. Gang rapes are common: the average number of aggressors per survivor was 3.86. Sometimes the rapes are conducted with pointed sticks that leave the victims incontinent from internal injuries. One can rightly say that in DRC it is more dangerous to be a woman than to be a soldier. One observes patterns of methodical, massive and systematic rape and it has become clear that mass rape is not just a by-product of war but also sometimes a deliberate weapon.

Rape in war has been going on since time immemorial but it has taken a new twist as commanders have used it as a strategy of war. There are two reasons for this. First, mass rape is very effective militarily. From the viewpoint of a militia, getting into a fire fight is risky, so it’s preferable to terrorize civilians sympathetic to a rival group and drive them away, depriving the rivals of support. Second, mass rape attracts less international scrutiny than piles of bodies do, because the issue is indelicate and the victims are usually too ashamed to speak up.

Initially⁴, rape was used as a tool of war by all the belligerent forces involved in the country’s recent conflicts, but now sexual violence is unfortunately not only perpetrated by armed factions but also by ordinary people occupying positions of authority, neighbours, friends and family members. The national army is allegedly responsible for 70% of all abuses⁵. But during the first half of 2008, only 46 percent of perpetrators in South Kivu were identified as uniformed.

In addition the number of rapes reported understates the true severity of sexual violence in the DRC. The weak application of the law on sexual violence allows perpetrators to act with impunity. Perpetrators benefit from the climate of impunity and the culture of violence to misuse the women and the children in the provinces, and in the country in general. Today, in

¹ Nicholas D. Kristof - Rape as a Strategy of War - Op-Ed – NYTimes; http://www.nytimes.com/2008/06/15/opinion/15kristof.html?_r=1&oref=slogin
² International Rescue Committee; http://www.theirc.org/special-report/rape-in-congo.html
⁵ Briefing by MONUC/Bukavu, 2008
the DRC, sexual violence constitutes one of the greatest forms of infringement of the basic rights of the populations and thus contributes to the increasing vulnerability of the communities as well as the institutions. Widespread sexual violence is also endemic in DRC post-conflict situation, where it perpetuates a cycle of anxiety and fear that impedes recovery.

Human rights abuses suffered by the population of eastern DRC, including sexual violence, and fear of government soldiers and militias alike are widespread. Many respondents of a recent survey were interrogated or persecuted by armed groups (55%), forced to work or enslaved (53%), beaten by armed groups (46%), threatened with death (46%), or had been abducted for at least a week (34%). In eastern DRC, 23 percent witnessed an act of sexual violence, and 16 percent reported having experienced sexual violence. One-third of the respondents said they would not accept victims of sexual violence back in their community. Offspring from unwanted pregnancies resulting from rape and their mother are suffering stigma and exclusion from the community.

Land is a fundamental asset: it is the main source of food production, a secure place to live, and a base for social and cultural identity. SGBV in DRC result in weakened women and children’s property rights - this is precisely one of the perpetrators objectives. Women in particular - as the main responsible for the family’s food security and nutrition - need access to land, management control of land based resources, and those economic incentives that the security of tenure provides. By destroying her, a chain of dependents, and more widely her own community, are deprived from their rights to land and food security.

The impact of sexual violence is devastating. Physical consequences include injuries, unwanted pregnancies, fistula and HIV. According to the FAO, 20 percent of rape survivors in Eastern DRC are HIV positive. Living with HIV can constitute a risk factor for SGBV survivors as violence occurs when a women discloses HIV status in her family / community or decides to go for HIV testing. A vicious cycle of increasing vulnerability to gender based violence and HIV is then established. Many survivors of sexual violence have received debilitating damage to their reproductive organs, resulting in multiple fistulas and incontinence. Women and girls have been left with broken bones, missing limbs and even burns. Some have been shot and stabbed in the vagina with bullets, bits of broken glass and cobs. Family men have been forced to sexually violate their daughters, sisters, and mothers at gun point.

Medical treatment is critical for someone who has been sexually assaulted. Survivors need antibiotics to prevent infection and may require treatment for abrasions, tears, or traumatic fistula, a devastating but operable injury that may occur as a result of sexual assault. In addition to physical injury, women and girls who are raped may be at risk of unwanted pregnancy or sexually transmitted infection. If provided in time, emergency contraception can prevent an unwanted pregnancy, and post-exposure prophylaxis can prevent the transmission of HIV and other sexually transmitted infections.

The challenge of providing assistance to the Congolese survivors of sexual violence has been compounded by budget limitations and the high cost of transportation in a country with a fragmentary and poorly maintained road system. The appalling weakness of health and social services and infrastructures in post-Mobutu DRC deprives victims of SGBV from receiving adequate care and psychosocial support. Furthermore, endemic corruption of justice system, mainly staffed by men, and the lack of adequate jails or prisons has led to the quick release of perpetrators. These factors, combined with cultural barriers and taboos,

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6 Living with fear, Human right Centre, August 2008
7 Gender and land compendium of country studies, FAO
8 UNFPA; [http://www.unfpa.org/emergencies/violence.htm](http://www.unfpa.org/emergencies/violence.htm)
have left many victims unwilling to come forward and report the crimes that have been committed.

Sexual violence is not inevitable. Better policing, involving women in the design of humanitarian assistance, working with displaced communities to develop systems of protection, and ending impunity for perpetrators are just a few of the actions that can help to minimize sexual violence. Information campaigns and community education can help to raise awareness of the issue, stimulate community dialogue, reduce stigma, and encourage survivors to report incidents and seek care. Effective campaigns positively engage men and promote reflection about cultural attitudes and gender inequalities that perpetuate violence against women. Radio Okapi programme is a key vehicle for prevention and information work.

2. Systems in place to prevent SGBV and address its humanitarian consequences

While DRC’s fragile political stability resulted in the neglect of the problem until a Law on Sexual Violence was adopted by the Parliament in 2006, it took long as well to the international community to recognise and understand the severity of SGBV in DRC. Media and NGOs highlighted its dreadful reality in 2003, but it was only recently that an ambitious coalition campaign was designed and that the MONUC established the Office of Senior Adviser and Coordinator for Sexual Violence, resulting in the elaboration of a Comprehensive Strategy on Combating Sexual Violence in DRC in a context of strategic void. Prior to this, humanitarian, development and state actors were ill-equipped to address the problem in a coherent and comprehensive manner. Ad hoc projects concentrated in the East of the country - where conflicts are ongoing - without sufficient efforts for coordination, synergy building and holistic approach as required. Laudable champions and prize-winning initiatives attracted much media and donor attention, while a response at scale was needed. Although not enough, more was done for response than for protection and prevention, resulting in repeated abuses.

Recent mapping of actors in South Kivu as of August 2008 identified coordination as a main challenge; UNFPA reported 160 actors offering medical response, 118 offering psychosocial support, 131 assisting with community re-integration and 21 providing legal assistance in the province. UNFPA-South Kivu has identified the following as gaps in services: incomplete coverage within the province, insufficient resources for economic re-insertion programs, few legal services and prisons in the province, insufficient medical facilities offering specialized services, insufficient psychological services, insufficient protection mechanisms for survivors and actors and care for “collateral victims”- those affected by the survivor’s experience. Access to remote areas and insecurity are obstacles to reach out a greater number of victims. Assistance tends to be concentrated in urban centres and internally displaced persons (IDP) sites, while needs are presumably immense beyond, in remote and vulnerable communities. One notices that stigmatisation and obstacle to legal assistance may be increased resulting from health personnel’s set to interact with sexual violence survivors without recognising the reality of their health and psychosocial needs.

9 Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies
10 United Nations Secretary-General's Campaign to End Violence Against Women; http://www.un.org/women/endviolence
At last, a UN Security Council Resolution (1794)\textsuperscript{12} in 2007 urged MONUC to create a common framework and platform for action to address widespread and systematic sexual violence. The overall goal of the new strategy is on strengthening prevention, protection and response to sexual violence by:
- Supporting the efforts of the UN system and the DRC Government to combat sexual violence;
- Streamlining coordination mechanisms;
- Providing strategic, technical and policy advice;
- Ensuring the inclusion of sexual violence in broader agendas (such as Justice and Security Sector Reform, the Protection of Civilians, the government-led thematic sub-group on Sexual violence);
- Ensuring complementarities with ongoing processes and initiatives (Security Sector Reform Working Group, Comité Mixte de la Justice, the National Police Reform Committee (Comité de Suivi pour la Réforme de la Police), the UN Stabilization Plan for Eastern DRC – UNSSSS and the work plan developed by the Sous Groupe Thématique, etc)
- Improving the methodology and focusing programmatic orientation of projects on sexual violence.

The Strategy includes 4 strategic objectives and identifies lead agencies for:
1. Combating Impunity for Cases of Sexual Violence (OHCHR)
2. Prevention and Protection of Sexual Violence (UNHCR)
3. Security Sector Reform and Sexual Violence (MONUC)
4. Multi-Sectoral Response for Survivors of Sexual Violence (Unicef and/or UNFPA)

Humanitarian partners, beside other actors, will be particularly mobilised for meeting the following specific objectives:
- Preventing and mitigating threats and reducing vulnerability and exposure to sexual violence;
- Strengthening resilience of survivors of sexual violence;
- Creating a protective environment for victims of sexual violence;
- Improving the referral pathway for a multi-sector response for sexual violence survivors;
- Contributing to building national and local capacities for the delivery of multi-sector assistance.

Risks and potential challenges are identified: funding gaps, insufficient political and institutional will to operationalize the strategy, relapse of conflicts and displacements.

3. Sida’s humanitarian contributions to address SGBV consequences

Beside and in complement to Sida’s development cooperation strategy in DRC which identifies health with a focus on Sexual and Reproductive Health and Rights (SRHR) as one of its three priority areas for 2009-2011, the response to SGBV has been integrated in Sida’s support to humanitarian action during 2008-2009.

This is done through three main channels:
\textbf{a) Contributions (280 MSEK) to the common humanitarian Pooled Fund (2008-2009)} managed by UNDP and OCHA to finance humanitarian action defined in annual interagency Humanitarian Action Plans; a critical number of Pooled Fund-supported projects have combating SGBV as either principal objective or as a significant objective;
- The Pooled Fund supported around 300 projects in 2008 with US$ 125 millions.
  OCHA reported in November that within the frame of the Humanitarian Action Plan for 2008, medical care was provided to 14,468 survivors of sexual violence; psychosocial

\textsuperscript{12} UNSC: \url{http://www.un.org/News/Press/docs/2007/sc9213.doc.htm}
Support was provided to 12,434 victims; 2,753 sexual and gender-based violence (SGBV) cases were referred to justice; 3,564 cases benefited from reintegration support; 5,441 sensitization workshops on SGBV were done for communities and authorities.

b) Contributions to the Red Cross / Red Crescent Movement (2008-2009):

- ICRC (41 MSEK) is mainstreaming protection and assistance to victims of SGBV within a multi-disciplinary approach including: coordinating with other organisations and with community leaders, making authorities and armed groups aware of their responsibilities, reporting alleged violations to weapon bearers, promoting International Humanitarian Law (IHL) and International Human Rights Law among weapon bearers, encouraging communities to accept and support victims of sexual violence and to enhance their capacity for self-protection, assisting the victims of sexual violence through medical support (6 hospitals and 8 health centres supported in South and North Kivu in 2007: 1,043 victims treated), psychosocial (23 posts), economic support and community awareness.

- The Swedish Red Cross and IFRC (10 MSEK) are supporting the DRC Red Cross Society in 12 reception and listening posts for SGBV survivors in North and South Kivu who are then transported and referred to medical services. The number of beneficiaries remains modest (150 clients in a 3 month time for all posts). Psychosocial support, mediation within affected families / communities and community sensitisation (42,300 beneficiaries) are part of DRC Red Cross project. Victims get access to rehabilitation assistance from the Red Cross consisting of non-food items, micro-projects and money pooling schemes.

c) Bilateral contributions to SGBV specific projects (2008-2009) and other projects integrating SGBV components:

- FAO (1.87 MSEK) is implementing a regional food security project with Sida’s support aiming at improving food self-sufficiency and nutrition status of survivors of sexual violence. FAO supports 3,000 households affected by SGBV (and HIV/AIDS) in DRC.

- PMU-InterLife and CEPAC (1.5 MSEK) are providing medical care and psychosocial support to 3,300 survivors of sexual violence at Bukavu’s Panzi hospital (South Kivu). The project includes rehabilitation components like vocational training, sanitation and food aid, as well as dissemination of information on SGBV through training workshops and radio programmes which are reaching 3 million listeners.

- Médecins Sans Frontières (22 MSEK) is integrating systematically management of SGBV cases in its primary and secondary health care projects. Sida is supporting 4 of them in Ituri (Bunia hospital, population catchments: 210,000 persons), Maniema (Lubutu hospital, population catchment: 120,000 persons) and Katanga (Dubié, population catchment: 68,000 persons; Shamwana, population catchment: 34,000 persons).

- Church of Sweden / Action of Churches Together (3.225 MSEK) are implementing psychosocial support and rehabilitation activities in North and South Kivus through a community based approach which mobilize local organisations and churches, targeting victims of SGBV among a group of 60,000 recent internally displaced persons (IDPs).

- Norwegian Refugee Council (13 MSEK) legal counselling project to IDPs refers SGBV survivors to judicial institutions.
- International Rescue Committee (IRC) submitted a project proposal to Sida for an intervention in 2009-2010 aiming at Breaking the Cycle of Vulnerability and Violence Against Women and Girls in Eastern DRC (21 MSEK). The assessment process is work in progress.

Sida’s development assistance in DRC supports as well SGBV prevention and response components in justice programmes (Rejusco, Global Witness), addressing cases of impunity. Sexual and Reproductive health and rights is one of the main sectors of the approved Strategy for development assistance 2009-2011.

The Swedish Ministry of Foreign Affairs is providing funds as well to a number of partners (MONUC, ICRC, UNHCR, Unicef, WFP, PMU-InterLife, Kvinna till Kvinna) in coordination with Sida.

d) Recommendations and follow up

- Sida’s Humanitarian and Country Teams should continue in 2009 initiated support to partners; ensure they are integrated in the wider SGBV national strategy and coordinated proactively with other actors within mechanisms put in place;

- Sida’s Humanitarian and Country Teams should explore potential new partnerships with organisations displaying a significant added value and programming at scale for prevention, protection and response to SGBV within the national framework;

- Reinforce coherence and synergies of contributions for SGBV from Sida’s Humanitarian team and from Sida’s Country team for development assistance in DRC, along their respective strategy and mandate, with a clear division of responsibilities.

- Contribute to scaled up and result-oriented advocacy in Sweden and within the international community regarding SGBV, especially in DRC.