Sexual Violence against Internally Displaced Women in North Kivu
Critical Examination of Effective Health-System Responses and Community Interventions

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51st International Course in Health Development/
Master of Public Health (ICHD/MPH)
September 22, 2014 – September 11, 2015

KIT (ROYAL TROPICAL INSTITUTE)
Vrije Universiteit Amsterdam
Amsterdam, The Netherlands

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A thesis submitted in partial fulfilment of the requirement for the degree of

Master of Public Health

by

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Declaration:
Where other people's work has been used (either from a printed source, internet or any other source) this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis Sexual Violence against Internally Displaced Women in North Kivu Critical Examination of Effective Health-System Responses and Community Interventions is my own work.

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Amsterdam, The Netherlands

September 2015

Organised by:
KIT (Royal Tropical Institute) Health Unit
Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam/Free University of Amsterdam (VU)
Amsterdam, The Netherlands

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iii. List of Abbreviations

ACORD	Agence de Coopération et de Recherche pour le Développement
AIDS	Acquired Immunodeficiency Syndrome
API	Additional Protocol I
APII	Additional Protocol II
AVIFEM	Agence nationale de lutte contre les Violences faites aux Femmes
BCC	Behaviour Change Communication
CAF	Country Assistance Framework
CBO	Community-Based Organization
DHS	Demographic and Health Survey
DOCS	Doctors On Call For Service
DRC	Democratic Republic of Congo
EC	Emergency Care
FARDC	Forces Armées de la RDC
FBO	Faith-Based Organization
FGM	Female Genital Mutilation
FONAFEN	Fonds National de la promotion de la Femme et de la protection de l'Enfant
GBV	Gender-based violence
GBVIMS	Gender-Based Violence Information Management System
GCIV	Fourth Geneva Convention
GDP	Gross Domestic Product
HAP	Humanitarian Action Plan
HDI	Human Development Index
HIC	High-Income Country
HIV	Human Immunodeficiency Virus
HS	Health System
IASC	Inter-Agency Standing Committee
IAWG	Inter-Agency Working Group
ICRC	International Red Cross and Red Crescent Movement
IDP	Internally Displaced Person
IHL	International Humanitarian Law
IPV	Intimate Partner Violence
IRC	International Rescue Committee
IMR	Infant Mortality Rate
LIC	Low-Income County
LMIC	Low- and Middle-Income Country
IPV	Intimate Partner Violence
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
mhGAP	Mental Health Gap Action Programme
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Ratio
MoGFC	Ministry of Gender, Family and Children

MoPH	Ministry of Public Health
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organization
OPP	Out-of-Pocket Payment
PEP	Post-Exposure Prophylaxis
PNC	Police Nationale Congolaise
PRB	Population Reference Bureau
PRGSP	Poverty Reduction and Growth Strategy Paper
PTSD	Post-Traumatic Stress Disorder
RCT	Randomised Control Trial
SNVBG	Stratégie Nationale de lutte contre les Violences Basées sur le Genre
SFVS	Synergie des Femmes pour les Victimes des Violences Sexuelles
SGBV	Sexual and Gender-based Violence
SOP	Standard Operating Procedure
SRHR	Sexual Reproductive Health and Rights
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
SV	Sexual Violence
U5MR	Under-five Mortality Rate
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHRC	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNSC	United Nations Security Council
USAID	United States Agency for International Development
VAW	Violence against Women
VSLA	Village Savings and Loan Association
WfWI	Women for Women International
WHO	World Health Organization

iv. Glossary

The focus of this thesis is on sexual violence (SV) against internally displaced women in North Kivu. As rape accounts for roughly 90% of SV in North Kivu, the terms SV and rape will be used interchangeably throughout this thesis. However, information on this subject is often treated in literature as a part of the broader concept of violence against women (VAW). The term VAW includes a number of abuses directed towards women and girls, including intimate partner violence (IPV), SV or non-partner sexual assault, trafficking of women, female genital mutilation (FGM), forced early marriage, and honour killings (1, 2).

The terms gender-based violence (GBV) and sexual and gender-based violence (SGBV) also fall under the heading of VAW. Though these terms are often used interchangeably as well, they may have different meanings and consequences depending on the specific situation or location. For complete definitions of these and other relevant terms, please refer to the Glossary below.

Glossary of Relevant Terms

Gender-Based Violence	Violence that is directed at a person on the basis of their gender or sex, including acts that inflict physical, mental, or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty (3).
Health System	People, institutions, and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health (4).
Internally Displaced Person	Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or human-made disasters, and who have not crossed an internationally recognized State border (5).
Primary Prevention	Directed towards preventing the initial occurrence of a disease or health problem (6, 7).
Rape	Physically forced or otherwise coerced penetration (even if slight) of the vulva or anus, using a penis, other body parts or an object (8).
Secondary Prevention	Seeks to stop or delay existing disease or health problem and its effects through early detection and

	prompt and appropriate treatment (6, 7).
Sexual Assault	Sexual assault is any type of sexual contact or behaviour that occurs without the explicit consent of the recipient (9)
Sexual and Gender-Based Violence	Any harmful act that is perpetrated against one person's will and that is based on socially ascribed gender differences between males and females. It includes acts that inflict physical, mental, or sexual harm or suffering, threats of such acts, coercion, and other deprivations of liberty, whether occurring in public or in private life (10).
Sexual Violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, acts to traffic, or other coercive actions directed against a person's sexuality by any person, irrespective of relationship to the victim, in any setting, including but not limited to home and work (1, 11).
Tertiary Prevention	Focuses on reducing or reversing the consequences of a disease or health problem once it has developed through effective rehabilitation. The goal of tertiary prevention is to eliminate, or at least delay, the onset of complications and disability due to the disease (6, 7).
Violence	The use of force to control another person or other people. Violence can include physical, emotional, social or economic abuse, coercion, or pressure. Violence can be open, in the form of a physical assault or threatening someone with a weapon; it can also be more hidden, in the form of intimidation, threats or other forms of psychological or social pressure (12).
Violence against Women	Any act of gender-based violence that results in, or is likely to result in, physical, sexual, and psychological harm to women and girls, whether occurring in private or in public (2).

v. Acknowledgements

First and foremost, I would like to thank God for the strength and courage to accomplish this work.

I would also like to thank my family, whose prayers and support carried me through, and express my deepest gratitude to my beloved father for his loving words of encouragement.

Sincere thanks to my thesis advisor and back-stopper for their patience and invaluable input during the thesis writing process.

Special thanks to Martin for giving me the support necessary to overcome the difficulties encountered during this time and to Maria for helping me to see the bigger picture. I appreciate you both for keeping me sane and on track.

To all those who proofread my paper, thank you for your contributions.

Last but not least, many thanks to my fellow ICHD classmates, and beloved friends, for the comic relief during this high-stress period.

vi. Abstract

Sexual violence against IDP women in DRC is a major public health problem. As of 2013, 80% of women living in North Kivu had been raped. Although the factors contributing to the violence and consequences have been researched and documented, information on evidence-based interventions for preventing sexual violence in this conflict-affected area is lacking.

This study aims to assess current policies and programme responses for primary, secondary and tertiary prevention of sexual violence. It also identifies effective interventions for sexual violence prevention in addition to care and support. A conceptual framework on the role of the health system to address violence against women was adapted and used to guide analysis of the findings.

It was found that current policies and responses are adequate and meet international standards; however, there are gaps in implementation. Some of the reasons for these gaps are lack of efficient coordination mechanisms and inadequate information system.

Interventions such as group training for women, girls and men, cognitive processing therapy and policy review are effective in the North Kivu context.

It is recommended that the government make sexual violence prevention programmes a public health priority. Furthermore, information systems should be strengthened and monitoring and evaluation systems installed. Mental health units should be established in all government-owned secondary and tertiary healthcare facilities, along with appropriate resources including healthcare professionals and equipment.

Keywords: "sexual violence," "prevention," "internally displaced persons," "health-system responses," "community interventions"

Word Count: 13,200

vii. Introduction

Women's health has always been a topic of interest for me and therefore sexual reproductive health and rights (SRHR) was the module that I enjoyed the most during my Master of Public Health/International Course in Health Development (MPH/ICHD) programme. Throughout my lectures, I contemplated over the poor conditions that women face in internally displaced persons (IDP) camps in the Democratic Republic of Congo (DRC). The situation in Eastern Congo (referring to North Kivu) is of major public health concern because of its ripple effect on women's health, community and social life, as well as on economic development. Several factors, including the weak health system (HS), have left women vulnerable to SV or rape, making them more likely to be disowned by their husbands and families or ostracized from their communities. This violence also increases their chances of contracting sexually transmitted infections (STIs) and human immunodeficiency virus and acquired immunodeficiency syndrome (HIV and AIDS), unintended pregnancies, unsafe abortions and consequent death, traumatic fistula, low-birthweight babies, psychological trauma and poverty. These consequences could, in turn, lead to many children becoming motherless, being exposed to severe trauma, and having increased risk of malnutrition. In short, the more women are being raped, the faster the fabric of Congolese society crumbles.

While my passport may say that I am American, I am truly African at heart. I was born in the DRC and even though I left the country at two years old, I knew that one day I would eventually return to my origins, and that is exactly what I did when I graduated from university. Equipped with a Bachelor's degree in economics, I headed back to Africa to work for an American non-governmental organization (NGO) in Benin. There, I supported the country's efforts in combatting malaria by participating in the design of several USAID-funded project proposals for scaling-up the fight against malaria. That was my first real exposure to public health and I immediately fell in love with the field. During my stay in West Africa I earned a second Bachelor's degree in health logistics and decided to move to the DRC where the health logistics need is abundant. While in Congo, I worked for the Expanded Programme on Immunization (EPI) as well as the World Food Programme (WFP), and it was during my time at the WFP that the problems going on in the Eastern part of the country came to light for me (mainly insecurity and its consequences on the local population). I became more knowledgeable about the grave human rights violations taking place in IDP camps and the massive amount of SV that women and girls were falling prey to, and I vowed to help be a part of the solution.

This thesis is about SV among internally displaced women in North Kivu and the HS and community response to the problem. I chose this topic

because the subject matter is relevant to the work that I would like to do in the future. My passion has always been to help the most vulnerable in our society, namely women and children. The topic also sprung from my growing interest in women's SRHR since learning more about SV during my Master's programme. With this thesis, I hope to gain better insight on both health-system responses and community interventions to SV in conflict areas. I also hope to propose effective and evidence-based recommendations on how best to respond to the problem, in order to help improve the health status and exercise of rights of women IDPs in North Kivu and to prevent future acts of SV.

1. Background Information

1.1. Country Profile

1.1.1. Geographic, Demographic, Socioeconomic and Cultural Situation

The DRC is a low-income country (LIC) located in Central Africa. Congo shares borders with nine other countries and is divided into eleven administrative provinces (Figure 1). The country has an area of 2,345,000 km², making it the second largest country on the African continent and eleventh largest in the world (13). Congo has a population of roughly 67 million people and climate conditions that are favourable for agriculture, forestry and mineral wealth (14). DRC has the potential to be one of the richest countries in the world, but its human development index (HDI) value for 2013 was 0.338, placing it in the low human development category. The country is ranked 186 out of 187 countries and territories (15).

Figure 1. Provincial Map of the Democratic Republic of Congo (16)

80% of Congolese live below the poverty line and only 54% of the population has access to an improved drinking-water source. Life expectancy at birth is 42 years, while the average in Sub-Saharan Africa (SSA) is 51 years. The adult literacy rate is 34.7%. Gender-related imbalances exist between Congolese women and men in all areas of

development: economic, social, cultural and political, as the presence of women in decision-making levels of the administration remains weak. These imbalances are obstacles to the enjoyment of the same human rights for all citizens and thus prevent women from playing their full role in the country's development process (16).

Although only 2.8% of women are represented in the formal work sector, 80% of households owe their survival to women. Women's economic activities are mainly concentrated in agriculture (70% in traditional agriculture) and in informal sector (60%), including commerce. These two sectors constitute the core of the average Congolese family's economy, making Congolese women the main breadwinners (17).

1.1.2. Political Instability and Violence

Since gaining independence in 1960, DRC has been characterized by decades of civil war and armed conflict. These wars have resulted in large-scale massacres with more than five million lives lost and well over two million IDPs and refugees. DRC consistently tops the list of African countries affected by internal displacement (18). Today, the provinces of North and South Kivu continue to be unstable and volatile as a result of a number of armed groups still active in these areas, leading to armed conflict between the groups and also with the Congolese government security forces (19). Countless families have relocated due to a long and multifaceted conflict that has resulted in serious deteriorations in North Kivu especially. Between January 2009 and March 2013, 63% of IDPs in DRC were from the Kivus. In addition, there were roughly 174,620 displaced people in DRC from April to May of 2013, more than 50% in North Kivu (19). By the end of 2013, there were more than 967,000 IDPs in North Kivu alone (18).

1.1.3. Health Situation

Typical of a LIC, health indicators in DRC show a poor state of health in comparison to other countries. For example, the estimated maternal mortality ratio (MMR) was 780 per 100,000 live births in 2013. During the same year, the infant mortality rate (IMR) was 58 per 1,000 live births and the under-five mortality rate (U5MR) was 104 per 1,000 live births. Moreover, the use of modern methods of contraception remains low, but has increased by over 30% from 3.3% in 2007 to 4.6% in 2013 in rural areas and 9.5% in 2007 to 14.6% in 2013 in urban areas (16). Presently, fertility rates vary from 5.4 children per woman in urban areas to 7.3 children per woman in rural areas. The current fertility rate of North Kivu is 6.5 children per woman (16).

55% of mortality in the DRC is due to 5 main diseases, namely malaria, diarrhoea, respiratory infections, tuberculosis and neonatal conditions

(16). HIV is also one of the main health concerns in Congo (20). The country presently has an HIV prevalence rate of 2.8%. When comparing further, prevalence is especially high among woman aged 15-24 (1.6%), who have the highest rates within the category of women as well as in the entire country (16). In addition, populations of internally displaced women have one of the highest prevalence of HIV within the country (7.6% in 2009) (21).

Mental health data have not been compiled in the last several years and little is known about the burden of mental health problems in Congo (22). However, research shows that mental health conditions in IDP and refugee populations can develop or worsen because of issues related to limited coping mechanisms (23), so it is expected that the prevalence of mental health problems like post-traumatic stress disorder (PTSD), depression and anxiety is high in North Kivu (24).

1.1.4. Health System

In 2013, Congo's total expenditure on health as a percentage of gross domestic product (GDP) was 3.5%. In the same year, the country's general government expenditure on health as a percentage of total expenditure on health was 53.1% and the general government expenditure as a percentage of total government expenditure was 12.9%. 52.4% of all health funding was through donors. Out-of-pocket payment (OPP) is a major source of HS financing in DRC, representing around 69.8% of all private expenditure on health. There is currently no information available on government expenditures on mental health and mental health hospitals (25). However, in 2011, there was 1 registered mental health outpatient facility and 1 registered day treatment facility registered (a rate of 0.001 per 100,000 population each). No community residential facilities were registered. Also, there were 6 mental hospitals (0.009 per 100,000 population) with 500 beds available in each (0.737 per 100,000 population) (22).

1.2. Sexual Violence in DRC

The most affected by the instability are women and children as they face the most risk of being subjected to SV when fleeing the fighting and seeking refuge. In addition, the IDP population in North Kivu is predominately female (19) and hundreds of thousands of women and girls have been made vulnerable to SV as a result of war (26). Research has shown that there is a link between conflict and SV against women as during these turbulent times, rape is often used as a military tactic to cause harm, humiliation and shame. Furthermore, conflict often weakens systems of protection, security and justice, which can aggravate the occurrence of SV (27, 28). In general, women and girls are the most affected by SV. Out of the 6,000 cases of SV reported at the beginning of

2009 in Eastern Congo, nearly 99.2% of the survivors were female, while only 0.8% were male. SV is one of the biggest public health problems that women are facing in North Kivu today (26).

According to the DRC's Millennium Development Goal (MDG) Progress Report from 2010, 35% of all women and girls in Congo are survivors of SV (26). That number is even higher among IDP women. In 2007, an alarming average of 40 women per day were raped in Eastern DRC (29). 70% of survivors were civilians aged 6 months to 80 years and 75% of survivors were minors (29). By 2013, a staggering 80% of women living in North Kivu had been raped (13).

2. Problem Statement and Study Approach

2.1. Problem Statement

It is well documented that SV is a widespread international human rights and public health issue, and that appropriate, good quality and effective prevention and response are inadequate in many countries worldwide; however, little research is conducted on the problem in most low- and middle-income countries (LMIC). Consequently, prevalence of SV can be difficult to obtain due to its often hidden and underreported nature (30). Cultural factors and the stigma associated with SV make it difficult to discuss (31), which could be the reason behind the underreporting. Some cases may also go undocumented because survivors feel ashamed, blame themselves or suffer from psychological distress, and the responses received from their communities as well as formal institutions (i.e. police, judiciary, and health) can be unsympathetic, discriminatory and traumatizing (32).

However, the available evidence shows that one in every three women will experience SV from an intimate partner or from someone other than a partner in her lifetime (33). SV infringes upon a person's human right to health, security, protection and honour (34). SV is also an important development challenge because it can act as a barrier to women and men's equal participation in society and can affect overall social and economic growth (31, 33). The consequences of SV, both direct (e.g. vaginal or perineal injury) and indirect (e.g. financial hardship), place a burden on households and economies (31, 35). These consequences also deal with rights issues in addition to having public health implications. For example, trauma, along with other health problems, has consequences for the individual, human rights and dignity violations have consequences for both the individual as well as society, and the economic costs to households can affect the macroeconomic situation of a country.

Political unrest and associated violence in and around DRC has greatly contributed to women's exposure to insecurity as during armed conflict,

social structures are disrupted. Family members are often dispersed during flight, leaving children separated from the rest of their families and women as solely responsible for protecting and maintaining their households (36). IDP women and girls are most at risk of SV compared to IDP men and boys. One of the main reasons for this is because most IDP camps in the country do not meet the minimum standards for protecting women and girls. Consequently, Congolese women suffer from extremely high levels of SV carried out by non-state armed groups as well as the Congolese army (37).

Factors making IDP women even more vulnerable to SV include unsafe shelters that are easily accessible to attackers and communal shelters that house both single men and women together. Due to poor site planning, women often have to walk long distances to collect firewood for cooking meals or to generate income. Women in these insecure territories are often left with no choice but to risk being raped in order to ensure their family's survival (37). In 2011, 10,322 cases of SV were reported in Congo and this number increased by roughly 52% in 2012 (15,654 cases). The Kivu provinces reported more SV incidents than any other provinces in 2011. In 2012, North Kivu was leading on reported SV incidents (36).

SV is a serious problem in DRC for a number of social and economic reasons as well. For example, because rape has often been a matter of stigma for the victim rather than the perpetrator (2), survivors of SV are highly stigmatized in Congo and are often outcast from society and even their families when they disclose that they have been raped, often pushing them into poverty (13, 20). SV also has adverse consequences on Congolese health. In 2007, the United Nations High Commissioner for Refugees (UNHCR) declared that "conflict-induced displacement makes affected populations more vulnerable to HIV transmission" (38). In 2014, HIV prevalence in IDP populations in Congo was estimated at 5.9%, compared to 1.1% among the general population (21). The Ministry of Public Health (MoPH) also reported that HIV prevalence among female survivors of rape in Congo was estimated to be 20% in March 2012 (39).

Post-violence or traumatic fistula is another major problem that Congolese women are facing. In 2004, a study of 100 women SV survivors in North Kivu revealed that around 17% of those survivors suffered from traumatic fistula (40). Survivors of SV also face psychological consequences that may require years of psychosocial support such as feelings of fear, anxiety, nervousness, shame or guilt, as well as distrust of others, emotional detachment, withdrawal, depression, low self-esteem, PTSD, and attempted or completed suicide (35). While research shows that there is a strong association between SV and human rights violations with physical and mental health problems (41), there is

currently no data available on the burden of mental health among IDP women in North Kivu.

In order to win the fight against SV and to ensure that Congolese women both participate equally in the nation's development as well as achieve equal representation in national, provincial, and local institutions, all stakeholders must take aggressive action to implement and enforce the necessary changes or improvements to SV policy and programme responses within the country. Furthermore, primary, secondary and tertiary prevention strategies need to be incorporated at all levels of the healthcare system in order to prevent the occurrence of SV, delay its effects through prompt and appropriate treatment and reverse its consequences through effective rehabilitation. For complete definitions of primary, secondary and tertiary prevention, please refer to the Glossary in section iv.

This thesis aims to answer 'What is being done for current survivors of SV in North Kivu (by the health sector and at the community level)?' and 'What can be done to prevent new cases of SV?' This thesis will focus on internally displaced women as evidence shows that SV among IDPs affects mostly female persons, representing 98% of reported cases in 2011 and 2012 respectively (36).

2.2. Justification

Globally, the average age of SV survivors is less than 21 years (42). These young women are often left with mental health problems that require long-term psychosocial support (33, 43), they face stigma from their communities (2) and they are more at risk of contracting HIV (2, 44). The factors contributing to and consequences of SV have been researched and documented (Table 1 and 2). However, not enough information is available on effective and evidence-based interventions for handling SV in conflict settings such as North Kivu. This research aims to study the effective interventions for SV prevention (primary prevention) in addition to care and support (secondary and tertiary prevention) to determine what works and why and what does not.

Table 1. Causes or Risk Factors Contributing to Sexual Violence (3)

Individual risks	• Loss of security • Dependence • Physical and mental disabilities • Lack of alternatives to cope with changes in socio-economic status • Alcohol, drug use/abuse • Psychological trauma and stress of conflict, flight, displacement • Disrupted roles within family and community • Ignorance/lack of knowledge of individual rights enshrined under national and international law
Social norms and culture	• Discriminatory cultural and traditional beliefs and practices • Religious beliefs
Legal framework and practices in host country and/or country of origin	• Discrimination and condone sexual and gender-based violence • Lack of legal protection for women's and children's rights • Lack of laws against sexual and gender-based violence • Lack of trust in the law enforcement authorities • Application of customary and traditional laws and practices that enforce gender discrimination • General insensitivity and lack of advocacy campaigns condemning and denouncing sexual and gender-based violence
	• Discriminatory practice in justice administration and law enforcement • Under-reporting of incidents and lack of confidence in the administration of justice • Lack of willingness to effectively prosecute all cases reported to authorities • Low number of prosecutions obtained in proportion to the number of cases reported • Police and courts inaccessible because of remote location of camp • Absence of female law enforcement officers • Lack of administrative resources and equipment by local courts and security officials • Laws or practices in the administration of justice that support gender
War and armed conflict	• Breakdown of social structures • Exertion of political power and control over other communities • Ethnic differences • Socio-economic discrimination
Refugee, returnee and internally displaced situations	• Collapse of social and family support structures • Geographical location and local environment (high crime area) • Design and social structure of camp (overcrowded, multi-household dwellings, communal shelter) • Discriminatory practice in justice administration and law enforcement • Under-reporting of incidents and lack of confidence in the administration of justice • Lack of willingness to effectively prosecute all cases reported to authorities • Low number of prosecutions obtained in proportion to the number of cases reported • Police and courts inaccessible because of remote location of camp • Absence of female law enforcement officers • Lack of administrative resources and equipment by local courts and security officials • Laws or practices in the administration of justice that support gender

Table 2. Consequences of Sexual Violence (3)

Emotional & Psychological Consequences	Social Consequences
• Post traumatic stress • Depression • Anxiety, fear • Anger • Shame, insecurity, self-hate, self-blame • Mental illness • Suicidal thoughts, behaviour	• Blaming the victim/survivor • Loss of role/functions in society (e.g. earn income, child care) • Social stigma • Social rejection and isolation • Feminisation of poverty • Increased gender inequalities

2.3. Objectives

2.3.1. General Objective

The overall objective of this research is to critically examine the different responses to SV among IDP women in North Kivu and other relevant contexts, so as to make evidence-based recommendations to the Congolese government and other relevant stakeholders on how to improve the health status and exercise of rights of this vulnerable group through primary, secondary and tertiary prevention.

2.3.2. Specific Objectives

1. To assess current policy and programme responses to SV (primary, secondary and tertiary prevention) among IDP women in North Kivu, in light of international standards and guidelines.
2. To identify and discuss effective interventions for SV in conflict settings from DRC and other relevant contexts in SSA.
3. To develop evidence-based recommendations for the Congolese government and other relevant stakeholders on how to improve the health status and exercise of rights of IDP women in North Kivu.

2.4. Methodology

The research design used was an exploratory study. A literature review was conducted in order to achieve the objectives. Relevant peer-reviewed literature was considered in order to gain insight on the topic. Grey literature was also reviewed. Other selected literature included published and unpublished qualitative and quantitative studies. The literature reviewed covered topics such as international standards and guidelines

regarding IDP protection and SV prevention, DRC policy and programme responses to SV (including interventions for primary, secondary and tertiary prevention) and effective interventions for SV from DRC as well as other SSA countries with a similar conflict setting to that of Congo in order to learn from other war-torn countries with proven interventions that could be easily translated to the North Kivu context.

2.4.1. Search Strategy

The desired data were derived from various sources. Searches were limited to publications produced within the last 15 years and language was limited to publications in English and French only. Please refer to Table 2, which summarizes the search strategy.

Table 3. Search Strategy

Type of document	Source	Objective 1	Objective 2
		Key words used	Key words used
Published peer reviewed paper	VU Library Google Scholar Google	Sexual, violence, women, North Kivu, society, incidence, Sub Saharan Africa,	healthcare service, prevention, sexual violence, North Kivu, intervention societal, attitudes, beliefs, behaviours
Grey literature	Google, UNHCR, UNIFEM, UNFPA, UNICEF CARE International, ICRC, MSF PRB, and Congolese government-	gender-based sexual violence, internally displaced people, women, North Kivu, DRC, Sub-Saharan Africa, incidence, policy, programme, interventions, responses, , effectiveness, impact, results, evaluation, evidence-based,", community, societal, attitudes,	gender-based sexual violence, gender-based sexual violence, impact, results, evaluation, evidence-based,", community, societal, attitudes, beliefs, behaviours

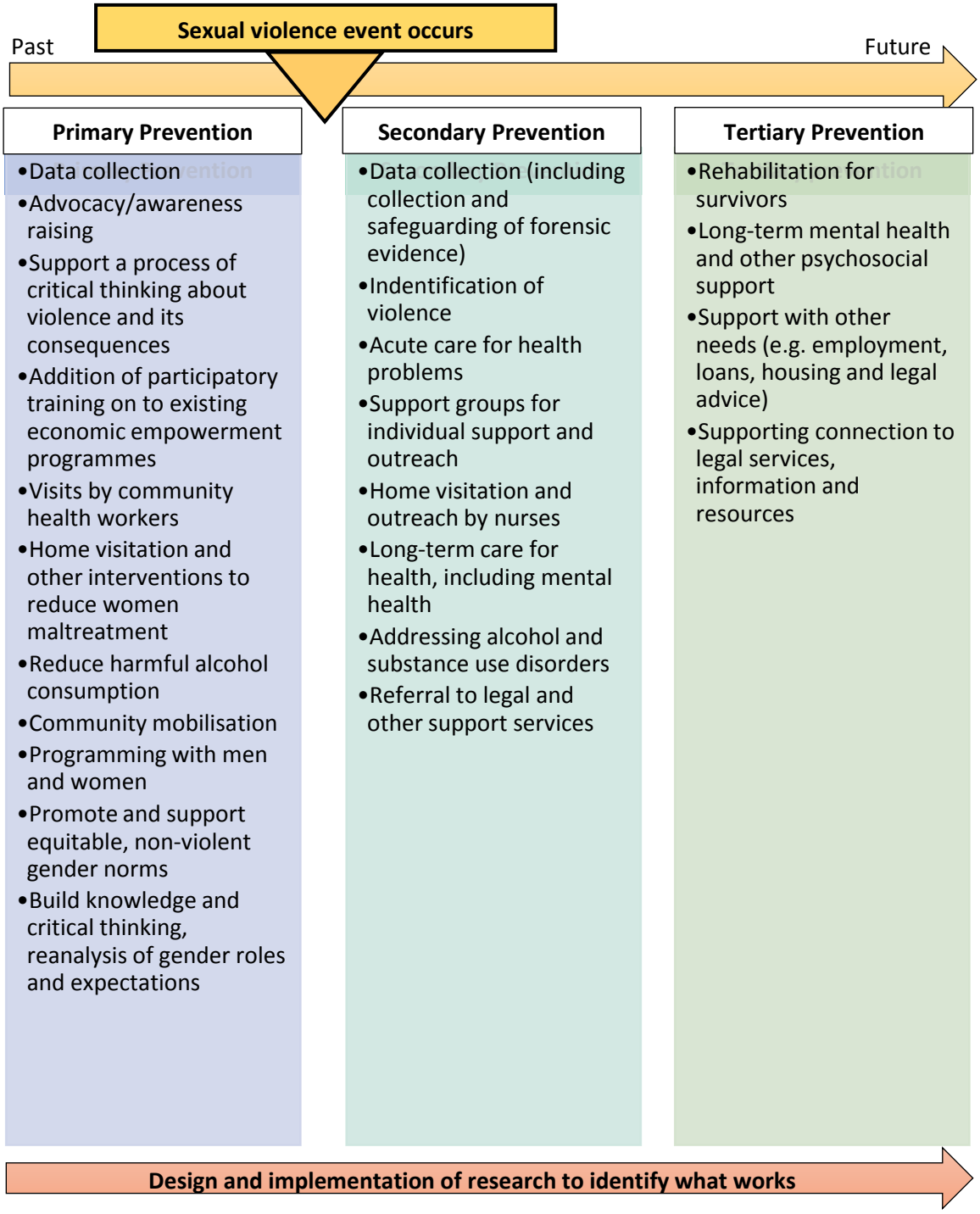
		beliefs, behaviours	
Reports	WHO	gender-based sexual violence, internally displaced people, interventions, responses, , effectiveness, impact	incidence, policy, programme, interventions, responses, , effectiveness, impact, results, evaluation, evidence-based,", community, societal, attitudes, beliefs, behaviours

2.4.2. Conceptual Framework

Assessing policy and programme responses is complex. In order to help guide this analysis, a conceptual framework that combined both the role of the HS as well as the community was used (Figure 2). While the formal definition of a health system includes all actors concerned with people's health (i.e. Ministries of Health, health providers, pharmaceutical companies, health financing bodies, NGOs, the private health sector, as well as patients, families and communities), for the purpose of this analysis, HS will refer to the public and private health sectors and not-for-profit organizations only. Communities will be considered separately in order to differentiate between responses that the government has put in place and interventions that communities themselves have established and implemented.

The adapted framework is a combination of two separate models that serve different purposes. The first model (Appendix 8.1.1) describes what HS can do to provide support for women facing the health effects of SV. This support can contribute to the prevention of SV recurrence and the mitigation of its consequences, in addition to addressing primary prevention interventions (43). The second model (Appendix 8.1.2) describes community programming needed in SV prevention. These interventions engage multiple stakeholders (including female and male community members, youth, political and other leaders, police and teachers) to address the different risk factors underlying SV and challenge unequal gender norms and the social acceptance of SV against women and girls in order to promote new behaviours (2). After careful thought and consideration, it became apparent that combining the two models would be more effective in order to present only one standard and to assess both what is happening in North Kivu (current interventions) as well as what has happened or is happening elsewhere (evidence-based interventions).

Figure 2. Conceptual Framework for the Role of the Health System and Community in Addressing Sexual Violence against Women (2, 43)



This framework was adapted from models developed by Garcia-Moreno et al. in the second of a series of five papers about violence against women (VAW) and girls published in November 2014 in The Lancet (43) and incorporates a focus on community-based responses (both linked to the HS and not), which are important when discussing existing and potential

interventions. Furthermore, community responses can also be seen as a part of a HS along with facility-based or health staff-initiated interventions. This model helped to guide the analysis of existing and potential interventions for SV in North Kivu and discover policy gaps. The model suggests that the main role of health systems for women facing the health effects of violence is to provide supportive care, including medical, nursing, psychosocial and rehabilitative support (43). This supportive care can contribute to prevention of violence recurrence and mitigation of the consequences, address associated problems, such as substance misuse and depression, and provide immediate and ongoing care (43). The HS also has a part to play in primary prevention (i.e. prevention of violence occurring before it starts), through documenting VAW, emphasizing its health burden, and advocating coordinated action with other sectors (43).

The model was also crucial in the examination of effective interventions for SV from other countries with similar conflict situations as well to formulate recommendations. The community interventions were taken from the model developed by Garcia-Moreno and colleagues in the fifth article in the Lancet series. For this reason, the following interventions were added to the model: combined economic and social empowerment programmes, community mobilization, and programming with men and women. These interventions suggest that alongside social and legislative revisions, direct and consistent investment in community programming is needed (2).The most successful interventions use multiple approaches, engage with many stakeholders over time, and seek to address various risk factors underlying violence (2). Components from the original models like "victim advocacy through case management" and "advocacy for survivors in the criminal justice system" were left out because the meaning was unclear.

The Heise integrated, ecological framework (Appendix 8.1.3) was also considered but eventually rejected. While the model was interesting because it combines issues regarding factors and issues regarding primary prevention interventions and also suggested the main mechanisms that sustain VAW at each level of the social ecology and offered examples of how these manifest within the overarching frame of gender inequality and imbalance of gender-power relations, the model's focus was primarily on primary prevention, which did not help to guide analysis on care or support after violence (secondary and tertiary prevention). The model also identified the intended positive outcomes of efforts to prevent VAW across the ecological model, showing strategies to achieve these outcomes at different levels (30) and a number of these strategies were also found in the framework that was ultimately used.

2.4.3. Study Limitations

The relevant contexts considered in this review were limited to other SSA countries that are or have passed through a similar conflict situation. There was also a limitation associated with only doing a secondary data review and not collecting primary data. It was difficult analysing the current state of SV in North Kivu specifically due to unavailability of sufficient data.

3. International Standards and Guidelines, Current Policy, and Programme Responses to SV among IDP women

This chapter presents the international standards and guidelines regarding the protection of IDPs and SV prevention and responses in conflict settings. Current SV policy and programme responses by various actors in DRC (government and other relevant stakeholders) are also presented.

3.1. International Standards and Guidelines

Numerous international standards and guidelines exist to ensure that the fundamental rights of IDPs are upheld. These standards help to safeguard the protection of IDPs. They also list the recommended measures to prevent the occurrence of SV in IDP camp settings (45).

Protection of IDPs

There is currently no international treaty on IDPs (regarding granting them asylum) and governments maintain the primary responsibility of providing protection and assistance to all IDPs within their borders (46). According to the Fourth Geneva Convention of 1949 (GCIV) and the Additional Protocols I and II (API and APII) relating to the protection of civilians during armed conflicts, states are responsible for ensuring the protection of IDPs and for taking measures to prevent the occurrence of displacement. In order to mitigate the effects of displacement and to ensure that the persons who are forced to flee are sheltered, International Humanitarian Law (IHL) contains clear provisions on human rights violations such as SV and on the need for adequate access to health care and other essential services (47).

Providing IDPs with appropriate shelter is another important part of any comprehensive protection strategy. Several factors must be taken into consideration to create a safe and secure environment for IDP women. UNHCR supports governments in securing access to adequate shelter (46). Table 5 below summarizes the protection considerations for different shelter options.

Table 3. Protection Considerations for Adequate IDP Shelter (46)

Minimum standards	• In addition to providing physical protection against the elements, provide sufficient floor space per person. • Avoid shared accommodation as much as possible to mitigate the risk of exploitation and abuse, particularly for single women and unaccompanied and separated children. • Adjust shelters to the specific needs of persons with disabilities or chronically ill, female-headed households or unaccompanied older persons. • To avoid gender-based violence, ensure that dwellings allow separation between the sexes, where culturally required, or between parents and children to provide privacy and safety. Provide material for partitions. Separate facilities like bathrooms and toilets should be constructed for women and men. They should not be isolated or in dark lonely areas where women and children may be sexually assaulted.

Prevention of SV

UNHCR, along with other UN agencies, governments, NGOs, community-based organizations (CBOs), faith-based organizations (FBOs), community representatives, and other experts, has also introduced policies and programmes addressing SV (48). Their original Policy on Refugee Women was issued in 1990. The organization has since produced a series of complementary initiatives to strengthen the response to SV (48).

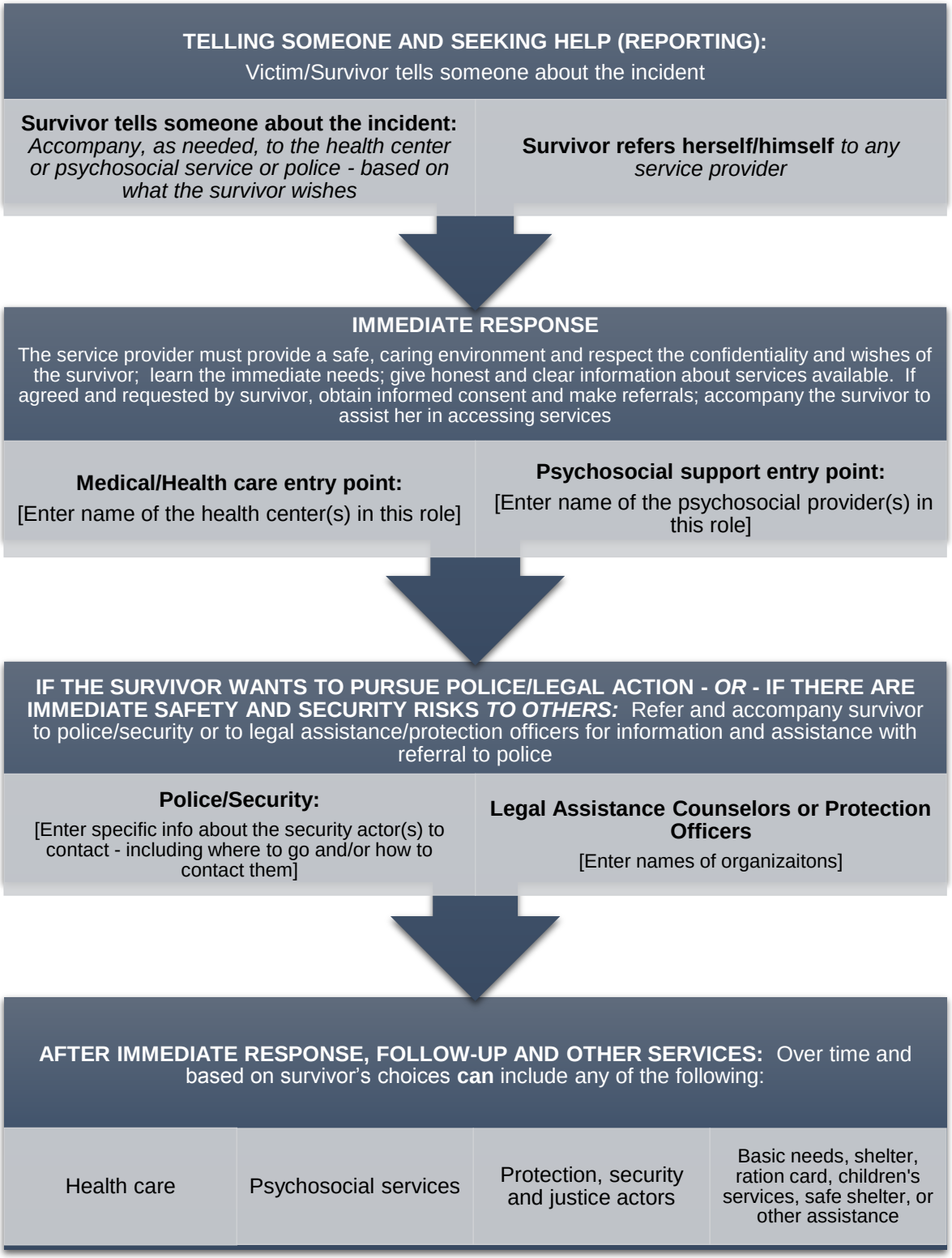
Another key guideline for all actors involved in preventing and responding to SV in emergencies is the Minimum Initial Service Package (MISP) for Reproductive Health. Developed at the Inter-Agency Symposium on Reproductive Health in Emergency Situations in 1995, the MISP sets the international standard for health-sector interventions addressing, among others, SV (12, 49). Appendix 8.2 contains a summary of the recommended key interventions for SV prevention and response in emergencies.

Likewise, in 1997, the United Nations Population Fund (UNFPA) along with the Inter-Agency Working Group (IAWG) on Reproductive Health developed a consolidated set of reproductive health kits for use by humanitarian agencies in an attempt to improve the provision of appropriate reproductive health services in emergency and refugee situations. Kits 3 and 9 are for the prevention and management of the consequences of SV and include a comprehensive package of post-rape care including STI presumptive treatment, emergency contraception, and post-exposure prophylaxis (PEP) for HIV prevention (50).

In 2004, the WHO and UNHCR published the Clinical Management of Rape Guidelines (49). In 2005, the Inter-Agency Standing Committee (IASC)[1] Sub-Working Group on Gender and Humanitarian Action developed the Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on Prevention and Response to Sexual Violence in Emergencies. The guidelines list the minimum actions required for actors responding to an emergency to plan, implement, and coordinate multisectoral interventions for the prevention and response to SV during the onset of an emergency (49). These guidelines are SV-focused, highlight both prevention and response, and strengthen existing good practices (49). They also include a sample help-seeking and referral pathway for SV (Figure 4) in addition to the responsibilities for survivor assistance (51).

[1] Established in June 1992, the Inter-Agency Standing Committee (IASC) is a forum gathering key UN and non-UN humanitarian partners. IASC acts as the primary mechanism for inter-agency coordination of humanitarian assistance (52).

Figure 3. Sample Help-Seeking and Referral Pathway (51)



The medical response for survivors SV must include at least an examination and history taking, treatment of injuries, STI and HIV prevention (along with other diseases), unwanted pregnancy prevention, collection of required forensic evidence, psychosocial and emotional

support, medical documentation, and follow-up care. The psychosocial response and emotion support should include assistance with psychological and spiritual recovery and healing from trauma, support and advocacy to help survivors in accessing needed services. The survivor is also entitled to support and assistance with social reintegration (51).

Legal actors also have the obligation to inform survivors about existing security measures that can protect them from further harm by the alleged perpetrator, as well as discuss the different procedures, timelines, and limitations or inadequacies in the national or traditional justice solutions (i.e. local justice mechanisms that do not meet international legal standards) (51).

In order to promote people's mental health and psychosocial well-being in emergency settings, the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings were published in 2007 (53). Likewise, to address the lack of care for those suffering from mental, neurological, and substance use disorders in LMIC especially, the WHO launched the Mental Health Gap Action Programme (mhGAP) in 2008. In 2010, WHO published the Mental Health GAP Intervention Guide for mental, neurological, and substance use disorders in non-specialized health settings. The guide lists good clinical practices for healthcare providers dealing with people seeking mental health care and includes an assessment tool and subsequent guide for the management of moderate to severe depression that all actors providing mental health support are expected to follow (Appendix 8.3) (54).

Data also plays a huge role in the prevention and response to SV (55). Developing a standardized system to record, analyse and disseminate data on SV has been a huge challenge for many LMIC. As a result, many countries do not have adequate procedures for documenting and analysing data on SV (45). In 2010, UNFPA published the Guidelines on Data Issues in Humanitarian Crisis Situations. These guidelines stress the importance of data collection and analysis during all phases of a crisis (i.e. preparedness phase, acute phase, chronic phase, and post-crisis phase) for effective programme response (56).

3.2. Current Policy

Three United Nations Security Council (UNSC) resolutions concerning the DRC have been adopted since 2000. The first (Resolution 1325) addresses the protection of women and their involvement in peace efforts during and after conflicts. The second (Resolution 1820), states that effective measures are required to prevent and punish acts of SV in order to help maintain peace and security in the DRC. The third (Resolution 1888) declares that women and children should be protected from SV during conflicts (57,58).

There are a number of existing gender norms and expectations between men and women in Congo that have placed women in a lower social status than that of their male counterparts. Consequently, these gender roles have subjected Congolese women to sexual vulnerability (59). In an attempt to correct these gender differences and promote equality, the Congolese government has adopted several policies to address SV in the country as a whole, as well as taking into account the specific needs of women affected by conflict.

The Congolese Constitution, passed in 2005, emphasizes in Articles 12, 13, and 14 equal rights, equal opportunities, and equality between Congolese women and men, as well as the obligation to eliminate all forms of VAW in both their public and private lives (60). In addition, two national laws were passed by Parliament in July 2006 to strengthen the crackdown on rape. Laws 06/018 and 06/019 are amendments to the Congolese Penal and Criminal Procedure Codes that strengthen the capacities of judicial institutions with regards to SV (29).

These laws are survivor-centred and focus on ensuring that survivors have improved access to justice and services (i.e. medical, psychological, and legal) that are adapted to their needs (29). In November 2009, the Ministry of Gender, Family, and Children (MoGFC) presented the National Strategy to Combat Sexual and Gender-Based Violence (SNVBG) to fight against SV and GBV in general. This strategy was developed and implemented for the effective and efficient coordination of the prevention, protection, and response to SV for not only the survivors, but the management of information and data as well (61).

The overall objective of the strategy is to contribute to the prevention and reduction of SV as well as improve the holistic care of survivors in addition to the rehabilitation of perpetrators after prosecution. The aim was to create and operationalize a common framework for action and a platform for concerted actions for all stakeholders in the fight against VAW and young girls in the DRC. The strategy also has nine specific objectives (26):

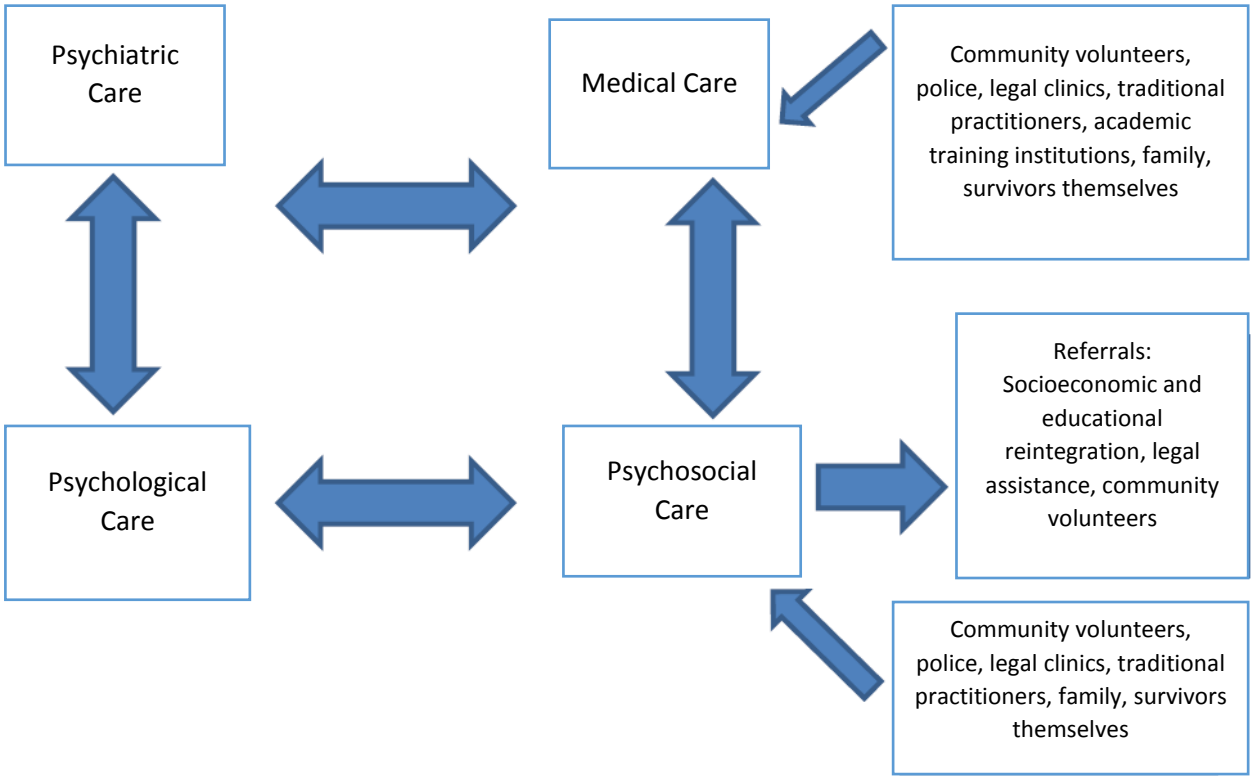
1. To ensure prevention of SV.
2. To improve understanding and knowledge of the problematics of SV and gender.
3. To ensure multisectoral care and support of survivors.
4. To ensure protection, security, and a fight against impunity.
5. To rehabilitate the perpetrators of SV and reintegrating them into their families and communities of origin.
6. To improve coordination of interventions against SV at national, provincial, and local levels.

7. To support the efforts of development partners, government, and civil society in the fight against VAW in the DRC.
8. To streamline multiple coordination mechanisms for interventions and actions in this area.
9. To strengthen the collection system, analysis, dissemination, and use of data.

In 2012, the MoPH published the National Protocol for the Management of Psychosocial and Mental Health for Survivors of Sexual Violence. The protocol aims to contribute to the reduction of mental health problems and other psychosocial consequences related to SV, as well as to provide mental health and psychosocial support to survivors according to the Mental Health GAP Intervention Guide. The protocol also details recommendations on how to ensure that survivors of SV receive appropriate psychosocial and mental health support (i.e. list of duties and responsibilities of service providers and guidelines on appropriate attitudes and behaviour for service providers) (24).

In addition, the protocol includes the pathway for the management of psychosocial and mental health (Figure 6), which illustrates the multiple entry points that survivors may use to access the health system to receive psychosocial, psychological and psychiatric health care. The diagram shows that survivors of SV can reach healthcare facilities through community volunteers, police, legal clinics, academic training institutions, traditional practitioners, family or by themselves (24). Psychiatric care tends to focus on the diagnosis of various mental disorders and there subsequent treatment with drugs or other types of medical interventions, while psychological care uses the same diagnostic system but usually treats patients with some sort of psychotherapy (intergrating mh WHO, psychiatric care WHO).

Figure 4. Management of Psychosocial and Mental Health for Survivors of Sexual Violence Pathway (24)



Source: National Protocol for the Management of Psychosocial and Mental Health 2012

The government has also carried out other actions such as launching the National Fund for the Empowerment and Protection of Women and Children (FONAFEN), which mobilises resources to fund women-initiated projects and the National Agency to Stop Violence against Women (AVIFEM), which compiles complaints from women on the violence that they face, including SV (29, 62).

Apart from sources such as the UNSC and the Agency for Cooperation and Research in Development (ACORD), information on these current policies was found in publications by the Government of DRC. These government publications could be biased and, as a result, data could also be distorted or missing (intentionally or unintentionally). More independent researcher should be commissioned to find out if the policies that the government claims to have adopted are actually in place. In addition, independent monitoring and evaluation teams should be put in place to evaluate policy implementation. It is also possible that independent researchers may want to or may have already attempted to conduct policy research in Congo but the government might not have granted them access to do so.

3.3. Programme Responses

History has shown that SV can be a powerful weapon of war. The magnitude of the situation in DRC echoes this notion. Today, living with the constant threat of SV has become second nature for thousands of women in North Kivu. Nevertheless, strategies and interventions have been put in place by the Congolese government as well as several local and international partners to reinforce the prevention, protection and response to SV through primary, secondary and tertiary prevention.

Currently, survivors of SV receive services in four main areas of intervention including medical care, psychosocial support, judicial and legal assistance, and socioeconomic and educational rehabilitation (36). Due to the shortage of sufficient information on programme responses to SV among IDP women in North Kivu specifically, data from South Kivu, that is facing a similar conflict situation and has comparable programme responses, was also considered.

North Kivu has an area of about 59,483 km^2 and consists of three cities: Goma (the capital city), Butembo and Beni. North Kivu is also comprised of six smaller territories and in 2010 the total population was roughly 5,767,945 (26). In 2013, the total IDP population was estimated at around 967,050 in 2013 (19). However, the exact number of female IDPs is unknown at this time.

3.3.1. Government Responses

In alignment with the SNVBG, the MoGFC and the MoPH, with the financial and technical support of UNFPA and other UN agencies, coordinates several activities to address SV in North Kivu (26). Through interventions that encompass elements of primary, secondary, as well as tertiary prevention, the Congolese government has managed to strengthen its response to SV in the East (including South Kivu). However, concrete data on the actual effects of these interventions (i.e. accessibility, quality, coverage and results) was not always available for each group of activities.

Furthermore, the SNVBG does not yet cover the whole of DRC. Some activities are carried out at the national level, others in only four or five provinces, and others (the majority) in the three eastern provinces of North Kivu, South Kivu and Orientale. The focus on the East reflects the gravity of the conflict situation prevailing in that area since the 90s and the consequent exacerbation of SV incidents (62).

Primary Prevention

During the last 6 years, the government has implemented several SV-related programmes in North and South Kivu. Some programme activities, such as awareness sessions, focus on primary prevention. These sessions are conducted with the involvement and participation of different actors (i.e. local authorities, opinion leaders, service providers, male authority figures in the family, and youth) and stress the harms of SV and the urgent need for its eradication (13). In North Kivu, the topics discussed during awareness sessions revolve specifically around SV prevention techniques, SV and the causes and consequences of SV, people living with HIV, the Universal Declaration of Human Rights (UDHR), and information on the legal consequences of committing SV. The government also implements other activities such as advocacy for gender equality, sensitization campaigns on SV including men and boys, and training on SV prevention methods through several programs (35).

From 2009 to 2011, government outreach activities that took place throughout all the territories in North Kivu reached an estimated 200,000 community members (62). In that same timeframe, the government also established youth centres which organized cultural and sporting activities, as well as youth awareness sessions on gender equality and the prevention of SV (13). These sessions have reached over 5,000 young Congolese men and women in the East (62).

Moreover, school activities including short plays in French, Swahili, and other local dialects or role playing scenarios addressing the prevention of SV were held for 5,634 students (13, 62). Awareness material for youths on SV prevention was also developed and distributed to schools (420 posters, 22 banners and 100 comic strips). To encourage the participation of men in the fight against SV, the government also organizes good parenting workshops for fathers or male authority figures in the family. In 2013, 952 men participated in these workshops that covered themes like gender equality and SV prevention (62).

To strengthen the capacity of community structures and local stakeholders involved in the prevention and fight against SV, 25 vigilance committees have been set up and 300 community leaders have been trained in North Kivu since 2011 (62). As for interventions dealing with information systems, the MoGFC has developed an integrated system for collecting and managing data on SV. This system has been operational in North Kivu since 2011 and more than 320 healthcare providers have been trained on how to use the new collection tools. Nevertheless, more trainings are necessary and there is no formal monitoring and evaluation system enforced as of yet. Moreover, material resources remain insufficient (13, 62).

Gradual support of the SNVBG can be observed through the population's strong participation in interactive programmes on SV such as awareness sessions, sensitization campaigns and trainings. This growing public interest suggests hope for the sustainability of the programmes. However, information on the results (accessibility, coverage, etc.) of these programmes was unavailable.

Secondary Prevention

In 2013, there were approximately 6,898 reported cases of SV in North Kivu (in a population of about 967,000 IDPs). 83.6% of those survivors received medical care (13). The government provides both curative and preventive medical care to survivors of SV in North Kivu. In 2012, 53% of reported SV survivors in North Kivu received care in healthcare facilities within 72 hours after being raped. These cases were registered once the survivor reached a support service. As a result of these cases being reported relatively early, the survivors were able to receive emergency contraception to prevent pregnancy, and PEP kits to prevent the transmission of HIV/AIDS. However, in the same year, 16% of cases did not receive a PEP kit in time (with 72 hours of the rape) due to stockouts and 31% of cases were too late to qualify for PEP (26).

Moreover, 66.7% of all reported cases of SV in North Kivu in 2013 also received psychosocial support (13). In North Kivu, psychosocial support consists of peer support sessions coupled with one-on-on counselling and other appropriate methods to mitigate or terminate trauma such as active listening, participation in support groups, and family and social mediation (26). According to a report by the MoGFC released in 2014, the following activities were being carried out in North Kivu to support the psychosocial care of SV survivors: the establishment of counselling centres within rural communities, and the establishment of mobile clinics using ambulances for faster medical treatment of SV (13). However, no concrete data is available on the implementation and coverage of these activities.

In 2013, 15.2% of all reported SV survivors in North Kivu received legal assistance from the government (13). Between 2009 and 2011, 61 survivors in South Kivu were able to take their cases to court, which resulted in 35 convictions. Data from North Kivu was not available. To strengthen the fight against impunity, the government constructed and rehabilitated a total of 20 buildings in North and South Kivu to be used as courthouses, police stations, and prisons. In South Kivu, software was also provided to these institutions and 40 clerks were trained in computer science and the use of other legal software. Again, information on North Kivu was lacking.

Tertiary Prevention

In North Kivu, the proportion of survivors who received socioeconomic support and educational reintegration from the government increased from 2.0% in 2011 to 21.8% in 2012 (35). However, by 2013, only 0.5% of reported SV survivors in North Kivu received government support with socioeconomic reintegration (13). The type of assistance (e.g. village savings and loan association or VSLA) was also not explicitly stated and there is no clear information regarding the drastic decrease. However, due to upsurges in rebel activity, services may have closed down. Furthermore, mobilization of financial resources has been a serious problem for the government. As a result, certain policies (like providing economic and legal support to survivors of SV) have not been able to be put into practice due to the lack of sufficient funding.

3.3.2. Partner Responses

Both local and international NGOs, CBOs, and FBOs are present in North Kivu, supporting the countries efforts in the fight against SV. These organizations provide services that also include primary, secondary and tertiary prevention. In order to keep in line with the framework, the allocation of actors to a specific level of prevention was made based on the organization's primary activities in the area. However, some organizations may appear under multiple headings if they are active in more than one level of prevention.

Primary Prevention

Synergy of Women for the Victims of Sexual Violence (SFVS) is a CBO located in Goma. Founded in 2002, the organization has helped to restructure local efforts in the fight against SV in North Kivu. SFVS interventions are mainly in the domain of judicial reform and lobbying (63). The organization is engaged in advocacy for the promotion and respect of human rights at the local, national, and international level, and lobbies for all actors to address the root causes of VAW. Their primary objective is to ensure that systems and laws protecting women's rights are not only implemented but enforced. SFVS was instrumental to the passing of the 2006 bill which states that SV is one of the highest punishable crimes (64).

In the same year, SFVS organized 27 community sensitization sessions on the fight against SV using a mobile cinema tool. This activity reached 1,469 community members spread over 18 sites in North Kivu (64).

Secondary Prevention

SFVS helped more than 2,200 survivors in North Kivu with legal assistance in 2009. In 2012, SFVS helped bring 38 cases to court, 7 of which led to convictions (64). SFVS also provides psychosocial support and organizes reference systems and counsellor trainings throughout North Kivu to provide consistent and quality psychosocial care for survivors. In 2012, SFVS organized 410 group therapy sessions for survivors of SV spread over the entire 6 territories of the North Kivu province. SFVS also promotes family mediation and community accompaniment for survivors. In 2012, SFVS organized 1,429 family mediation sessions with survivors and their families. The organization also provides medical assistance, treating over 800 survivors of SV in 2012 (including 581 new cases and 277 old cases) (64).

In 2003, HEAL Africa launched its Heal My People programme in Eastern Congo, a strategic response to GBV in the region. HEAL Africa is a local Christian organization that provides free health and psychosocial services to survivors of GBV in North and South Kivu (65). HEAL Africa has a hospital in Goma that offers testing for diseases (including STIs and HIV/AIDS), counselling services for psychosocial support, and medical and surgical care such as obstetric fistula repair. Today, the organization partners with over 60 local health centres in order to reach those in need of emergency medical support services within the first 48 hours (well before the 72 hours cut-off point for PEP). Since its start 12 years ago, the programme has worked with over 30,000 women service clients (65, 66). HEAL Africa is also concerned with fighting against women's isolation, empowering them economically, and teaching them and their communities the importance of holistic community development (66).

Tertiary Prevention

The Heal My People programme also aims to heal women beyond essential medical care and support their reintegration and acceptance back into their communities through education, training in village sensitization with traditional or tribal chiefs, religious and political leaders, and the local community, in addition to family mediation. To help survivors regain their confidence and independence, HEAL Africa provides savings and loans programmes that give loans of $50 to $200 to women's groups who then divide the money among its members based on individual proposals submitted. The loans are given for a period of 6 months with a small interest rate. The loan repayment rate was 98% for the first 6 months of the programme. Furthermore, the organization has legal offices in the area that assist survivors with legal issues. In 2010, HEAL Africa contributed to the rise in prosecution of perpetrators from 12 prosecutions to 140 (65, 66).

Women for Women International (WfWI) is an American non-profit organization that provides financial, educational, and interpersonal

support to women survivors of war, poverty, and injustice (67). The organization has been active in North and South Kivu since 2004 and has impacted over 80,000 Congolese women. Through a 12-month programme, WfWI equips survivors of SV with knowledge on how to earn and save money, develop health and well-being, influence decisions in the home and community, and create and connect to networks for support and advocacy. In 2014, roughly 20,000 women received vocational skills and training in agribusiness, basket-making, beauty care, bread-making, restaurant and catering, soap-making, and tailoring. Participants are placed in groups of 25 women and learn together by attending bi-weekly meetings that include lessons on health awareness, decision-making, negotiation, as well as civic participation. The women also receive a small monthly training stipend. Trainings are facilitated by local trainers and are carefully tailored to the local context (68).

A report from 2014 shows that from the time of enrolment to about 2 years after completing the programme, WfWI's initiative has yielded 4 main outcomes: the number of women earning more than $1 a day has risen from 8% to 86% (with an average earning increasing from roughly $0.53 to $1.87), the number of women practicing family planning has risen from 6% to 58%, the number of women involved in household financial decisions has risen from 87% to 100%, and the number of women educating other women on their rights has risen from 3% to 85% (68).

4. Effective Interventions for Sexual Violence in Emergency Settings and Other Relevant Contexts

In this chapter, effective interventions for SV in emergency settings from DRC, including, but not limited to, North Kivu will be presented. In addition, this chapter will also present evidence-based interventions from other SSA countries with relevant contexts. For the purpose of showing the effectiveness of a programme, each intervention was examined holistically and not separately across different components like in previous chapters. Therefore, even if the intervention spreads over more than one level of prevention, the chapter is not structured according to primary, secondary and tertiary prevention.

4.1. Interventions from DRC

4.1.1. Psychotherapy for Congolese Survivors of Sexual Violence (69)

In an area were over 80% of women have been raped (DRC review Beijing20), finding effective mental health interventions is vital for the recovery of SV survivors in North Kivu.

Description and Aim of the Programme

In 2013, the New England journal of Medicine published a randomized controlled trial by J. Bass et al. on psychotherapy for survivors of SV in conflict-prone Eastern Congo. The study aimed to prove that group psychotherapy reduces post-traumatic stress disorder (PTSD), depression and anxiety symptoms, in addition to improving the day-to-day functioning of SV survivors.

Evaluation Methods

The theory was tested by using group therapy rather than individual support therapy administered by lay counsellors. A total of 405 women from 15 villages in Eastern Congo (14 villages in South Kivu and 2 villages in North Kivu) were enrolled in the study. Nearly all of the women (aged between 13.4 and 36.9 years in the therapy group and between 12.4 and 33.8 years in the individual support group) had been raped.
Psychological assessments of PTSD symptoms, depression and anxiety symptoms, as well as their level of functional impairment were performed at baseline, at the end of treatment, and six months after treatment ended. These assessments showed that most of the women suffered from PTSD along with depression or anxiety. Several of the women were also functionally impaired and unable to perform their daily activities. Researchers assigned 248 women in eight of the villages to get individual support counselling, which is a standard crisis response. The other 157 women in the remaining seven villages were divided into groups of six to eight and received 12 sessions of cognitive processing therapy.

Results of the Programme

The study found that women with PTSD from witnessing or physically experiencing SV are more likely to recover through group therapy than through private counselling.

Using cognitive processing therapy (1 individual session and 11 group sessions), the SV survivors suffering from the highest levels of PTSD symptoms combined with depression and anxiety symptoms were taught how to reassess how they thought about the event. Survivors of SV often blame themselves, thinking that it was their fault or that they could have done something to prevent it. Cognitive processing therapy teaches survivors mental techniques to identify this maladaptive line of thinking in order to address it and move on.

Four months later, data from the cognitive processing therapy group showed that the proportion of women with probable PTSD decreased from 60% to 8%. Moreover, the proportion of women with depression or anxiety associated with PTSD dropped from 71% to 10% and their

functional impairment was also reduced by 50%. Data from the women who received individual support counselling had rates of probable PTSD, depression, or anxiety fall from 83% to roughly 54%.

Comments

The results of this study show that with appropriate training and supervision, cognitive processing therapy can be implemented as an effective mental health intervention for survivors of SV in low-income and war-torn settings. Furthermore, this type of intervention can still produce results in settings with few mental health professionals or facilities.

This 12-session psychotherapeutic treatment has been used before to treat PTSD in rape victims, battered women and war veterans elsewhere. Testing the cognitive processing therapy in Congo was a real achievement as many of the women were illiterate and the therapeutic strategy would normally involve giving clients a notebook that they would use to identify and jot down problem thoughts and coping techniques. This approach can be adapted to other conflict-affected areas in DRC where literacy may also be low, as that is no longer a barrier to achieving positive results. This therapy could be a promising community-based service for survivors of SV in North Kivu.

4.1.2. Combating Violence against Women in South Kivu through Policy Review (70)

The main focus of humanitarian and development programmes for survivors of SV are usually activities dealing with health and social protection but survivors may have other needs and interests that require policies to adopt a more aggressive gender perspective.

Description and Aim of the Programme

In this 2009 study by Giulia D'Odorico and Nathalie Holvoet a critical analysis of policy on the fight against VAW in Bukavu, South Kivu was done. This study looked at interventions for VAW in South Kivu and aimed to describe and assess aid delivery to survivors of SV.

Evaluation Methods

Aid practices as well as the policy framework in Congo were critically analysed through a gender perspective. Field research from Bukavu, where various types of interviews with different groups of interviewees were conducted, was combined with policy analysis. The country's Humanitarian Action Plan (HAP), which details interventions aimed at saving lives and protecting rights as well as addressing the causes of vulnerability to disasters, fragility and conflict (UNICEF), the Poverty

Reduction and Growth Strategy Paper (PRGSP), which presents a logical strategy to help poor countries attain faster sustainable growth and a significant reduction in poverty (OCHA), and the Country Assistance Framework (CAF), which is a common strategic approach for economic aid that several donors have developed (OCHA), were all examined.

Semi-structured interviews were conducted with 32 women, all survivors of SV. The interviews were used to obtain information on the types of aid that they had had access to, the types of aid that they considered a priority, the impact that they expected the aid would have on them individually and as a community of women survivors of SV. Research also included interviews with 12 leaders and officers of women's groups and organizations supporting SV survivors in order to discuss the degree to which a gender perspective had been integrated into the planning of their programme responses.

Results of the Programme

Evidence from field research suggested that the efforts of local associations in South Kivu are limited and sometimes disconnected. For example, activities such as micro-loan projects or non-repayable grants to survivors are not sustainable and do not address the complex nature of the VAW problem. In addition, it appears that organizations have different views on the factors and consequences of VAW and do not always tackle the root causes, which results in responses that foster unsustainable aid practices and do not cater to the full needs of survivors.

Insufficient financial resources along with few and often inadequate technical resources such as information systems or other tools make it unlikely for survivors of SV to be receive full and effective support and for organizations to implement effective policies for the fight against VAW. Many survivors (exact number not mentioned) had not received any type of support, especially in rural areas where local health centres lack medicine and trained personnel. Moreover, psychological support for survivors consisted of counselling and trauma relief that was not very professional due to improper or insufficient training of the staff. In general, the support women received was mainly short-term.

The study proposed the adoption of a gendered approach to VAW programme design and implementation. So far, the problem of SV has not been addressed in terms of gender but is rather defined as a health and human rights violation issue. This has resulted in the clusters which will address SV being somewhat limited to Health, Protection and Food Security. Had the plan to fight against SV taken a gender approach, SV would have been a problem mainstreamed into all the various clusters. An equity approach looks at top-down interventions, and focuses more on legislative and political measures as the most effective way to achieve

equity. However, a bottom-up approach is needed to effectively fight against VAW.

Comments

Actions and policies including a gender dimension will make it possible for Congo to work towards change geared towards building a more equitable society. The lack of a gender perspective in humanitarian and development policies and interventions could also explain why programme responses have been insufficient. Primary prevention interventions are needed to address sexist attitudes, beliefs, and values among Congolese men and women alike. Responses to SV need to be coordinated, multifaceted, and implemented at many different levels of the health system. Humanitarian and development plans need take into consideration the practical and strategic interests of SV survivors.

This study shows the effectiveness of countries adopting interventions with a gender perspective. This approach could bring the country closer to reaching a deeper understanding of not only a survivors practical gender needs, but also of the nature and causes of SV. As a result, survivors of SV can have more of their strategic gender needs met (as many interventions on the ground are mainly one dimensional). Policy review is necessary to help devise more appropriate and complete responses in North Kivu.

4.2. Interventions from Other Relevant Contexts in SSA

4.2.1. Prevention through Empowerment of Adolescent Girls (71)

Many prevention programmes in LMIC include participatory group trainings. These trainings are usually comprised of a series of educational meetings or workshops with a target population (Lancet VAW series #1).

Description and Aim of the Programme

The 2014 study by Sarnquist et al. addressed an intervention for rape prevention in the African context. Roughly 11.3% to 46% of Kenyan women report experiencing childhood sexual assault (these numbers vary greatly by the source). The programme aimed to empower young girls living in informal settlements in Nairobi using a self-defence training intervention. Due to their high rates of crime, settlements were the ideal location for this kind of programme.

Evaluation Method

This quasi-experimental study was carried out in four neighbourhoods in Nairobi and targeted adolescent girls aged 13-20 years, with about 80% being 15 to 18. All the adolescents selected were living in extreme poverty (generally coming from houses made from materials found in the trash and lacking either fresh water or a sewer). Furthermore, all the girls were also all enrolled in secondary schools that were uniformly low-performing. A total of 1978 girls were taught empowerment, de-escalation, and self-defence during six 2-hour sessions for 6 weeks. Self-reported and anonymous survey data was collected at baseline and then again at 10.5 months after the intervention.

Upon enrollment in the study, the sexual assault prevalence was 22.9% in the intervention group and 19.5% in the comparison group. The rates reported in the study were considerably higher than those reported for the Nairobi region by the Kenyan police (which reported an annual incidence of 5.5% in 2011), or the African Population and Health Research Center (which reported an incidence of 12.1%), or the Kenya Demographic and Health Survey (which reported an incidence of 14.5%).

Results of the Programme

A little over 10 months after the end of the intervention, the rate of sexual assault among the intervention group decreased by 60%. In the comparison group, no difference was experienced. Likewise, the number of disclosures of sexual assault in the intervention group also increased considerably but not in the comparison group. The number of rapes disclosed increased from 56.1% to 75.0% in the intervention group and from 52.5% to 52.6% in the comparison group. These increased disclosures also lead to the identification and prosecution of perpetrators (although, more data on this was not available).

Comments

This intervention proved to be highly effective at decreasing the incidence of sexual assault and harassment in Nairobi. The programme helped to prevent sexual assault by addressing the underlying cause (i.e. socially-ascribed male and female gender roles and behaviour expectations). The programme also helped young Kenyans to develop new communication and conflict resolution skills through a process of critical reflection, discussion, and role play. In addition, this intervention helped increase disclosure of assaults and enabled survivors to seek care and support.

Although this intervention is not from a conflict or IDP setting, the context of the informal settlements is quite violent and could still be relevant to DRC's situation. This intervention shows that group-based training is

another effective approach to fight against SV and to empower women and girls. The success of this programme warrants it adaption to the DRC context and its replication in North Kivu.

4.2.2. Stepping Stones : A Participatory Learning Programme (72)

There has been increasing recognition that both men and women should be engaged in efforts to prevent VAW and girls. As a result, more programmes are using synchronized approaches that intentionally reach out to both men and women in a coordinated way (33).

Description and Aim of the Programme

Stepping Stones is a programme that was originally developed for Uganda in 1995. Since then, it has been widely adapted and used in over 40 countries. The 50-hour programme uses a participatory leaning approach that involves both men and women to build knowledge, risk awareness, communication skills and stimulate critical reflection about gender, violence and HIV. In 2002, the programme was run in the rural Eastern Cape province of South Africa, making it the third randomized controlled trial (RCT) in Africa.

Evaluation Method

This study was a cluster RCT of 70 villages (clusters) in Eastern Cape. The villages were randomised and received either the Stepping Stones programme or a 3-hour intervention on HIV and safer sex. Questionnaires were administered at baseline, 12 months, and 2 months. Blood tests for HIV and herpes simplex virus 2 (HSV-2) were also taken. Generalized linear mixed models were used to analyse and compare the differences between the two groups.

In total, 1360 men and 1416 women aged 15-26 years participated in the study. 97% of the participants attended school. The participatory learning approaches used included role-playing exercises and critical reflection. Men and women were in separate group and the activities ran in parallel. At the end of the program, a community meeting was held where parts of the programme were presented from each peer group to the broader community.

Results of the Programme

2 years after the intervention, men's self-reported perpetration of physical and sexual IPV was considerably lower than those from men in control villages. The programme also achieved a significant drop in infections of HSV-2 in both men and women. However, no differences were observed

between the intervention and control villages regarding women's reports of victimization from IPV (at 12 months or 24 months).

There was no evidence that the programme decreased HIV incidence. However, it did decrease a number of risk behaviours in men. A decrease in alcohol abuse and depression was observed in men after 12 months. In addition, men reported lower acts of IPV after two years. These data were collected through men's self-reporting. Evidence failed to show any desirable behaviour change in women.

Comments

This programme shows the effectiveness of group training interventions for women and men. The study showed that when ideas about male superiority and masculinity are changed, men's behaviour also changes. The intervention also proved effective in reducing and possibly preventing violent behaviour as there was a reduction of IPV associated with this behaviour change.

Although Eastern Cape does not have the same conflict setting as North Kivu, the area is also very poor. In 2004, it had the highest unemployment rate in South Africa (49%). This intervention shows that group-based training (with separate groups for men and women) is an effective approach to fight against SV and to empower women and girls. Given Stepping Stones proven ability to transform gender norms, it should be implemented in North Kivu to insight more respect for women and less SV.

5. Discussion

This chapter will include a discussion on the major findings from the literature review in relation to the objectives.

5.1. Current Policy on Sexual Violence in DRC

The Congolese government recognizes that SV is a problem of enormous magnitude within its borders and has made great strides in reforming its policies on SV to conform to international standards and guidelines. The bill enacted in 2006 which made SV one of the highest punishable crimes in the country, is an example of such efforts by the government to scale-up the fight against SV. Furthermore, all national strategies and action plans to combat SV include the recommended minimum response packages for both the medical and psychosocial care of SV survivors. One of the components of the SNVBG that stood out from most guidelines was the incorporation of rehabilitation services for perpetrators, to reintegrate them into their families and communities. This rehabilitation could play a huge role in preventing repetition of the same SV crimes.

Though there are no major policy gaps between what the international community expects of a nation's actions towards the prevention and response to SV and what the Congolese government has committed to, the country still has a long way to go in terms of the actual implementation on the ground. These particular gaps will be discussed in the next session addressing programme responses. The financial contribution of the Government also remains insufficient to put policies into practice in terms of services available to SV survivors. Furthermore, the mobilization of resources for the effective implementation of planned activities is a major challenge in SV prevention and response in North Kivu.

5.2. Programme Responses to Sexual Violence in North Kivu

5.2.1. Primary Prevention

The government has implemented a number of primary prevention activities including awareness sessions revolving around important themes such as gender equality, SV prevention, and the legal consequences for perpetrators. Local and international NGOs, CBOs, and FBOs on the ground also support the government through village sensitization and other outreach activities of their own. These combined efforts have helped to increase knowledge and understanding of the complexity of SV in the community. However, knowledge and understanding along is not enough to help prevent SV and more activities that focus on the need to prevent SV are essential in terms of primary prevention.

Due to the insecure environment in North Kivu that poses an enormous threat to humanitarian access and the provision of services, it is often difficult for the government to enforce the protection and respect of women IDPs' rights. Also, many IDP camps in the area do not always meet the minimum standards for protecting women and girls. Makeshift shelters are easily accessible to perpetrators and the communal shelters that house both single men and women together are also conducive factors for SV. Moreover, women sometimes have very long distances to walk in order to collect firewood, which only increases their vulnerability to SV. This means that the access to basic needs like water, firewood, and washrooms ought to be improved. Roads/pathways to these areas need to be better lit. There is also a need for the construction of more solid shelters that would make break-ins less easy and allow women to lock their doors.

Furthermore, the lack of proper monitoring and evaluation systems makes effective coordination challenging at all levels (national, provincial, and local). It is difficult to identify and manage a problem that has only a

fraction of the data necessary for proper understanding of its magnitude, response, planning, and monitoring. Although an integrated system for collecting and managing data on SV in North Kivu has been established, the complementary capacity-building and training of human resources as well as the provision of the material resources required to yield better results lags far behind. It is highly likely that the prevalence data available on SV in North Kivu is a gross underestimation.

5.2.2. Secondary Prevention

The government currently provides curative and preventive medical care to survivors of SV in North Kivu. Although the proportion of survivors receiving care within the first 72 hours after being raped is still low (53% of reported cases in 2012), over 80% and 60% of the reported SV survivors in 2013 received medical and psychosocial care respectively. Although 80% seems good, 'seeking care' is the main entry point for registering as a survivor (as facilities are not actively looking for them). This means that only the survivors that actively seek care are registered and receive care and those who do not seek care are not registered and do not receive care.

The government is also said to be carrying out other secondary prevention activities in North Kivu. However, no data is available on the actual implementation of these activities and services. The activities would include the building of counselling centres within rural communities to facilitate the psychosocial care of SV survivors and the establishment of ambulances as mobile clinics for faster medical treatment. Due to lack of data, the status of these intended services and activities is unclear.

Support from the humanitarian community through other initiatives helps to complement services or even fill the gaps in service provision. For example, HEAL Africa's hospital in Goma that offers HIV and STI testing, counselling services, and surgical care like fistula repair. HEAL Africa, along with several other partners, supports the government and local health centres to help reach survivors of SV as quickly as possible. Though these programmes have a huge impact and rescue rates are high. Organisations are carrying out their work in a very insecure and sometimes unfriendly environment. The challenges they encounter can range from mere harassment from members from the communities they are trying to help to more serious risks such as the threat of death and kidnapping from armed militia groups operating in these areas.

To reinforce its stand against impunity, the Congolese government has built and rehabilitated buildings in North and South Kivu to serve as courthouses, police stations, and prisons. In South Kivu, clerks were even trained in computer science and provided with legal software. Government performance in these areas is extremely unsatisfactory,

especially when considering that the government committed itself to providing legal and economic assistance to survivors of SV by law. Legal support for survivors, among others to bring perpetrators to court, is essential to secondary prevention and forensic medical evidence is also needed.

5.2.3. Tertiary Prevention

There are several international actors involved in SV tertiary prevention in Congo. WfWI, for example, provides financial and educational support to women survivors of SV. The vocational skills and training that WfWI provides have allowed women in North Kivu to earn a living and contribute to household financial decisions. Similarly, HEAL Africa among other NGOS present in the region also organizes family mediation sessions to help survivors reintegrate into their families and communities and return to their daily activities. Even though these programmes have had a tremendous impact in improving the overall quality of life of SV survivors in North Kivu, their main role should be to complement, not replace, the government's responsibility. The obligation to protect, care for, and support women IDPs should rest primarily on national authorities, who now rely heavily on the international humanitarian community for funding and programme implementation.

5.3. Effective Interventions for Sexual Violence in DRC and other Relevant Contexts in SSA

A total of four evidence-based studies were selected. Two of the studies were conducted in the DRC and two others took place in other SSA with relevant contexts. The programme responses are described in more detail in Chapter 4 of this thesis.

5.3.1. Interventions from DRC

Psychotherapy for Congolese Survivors of Sexual Violence

This case study was selected because it involved women survivors of SV in North and South Kivu. These two provinces have nearly identical geographic, demographic, socioeconomic, and political features, so the results of the study were highly applicable to the North Kivu context. The study also dealt with the mental health and psychosocial well-being of survivors of SV in emergency settings, which is an often neglected aspect of health, especially in LMIC.

The study found that women suffering from PTSD are more likely to recover through group therapy than through one-on-one counselling, which is a standard response in North Kivu and elsewhere. Results could be seen as early as four months after the intervention as rates of

depression or anxiety fell from 71% to 10% and functional impairment decreased by 50%. Although support groups for SV survivors are already in place in North Kivu, the cognitive processing therapy that this study tested has not yet been added to national mental health protocols. The intervention was piloted in only 2 villages in North Kivu but its overwhelming success gives reason for its adoption in all the territories of North Kivu, where well over 50% of women are survivors of SV.

Combating VAW in South Kivu through Policy Review

This study was selected because it critically analysed the various policies and practices for VAW being implemented in South Kivu. As previously mentioned, the similarities between North and South Kivu allow results from this study to easily be translated to address the situation in North Kivu as well. The study also described and assessed the aid provided to survivors of SV specifically.

Interviews conducted with a number of survivors revealed that the type of aid that they received after the incident was not always a priority for them. The study showed that primary prevention interventions were needed to address understanding and knowledge gaps by community members about the problematics of SV and gender. However, this needs to go one step further. While understanding the problem is an important first step, understanding the need to address and prevent SV should rather be one of the main goals of primary prevention. In addition, the study showed that a review of policy through a gender perspective is important in order to ensure that women's real needs and concerns are taken into consideration in SV programme design and implementation. This will help with acceptance and sustainability. This study is applicable to the North Kivu context where similar interventions are in place, but do not always tackle the root causes of SV. Men and women alike need to be made aware of women's rights and the protection afforded to them by the law and SV survivors need to know exactly what they are entitled to in order to demand it.

5.3.2. Interventions from Other Relevant Contexts in SSA

Prevention through Empowerment of Adolescent Girls

This study was selected because it involved an intervention for the prevention of rape among young girls living in informal settlements. Even though Kenya does not have the same history of conflict and instability, it remains a LMIC and the area in which the study was conducted (informal settlement with high rates of crime and SV), there were still lessons learned that could be applied to the North Kivu context.

This study showed that group-based training is an effective programme response to fighting SV. By teaching young women and girls conflict resolution skills through a process of critical reflection, discussion, and

role play they felt empowered. The participants also received a number of self-defence lessons. Furthermore, the number of disclosures of sexual assault increased substantially. In North Kivu, SV goes mostly unreported because of women's fear of stigma and marginalization. By empowering the women to speak up and denounce rape, the true magnitude of the problem can be known and addressed accordingly. Moreover, teaching women and girls self-defence can also be a practical prevention strategy that the DRC can also adopt.

Stepping Stones: A Participatory Learning Programme

The study was selected because it dealt with group training interventions that involved both women and men. Though men and women were divided into separate groups, the trainings were run in simultaneously. Which proved to be an effective way giving men and women access to the same information at the same, rather than have awareness campaigns targeted for men at one time and then others targeted for women at another.

The study showed that when ideas about male authority and masculinity are changed, men's behaviour also changes accordingly. By tackling one of the root causes of SV, a consequent reduction in its occurrence is possible. Transforming gender norms is essential to SV prevention. The more women gain respect, the less SV occurs.

5.4. Effective Interventions and Policy Gaps

Current policies, responses and related gaps were discussed above and examples of effective interventions where given.

One of the key identified gaps included awareness and other outreach activities that helped to improve the understanding and knowledge of SV but not the need to address and prevent SV. A proven primary prevention intervention to respond to this gap is a policy review to ensure that survivor's needs and priorities are fully considered when formulating SV policies. One key gap was the multisectoral care and support of survivors which for the most part now, consists of medical and psychosocial care as access to legal services and financial support is insufficient. One of the evidence-based secondary interventions identified cognitive processing therapy the most effective therapy for women suffering from PTSD.
Another policy gap dealt with the weak data collection system. Since only those survivors who seek care are registered at healthcare facilities, women need to be encouraged to come forward more. An intervention that addresses this is group training for women to empower them and increase the number of disclosures of SV. Although there is a policy on the rehabilitation and reintegration of perpetrators, no programmes have been implemented that deal with this. An intervention that could be used

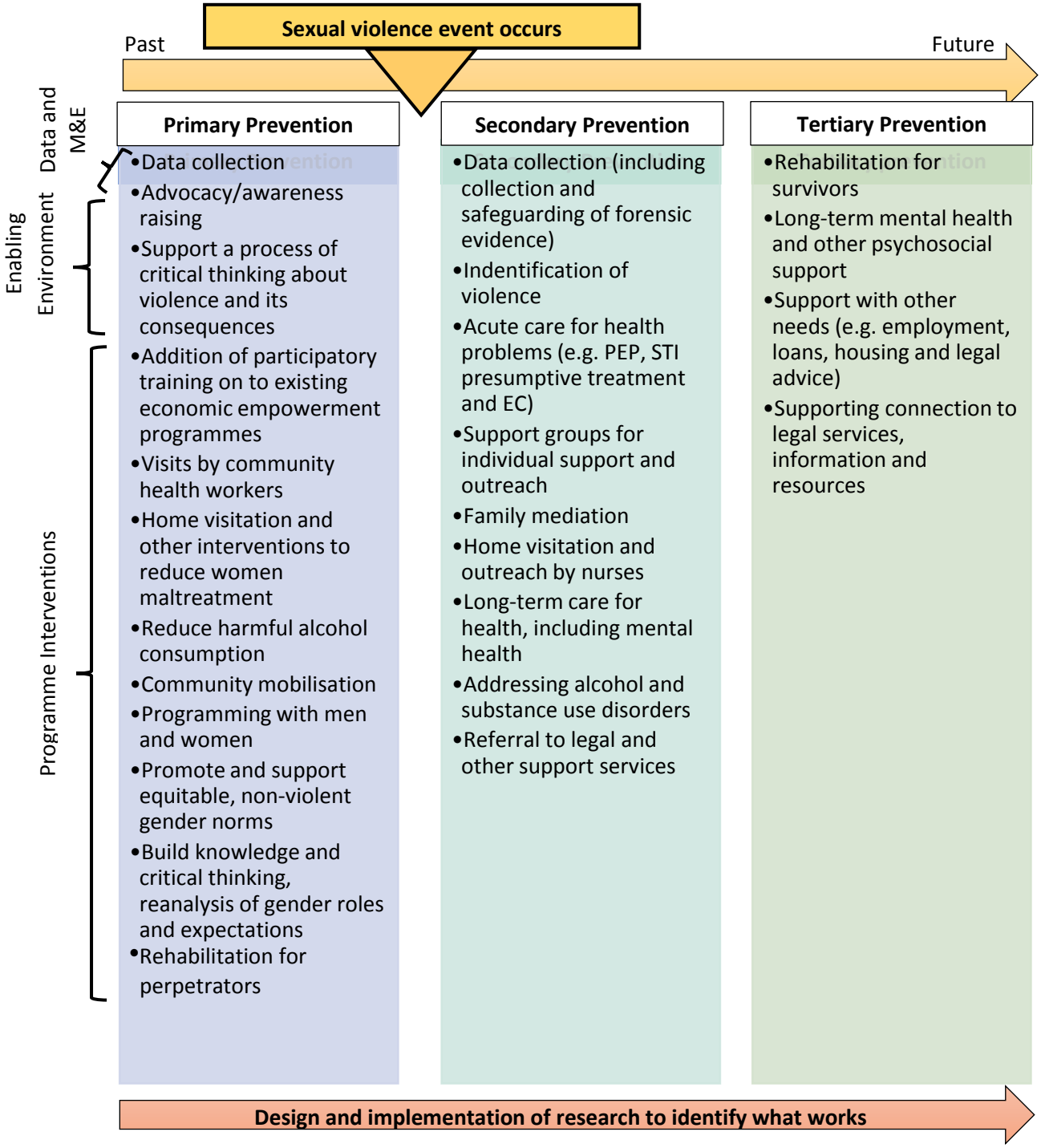
to help with this rehabilitation is group training with women and men to help transform gender norms and ideas about male authority and masculinity and reduce the recurrence of the SV crime.

5.5. Relevance of Conceptual Framework

The conceptual framework utilised helped with the analysis of the literature review. There were, however, short in missing elements that were discovered during the review of SV policy and programme responses in DRC. One of the objectives of the SNVBG is to rehabilitate the perpetrators of SV and reintegrating them into their families and communities of origin. Another element which was found in the SFVS and HEAL Africa programme is family mediation to help survivors reintegrate into their families. There were also some other parts of the framework that could be elaborated on. For example, HIV prophylaxis, STI presumptive treatment, and emergency care could be added under 'Acute care for health problems.' Furthermore, several of the columns have many bullet points which could be reorganized under subheadings.

As a contribution towards the discourse of SV, a new framework is proposed to incorporate this interesting feature of programmes for the rehabilitation of perpetrators as a primary prevention activity as well as family mediation under secondary prevention. Also, the difference activities in each column are grouped into subheadings.

Figure 5. Revised Conceptual Framework for the Role of the Health System and Community in Addressing Sexual Violence against Women (2, 43)



6. Conclusions and Recommendations

This chapter contains conclusions and recommendations made based on the findings from the literature review and the discussion.

6.1. Conclusions

By 2013, 80% of women living in North Kivu had been raped. There currently a number of programmes in place to support the fight against SV. These programme responses are carried out by the government, as well as local and international partners but coordination between these different stakeholders is difficult. There are also several insufficiencies with the SV information system on the ground. This has resulted in a large number of SV cases going unreported not to mention the cultural stigma and local perception towards victim. Today, no one really knows the true magnitude of the problem in North Kivu.

This review has highlighted several evidence-based interventions to learn from, and the following recommendations are provided to help improve the health status and exercise of rights of IDP women in North Kivu.

6.2. Recommendations

6.2.1. Policy Recommendations

The government of DRC should leverage to provide adequate means to the implementation of the policies in place. This includes:

1. Prioritization of SV prevention programs as a major public health problem in the country
2. Integration of cognitive processing therapy in National Protocol for the Management of Psychosocial and Mental Health
3. Dedicating adequate ressources (Human and financial) for programme implementation, especially in the North Kivu region of the country.
4. Ensure that efficient coordination mecanisms are in place for implementing actors at different levels to avoid dispersion/duplication and waste of limited resources

6.2.2. Programme Response Recommendations (for the government)

1. Prioritization and restructuring of programmes or activities related to prevention to include BCC and self-defence lessons, and workshops specifically on women's rights laws

2. Strengthen all data collection structures through capacity-building for staff and the provision of other resources (financial, infrastructure, equipment, means of communication)
3. Full legal support for survivors of SV and related forensic evidence plus protection of survivors who register a case
4. Awareness and outreach activities addressing the need to tackle and prevent SV as a national priority and an impediment to soci-economic development of the country and particularly of the North Kivu region.

6.2.3. Research Recommendations (for Research Institutions)

1. Conduct a situation analysis to determine the current prevalence and incidence rates of SV to help with planning of prevention programmes
2. Impact analysis of the current response mechanisms need to also be conducted in order to determine best practices for scaling up of efficient interventions

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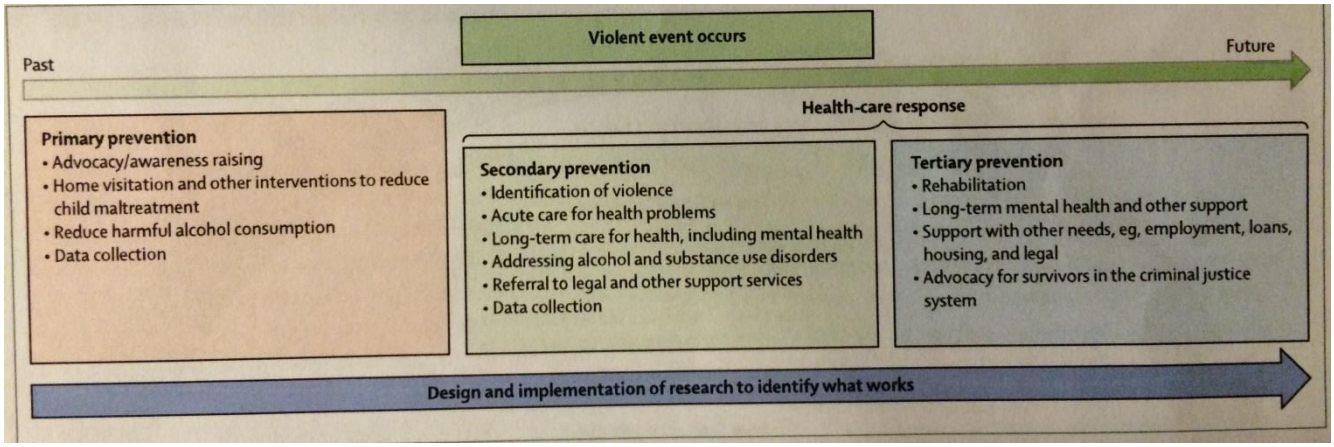
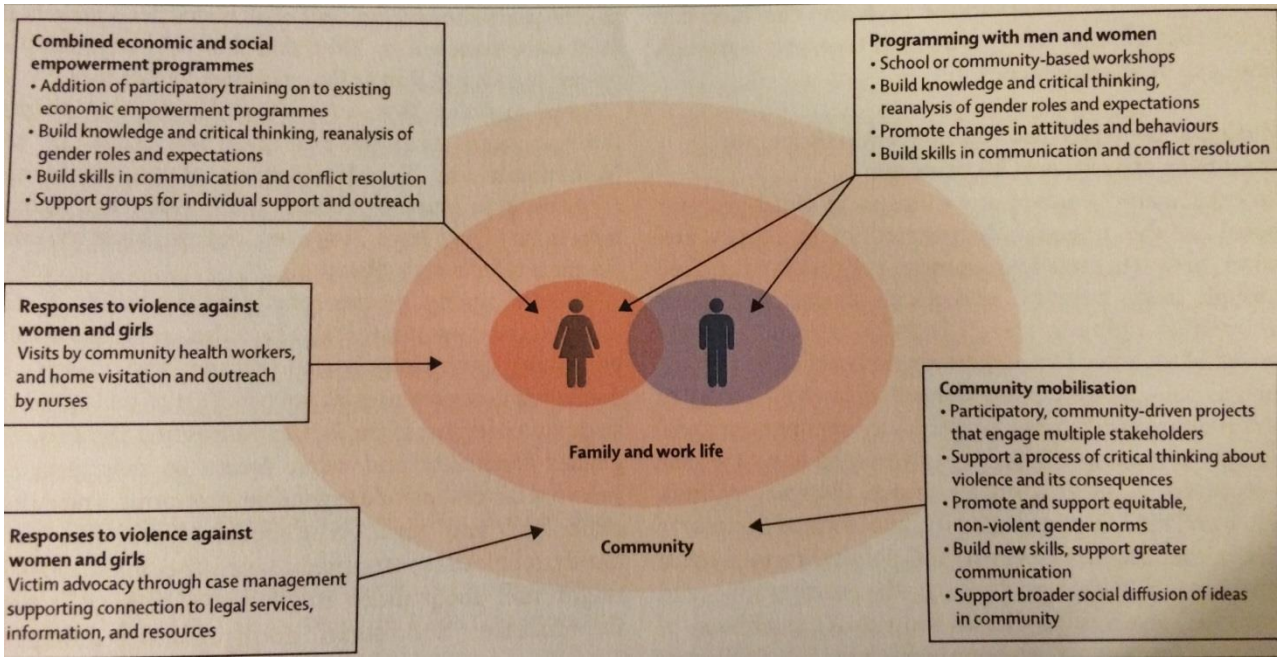
8. Appendices

8.1. Conceptual Frameworks

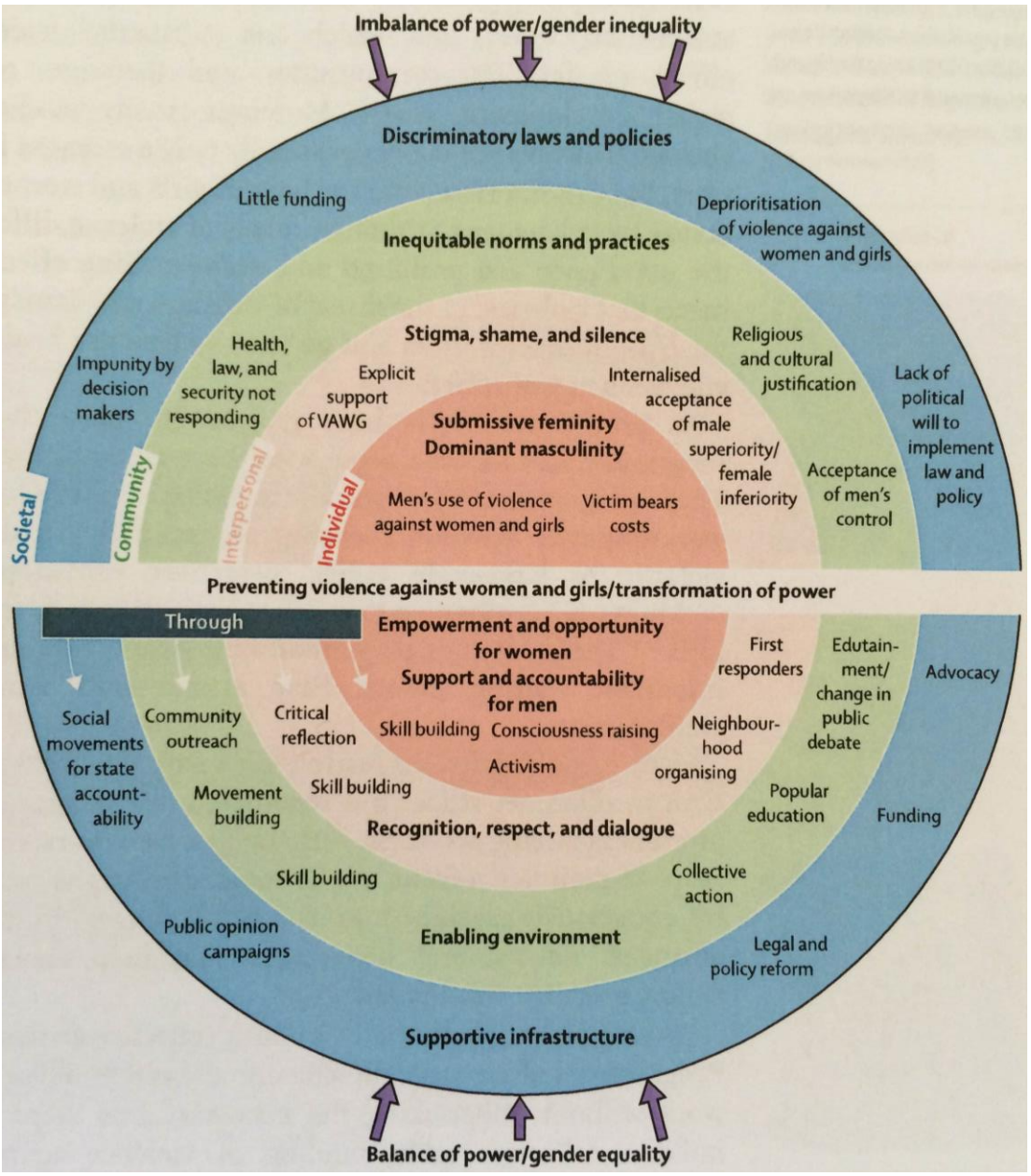
8.1.1. The Role of the Health System to address Violence against Women (43)



8.1.2. Promising Interventions to address Violence against Women and Girls (2)



8.1.3. Conceptual Framework for the Transformation of Power across the Ecological Model (30)



8.2. Strategic Interventions for the Prevention and Response to Sexual Violence in Humanitarian Emergencies

Recommended Key Interventions for Preventing and Responding to Sexual Violence in Emergencies (gbv_emergencies)

Minimum Prevention and Response (to be conducted even in the midst of emergency)	Comprehensive Prevention & Response (Stabilised phase)
1.1 Establish coordination mechanisms and orient partners 1.2 Advocate and raise funds 1.3 Ensure Sphere standards are disseminated and adhered to	• Continue fundraising • Transfer coordination to local counterpart • Integrate comprehensive GBV activities into national programmes • Strengthen networks • Enhance information sharing • Build (human) capacity • Include governments and non-state entities in coordination mechanisms • Engage community in GBV prevention and response
2.1 Conduct coordinated rapid situation analysis 2.2 Monitor and evaluate activities	• Maintain a comprehensive confidential database • Conduct a comprehensive situation analysis • Monitor and evaluate GBV programs, gender-balanced hiring, application of Code of Conduct • Review data on prevention measures, incidence, policies and instruments, judicial response, social support structures • Assess and use data to improve activities
3.1 Assess security and define protection strategy 3.2 Provide security in accordance with needs 3.3 Advocate for implementation of and compliance with international instruments	• Expand prevention of and response to GBV • Provide technical assistance to judicial and criminal justice systems for reforms and effective implementation of laws in accordance with international standards • Strengthen national capacity to monitor, and seek redress for, violations of human rights/international humanitarian law • Encourage ratification of international instruments, and advocate for full compliance and effective implementation • Promote human rights, IHL and good practices • Ensure that GBV is addressed by accountability mechanisms • Ensure that programmes for demobilisation, reintegration and rehabilitation include women and children affiliated with warring factions • Ensure that programmes for reintegration and rehabilitation include survivors/victims of GBV and children born of rape • Provide training to relevant sectors including security forces, judges and lawyers, health practitioners, and service providers

Minimum Prevention and Response (to be conducted even in the midst of emergency)	**Comprehensive Prevention and Response** (Stabilised phase)
4.1 Recruit staff in a manner that will discourage SEA 4.2 Disseminate and inform all partners on codes of conduct 4.3 Implement confidential complaints mechanisms 4.4 Implement SEA focal group network	• Monitor effectiveness of complaint mechanisms and institute changes where necessary • Institutionalise training on SEA for all staff, including peacekeepers
5.1 Implement safe water/sanitation programmes	• Conduct ongoing assessments to determine gender-based issues related to the provision of water and sanitation • Ensure representation of women in WATSAN committees
6.1 Implement safe food security and nutrition programmes	• Monitor nutrition levels to determine any gender-based issues related to food security and nutrition
7.1 Implement safe site planning and shelter programmes 7.2 Ensure that survivors/victims of sexual violence have safe shelter 7.3 Implement safe fuel collection strategies 7.4 Provide sanitary materials to women and girls	• Conduct ongoing monitoring to determine any gender-based issues related to shelter and site location and design
7.1 Implement safe site planning and shelter programmes 7.2 Ensure that survivors/victims of sexual violence have safe shelter 7.3 Implement safe fuel collection strategies 7.4 Provide sanitary materials to women and girls	• Conduct ongoing monitoring to determine any gender-based issues related to shelter and site location and design
8.1 Ensure women's access to basic health services 8.2 Provide sexual violence-related health services 8.3 Provide community-based psychological and social support for survivors/victims	• Expand medical and psychological care for survivors/victims • Establish or improve protocols for medico-legal evidence collection • Integrate GBV medical management into existing health system structures, national policies, programmes, and curricula • Conduct ongoing training and supportive supervision of health staff • Conduct regular assessments on quality of care • Support community-based initiatives to support survivors/victims and their children • Actively involve men in efforts to prevent GBV • Target income generation programmes to girls and women
9.1 Ensure girls' and boys' access to safe education	• Include GBV in life skills training for teachers, girls, and boys in all educational settings • Establish prevention and response mechanisms to SEA in educational settings
10.1 Inform community about sexual violence and the availability of services 10.2 Disseminate information on International Humanitarian Law to arms bearers	• Provide IEC through different channels • Support women's groups and men's participation to strengthen outreach programmes • Implement behaviour change communication programmes

8.3. Assessment Tool and Management Guide for Depression

Assessment and Management Guide for Depression Source: mhGAP 2010