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Ordeals of Sexually Violated Women and Access to Comprehensive Healthcare: A Case Study Of Victims Of Sexual Violence in North Kivu, Eastern Congo

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ABSTRACT

Background : The impact of sexual violence in any community is extremely devastating and women in the Eastern part of the Congo are no exception. Sexual violence not only affects the health of women, but it impacts their social life within the community too.

Objective : The study aims to investigate the experiences of female victims of sexual violence in accessing medical care in North Kivu.

Design : An interpretive, phenomenological approach was used for this inductive and qualitative study. In-depth informant interviews were the main data collection tool. Open-ended questions were used during the interviews in order to garner more information from the interviewees. Heidegger's approach was utilized in analyzing the collected data.

Results : The analyzed and interpreted results of the data indicated that survivors of sexual violence are engaged in an ongoing struggle. The victims demonstrated immense resilience despite the lack of comprehensive medical care and have continued to reassemble their broken lives. In order to present the outcomes of the research in a succinct and coherent manner, the outcomes are categorized into five sub-themes: managing worries and shame; regaining happiness; healing and restoration; the need for professional assistance and struggles in daily life.

Conclusion : The study provides an understanding of the recovery processes of survivors of sexual violence in North Kivu, with important insights into dimensions that rehabilitation programs should take into consideration.

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Introduction

The war in the Democratic Republic of Congo (DRC) has been called a 'war against women' due to the high mortality rate among them and their atrocious treatment by all fighting groups[1]. The war is not just named a 'war against women' but has been declared a crime against humanity[2]. According to Kangi, while approximately 12,254 sexual gender based violence (SGBV) incidents were reported in 2014, the number increased in 2015, where 15,308 incidents were reported[3].

Evidence shows that North Kivu province reported more SGBV incidents than any other province[4]. This war has been compared to World War II and the Holocaust[5]. The violence, as in WWII, involved multiple foreign armies and invaders from Rwanda, Zimbabwe, Angola, South Africa, Namibia, Chad, Libya, and Sudan, among others, and has been devastating. Other scholars have named it the forgotten holocaust[6], mainly due to the large number of deaths. The number of deaths since 1996 is estimated at 5.4 million[7], although some estimates reach 10,000,000[8].

According to the Rape, Abuse, and Incest National Network (RAINN) Journal, each year, worldwide, there are, on average, 293,066 girls and women aged 12 and above, who are victims of rape and sexual assault[9]. The World Health Organization's guidelines require that victims of sexual assault should be provided with comprehensive, gender-sensitive health services in order to cope with the physical and mental health consequences of these horrific experiences and to aid their recovery from extreme stress and trauma. Since SGBV has a significant negative impact on the health of the population, particularly women and girls, medical and psychosocial forms of support are greatly needed to help women, who have been assaulted, to deal with violation, grief, anger, depression, betrayal, fear, hopelessness etc. In conflicts around the world, the rape of women and girls has always been one of the most horrific weapons of choice systematically used to attack women, devastate families and societies.

The unstable political climate in a number of African countries has continued to create spaces for violent conflicts to occur, in which rape is often used as a "weapon of war"[10].

It is a common occurrence in most conflict situations in the DRC that women were sexually abused as their spouses and other family members were forced to watch. Such situations were double tragedies for the women due to humiliation and helplessness. The situation of the abused women is further complicated when their spouses abandon them because of the sexual abuses[11]. It compels one to ask, why is sexual assault used as a weapon against women and families, especially husbands? It is common knowledge that no married man anywhere wants to see his spouse sexually violated. There is no doubt that if the situation (where a woman has been sexually assaulted) is not properly managed, it will lead to devastating outcomes. One of the possible outcomes is the discontinuation of any intimate romantic relations between the husband and his assaulted partner.

The research revealed that SGBV remains a major obstacle to social and economic reconstruction in the DRC. Widespread SGBV has continued with impunity even after the wars partially ended. The impacts of SGBV still persist, manifesting in unwanted pregnancies, sexually transmitted infections and stigmatization[12]. Violence against women impacts on the physical, sexual, and mental health of victims. Gender-based violence is widely considered to be more common and less reported in the context of complex humanitarian emergencies[13].

A study conducted by Kaboru, Andersson, Borneskog, Adolfsson & Namegabe[14], on knowledge of and attitudes towards sexual violence in DRC, found that health workers who were providing care to the victims (women) reported huge shortfalls in human resource capacities. There is a limited number of medical, nursing and psychosocial support personnel. As a result of this significant lack of such professionals, less is known about the plight of victims of SGBV than should be the case. This undoubtedly impedes efforts to respond to their needs.

Objective

The study aims to investigate the experiences of victims (women) of sexual violence in accessing medical

care in North Kivu

Specific objectives

The following are the specific objectives which inform the presentation of the research results presented in the subsequent section, in the following sequence:

Description of the impacts of SGBV on victims' social, physiological and psychological health

Description of the difficulties encountered by victims of SGBV in accessing health care

Description of the findings of interpretive phenomenology amongst the women research participants.

Methods

Design

The study employed an interpretive phenomenological approach as advocated by Heidegger (1962), in order to understand the perceptions and experiences of victims of sexual violence. Arguably, the premise for this kind of research is grounded on the notion that life experiences are inherently interpretive processes[15].

Study Population and Sampling Procedure

The study was carried out in Goma city, North Kivu Province, Eastern DRC. Two referral hospitals were selected as study areas: HEAL AFRICA and the General Hospital of 8e *Communauté Evangélique de Pentecôte en Afrrique Centrale* (CEPAC) KYESHERO. These two hospitals were chosen because of their high numbers of records of assaulted women. A total of 15 women, aged between 21 and 45 years, were selected to participate in the study, based on the following criteria: they were 18 years and older; had experienced sexual violence in the last six months; were able to speak a local language; had an understanding of the purpose of the research; and expressed willingness to participate in the study.

To select the specific number of informants, the researcher considered the type of violence that the victims had experienced. Social workers assisted in the selection process in line with global standards. The consent of the informants was sought and granted; the sample was made up of 15 women, the majority of whom were uneducated. The demographic information of the informants is described in Table 1 below:

Data Collection Process

Key informant in-depth interviews were used as a data collection tool. An interview guide was developed. All the questions were open-ended to allow the participants to speak broadly on their experiences as victims of SGBV. The questions were pre-tested on four victims of SGBV; this was done at a health center. The results were taken into account because this enabled the researcher to modify the interview questions, one of which was rephrased.

The first author (BKE) was assisted by two female social workers from the two hospitals because of Swahili language communication limitations between the interviewer and the respondents. The social worker attended a short training program on how to collect data in the field. The training helped the social workers to familiarize themselves with the interview guide. The last training session concerned the assessment of the interview situation by two persons: one as an interviewer and the other as a respondent (Kvale). The translation of the interview guide into the local language was completed at the end of the training. The entire training stage was aimed at reducing investigator related bias to a minimum.

The data collection procedure took place between March and April 2015. Each interview started with the question, "Could you tell me your experiences of life after being raped?"

Interviews were conducted in a private setting at the local hospital and lasted between 45 and 60 minutes. All interviews were conducted in Swahili with the assistance of the female social workers, as earlier indicated. The interviews were recorded, transcribed verbatim into Swahili by the research assistants, and then translated into English by a secretary and the first author (BKE).

Ethical Considerations

Ethical clearance was sought for and obtained from the research and publications committee of Université Libre des Pays des Grands Lacs (ULPGL) in Congo in line with the Helsinki declaration (Helsinki, 2013, Article 23)[16]. Ethical approval for this research was

Table 1. Characteristics of the 15 informants.

Number	Age	Education	Marital status	Children	Occupation	Place	Hospital
1	23	None	Married	4	Farmer	Village	1
2	21	High School	Single	None	Student	City	2
3	29	None	Widow	4	Trader	City	2
4	28	None	Married	2	Farmer	Village	2
5	22	Primary School	Single	None	None	Village	2
6	25	None	Married	None	Farmer	Village	1
7	30	None	Married	4	None	Village	2
8	24	Primary School	Single	None	Trader	Village	1
9	26	Secondary School	Married	3	Trader	City	1
10	26	None	Married	4	Farmer	Village	1
11	38	None	Married	4	Farmer	Village	1
12	33	None	Married	2	Farmer	Village	1
13	36	None	Married	4	Farmer	Village	1
14	35	None	Married	6	Farmer	Village	1
15	45	None	Married	None	Farmer	Village	1

needed for the following reasons: to protect the rights and welfare of participants and minimize the risk of physical and mental discomfort, harm and/or danger from research procedures. To protect the rights of the researcher to carry out any legitimate investigation as well as the reputation of the University as regards the research conducted, and to minimize the likelihood of claims of negligence against the individual researcher, the University and any collaborating persons or organizations. Informed consent was sought and obtained from participants prior to the research. Specifically, informants were made aware of the aim and purpose of the study. As mentioned earlier, their participation was voluntary and it was clarified that the information obtained was for research purposes and would be managed in a strictly confidential manner. The informants were also apprised of the fact that they reserved the right not to respond to all questions and that they could withdraw from the process at any point without negative consequences. Letters of permission were obtained from each institution for use by the social workers, and were interpreted during the interviews. Permission to use the audio-recorder was also sought from both participants and hospitals before use.

Data Analysis

Data analysis was performed in line with Heidegger's (1962) approach. The informants' experiences were treated in an unprejudiced manner as well as with a reflective and, not least, a self-reflective attitude[17,18,19]. The interviews were transcribed in their original language and then translated into English with the help of a translator and carefully checked by the author (BKE) in order not to lose important details about the experiences of the informants. The narratives that arose from the interviews constituted the data and are referred to as text[20]. Data analysis first involved reading the transcriptions several times for adequate comprehension. Secondly, it involved selection of words or phrases that best described the informant's lived experience after the incidents of sexual violence (SV). These words and phrases were linked to the meaning units where they were condensed and allocated different codes. The prominent codes were: *concern, uncertainty, powerlessness, worries, disappointment, sadness, irritation, insecurity, poverty, patients' insufficient information about their situation, relief, happiness, energetic, hope and optimism.*

The codes were grouped into categories. By examining the categories in the words of the women, the researcher identified themes of the overall experiences. These themes were discussed within the research group. The lived experiences of the women after being sexually violated were intensively reviewed and discussed through a constant, circular process of reflecting, reading, writing and re-writing as described by Kvale. According to Speziale and Carpenter, apprehending or capturing the essential relationships among the statements and preparing an exhaustive description of the phenomenon constitutes the essence of this process[21]. In this study, the themes were brought together to develop a comprehensive description of the essence of the central theme of the research, "Women's struggles after sexual violence".

Results

The findings are presented in three thematic areas of the specific objectives: social, physiological and psychological health; difficulties encountered by victims of SGBV in accessing health care and their legal rights; and interpretive phenomenology among women participants in the research.

Social, Physiological and Psychological Health Impact of SGBV on Victims

Physio-Health Level

The study reveals that the majority of women interviewed still encounter gynecological problems following their sexual assault: some of the women incurred vaginal or rectal injury after the incidents of rape. Others have contracted various sexually transmitted infections, including HIV, but have no access to treatment or antiretroviral therapy. Some of them resort to certain crude ways of managing the infections; their bodies have been objectified by their assaulters and/or abusers and they have experienced physical injuries and mutilations.

Psychological Level

The research reveals that most of the women suffered mental and psychological trauma as a result of their ordeal. Some suffered the loss of husbands,

children and close relatives. Some were even forced to have sexual intercourse with their own sons. Such horrendous experiences had immense consequences for their mental stability and alertness. Some of the victims have become schizophrenic as a result of the mental torture inflicted. They rapidly become hysterical and are easily rendered emotional by the slightest provocation. The victims constantly blame themselves for their woes, and have lost the self-confidence to go out to the fields for cultivation of plants and other activities. Many have developed low self-esteem as a result and they live in perpetual fear of the unknown; others contemplate suicide. The victims concurred that psychological (behavioral) disorders were caused by the abhorrent acts of gang rape, with some of them even being raped in public and their traumatic experiences fundamentally form the basis of the behavioral problems.

Social Level

At the social level, the respondents say they suffer rejection, are despised, marginalized and abandoned to their fate. Some of them have born children arising from the rape and these mothers could not even associate with the other children because of shame. Because of the mockery they receive from some members of the community, they often transfer their anger or aggression to these innocent children. Some of these children are accepted in some certain communities while in others they face abuse, humiliation and mockery. All the respondents agreed that their neighbors know they were raped. For the majority of them, the rape was public. The women were abandoned or rejected by relatives including, in most cases, their spouses. The victims were and are still being stigmatized and discriminated against by members of the community. In most cases they are labeled as HIV infected while others think that the women are bearers of misfortunes, deserved to be thrown out of the community and are regarded as aliens.

Difficulties Encountered by Victims of SGBV in Accessing Health Care and their Legal Rights

At this level, it becomes more complicated because the respondents said they do not know the perpetrators, making litigation and prosecution impossible. Furthermore, the judicial system and justice administration are not transparent nor accountable. In situations where perpetrators are known, cases drag in the courts; in some cases, the perpetrators are acquitted while others are leniently sentenced. In normal circumstances, it is expected that the government will set up legal clinics where victims can lay their complaints and receive legal aid, but these clinics are not well organized, making access to private legal intervention extremely costly for the victims, who are very poor. Some of the informants expressed fear of retaliation should they take the matter to court, while others said that they do not have the time to appear in court regularly as unnecessary adjournments characterize the courts. They would rather resign themselves to their fate, and nurse their wounds and pain with minimal support from some family members.

Interpretive Phenomenology Applied to Women Participants in the Research.

Managing Worries and Shame

Most of the women expressed feelings of fear, anxiety, shame, worthlessness, insecurity and permanent danger during the interviews. The majority of the victims continue to feel worthless and discouraged, and expressed sadness towards life in its entirety. They harbour fear of the unknown and some of them were on the brink of committing suicide. Some witnessed the killing of their husbands and family members (children, brothers, sisters and parents) and such horrifying experiences have continued to disturb them intermittently.

Regaining Happiness

Some respondents expressed positive emotions such as joy and happiness, despite the fact that they were experiencing serious medical problems, such as chronic pelvic pains, genital-urinary problems, distress, gastrointestinal aches, pericardial accelerated frequency, tiredness, muscular tension, numbness, agitation or irritation and unwanted pregnancies resulting from the SV.

Healing and Restoration

The transition from illness to recovery made most of the respondents feel energetic and optimistic about life, whereas some were unsure of how they would live their lives after they were discharged from

Table 2: Provides the overview of the meaning and implementation of the women's participation from the interview categorized according to interpretive phenomenology

Codes	Categories	Themes	
Concern Uncertainty and Powerless-ness	Palliative care	Managing worries and Shames	Women's struggles after sexual violence
Finally diagnosed: relief and happiness	Under treatment	Regaining happiness	
Receiving treatment when they were seriously ill: Disappointed depending on one's health Sadness and worries	Having hope of recovery	Healing and restoration	
Energetic Optimistic Wonder about the future after discharge	Recovering		
Lack of answers about her health condition Powerlessness Irritation	Insufficient information about their situation	Need to be met in a professional way	
Hope Optimism	Seeking specialized care		
Optimistic Worries Insecurity	Having aspiration to cultivate	Struggles in daily life	
No money New skills	Taking responsibility after leaving the hospital		

the hospital; one of the respondents said: *"Yes, I have hoped to get well and I no longer have urine and blood discomfort. I am now waiting to start getting my monthly period, all my bills were covered and I was taken back to school. This place is now where I call home."*

Need to be met in a Professional Way

At the hospital, the respondents wanted to know what was going on in their condition on day to day basis lives. Some reported that they had received insufficient information about their personal situation. The lack of answers about their health conditions made them feel powerless, fearful, and irritable. They felt that the health care personnel were hiding information concerning their health status from them. For example, one of them said: *"The Doctor of this hospital told me to wait for a surgery. I asked him why I am staying here for this long, and I told him to help me so that I may return home soon. He said that he is waiting for special tools for the surgery to be done."*

Some women reported that the clinics and medical facilities did not stock adequate medication, while others indicated that they were unable to obtain the right medications on time. One victim referred to the lack of professionals and the need for newer equipment, saying: *"When I was operated on the Doctor closed one way; my periods have become very painful; blood and urine get out only through one way. That gives me more pain. I don't know when I will be operated again; the doctor may open that second way or not. Because when they operated me for the fourth time, they decided to close one so that they may follow up well with this urine problem".*

Struggles in Daily Life

All respondents talked about their losses and struggles in life since these atrocious experiences. Their losses were not only physical and psychological, but were also social and economic. Most of the victims were farmers and survived on small-scale businesses (selling fish, charcoal, vegetables in local markets), but because of the SGBV, they had abandoned everything. They expressed the aspiration to return to farming for the survival of their families, but they were worried and felt insecure, especially because of their financial situation. One of the respondents said: *"I used to farm and manage small business but now due to this illness which is troubling me, I cannot make it, the field where we cultivate is far and I no longer have the strength needed. I will continue to praise God and I will leave the rest in His hands. I believe He will give me what to do."*

Some of the women also described their stay in the hospital as empowering. They were given food and clothes and were trained in some vocational manual skills, so that they would be able to survive after their hospitalization. They wanted to take responsibility for survival after going home, but they wondered where to obtain money (funds) to start small businesses, while having difficulties adjusting to life after SGBV. Some of their challenges included the fact that they were no longer able to work because their tools had disappeared and they had no money to send their children to school. One of the victims shared: *"I can use the skills I have learned here to do manual work like making baskets or sewing clothes. I have somewhere I can go to but the problem is the poverty."*

Most of the women faced urgent basis needs, such as food, shelter, health care and education for their children. They lacked funds to pay for health care and for transport to treatment facilities. There were no family members to assume nursing, child-care and household responsibilities. Many did not have enough to eat, which made their health deteriorate further. A woman with mixed feelings said: *"If this health care institution stops working now, what I will do is go back to our Church members to ask for assistance and I can use the skills I have learned here to do the manual work like making baskets or sewing clothes."*

The Essence – Women's Struggles after Sexual Violence

From the respondents' narrations, the themes and sub-themes revealed that the women felt that their lives had been distorted by the SGBV. Throughout their narratives they described how these distortions led them away from their previous lives. Many of them expressed a desire for normalcy to return. Clearly, their testimonies were haunting, but they had the desire to reassemble their lives (figure 1).

Discussion

However, in the midst of their hurt, some of the

victims have shown resilience, resulting in the commitment to reconstruct their dislocated existence, expressed in striving to regain happiness. Assistance with managing worries and shame needs to be offered in a professional manner as struggles are expected along the way. Certainly, the victims go through atrocious pain and stress with profound sorrow about life.

The study also revealed that the respondents did not receive sufficient information from the health care providers (doctors, nurses and other healthcare professionals) regarding their condition. This is not in keeping with the Lisbon declaration which stipulates the rights of patients such as: the right to ask questions about his/her situation and receive answers in a timely manner[22]. It further states that if a patient is not satisfied with the treatment that he/she is receiving, he/she has the right to take action. Furthermore, before undergoing treatment, he/she has the right to give his/her consent or refuse the treatment. This emphasizes the importance of the patient understanding why he/she is being examined, as well as the medicine/ treatment or operations that are proposed. The declaration also suggests that the patient may be referred to other specialized care. All this ensures that when patients know their state of health, they will be likely to be hopeful, optimistic, and trust that the challenges can be overcome; and thus improve their health. After all, the restoration of a person is built on their strengths, coping skills, resources and inherent values[23].

Furthermore, the study revealed that women faced many difficulties due to the lack of competent healthcare professionals. Feelings of helplessness and irritation could be associated with patients' emotions regarding the competence of health workers who cared for them. Lack of capacity within hospitals and clinics often prevents victims of sexual violence from receiving appropriate and timely treatment[24,25,26]. Victims seeking care from a clinic may not be able to see the nurse or doctor for several days, further diminishing the already small window of opportunity to address the medical consequences of sexual assault[27]. Issues concerning sexual violence need to be addressed in the training of all healthcare providers (medical staff); by so doing, they may be more competent, compassionate, and confident in providing care to survivors of sexual assault. It is absolutely necessary that health and human service professionals be well trained on how to appropriately and sensitively screen victims of such violence, so that any needed interventions may be timeously provided[28,29] .

The nurses are encouraged to ask patients

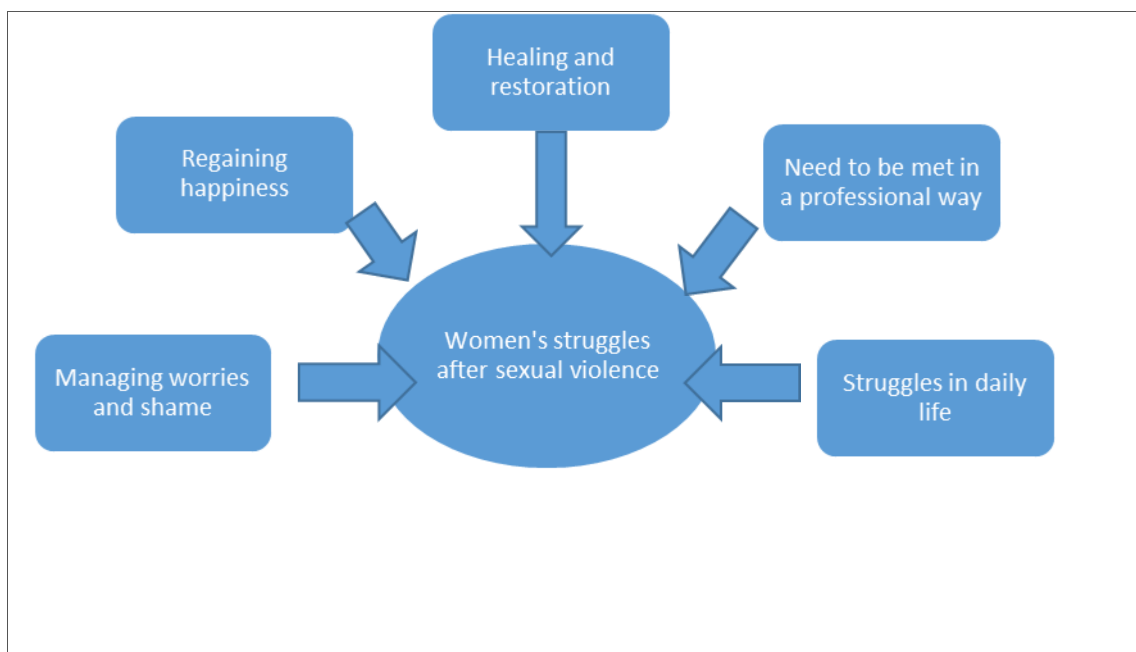

Figure 1: A conceptual model for life experience of women in North-Kivu.

about their situation, providing supportive responses for immediate disclosure of sexual violence; offering follow-up support and making appropriate referrals available because the women need to talk to someone who can listen to them, allowing enough time at the end of the appointment for questions[30]. The women presented with a multitude of different needs[31,32,33] .

The Implications

From these findings, it is evident that healthcare professionals need to be more sensitive to women's experiences and appreciate the need for specialists to provide appropriate care to the victims. There is also a need to challenge policies that do not address the best means of combating impunity. In addition, further research concerning the needs of women victims of SGBV should be carried out. Such investigations have significant implications for promoting gender equality since the present study has revealed covert barriers inherent in Congolese society.

The Strengths and Weakness of this Study

As indicated earlier, a qualitative interpretive phenomenological method was chosen for this study, which allowed women victims of SGBV to express their own thoughts and feelings, as well as the experiences they had gone through after the horrifying assault. This approach enabled the researcher to gain a deeper understanding of the meaning of the experience of women living in eastern Congo who are victims of sexual violence.

Study participants constituted an exhaustive and non-probability sample, which might be regarded as a limitation, but all participants had very different life situations and represented a diversity of experiences. Participants provided insightful and varied experiences of life after being sexually violated. Another limitation of the study was due to the fact that all the women were found in the hospitals; those from outside a hospital setting were not taken into account.

The use of the social workers to assist the interviewer (BKE) during the interviews may have had some negative implications for the data obtained. This is because most of the participants were very careful to give the responses to certain questions related to their stay in the hospital. In an attempt to mitigate this, the researcher took great care to observe and monitor the way participants were reacting and interacting during the interview

Conclusions

The findings indicate that healthcare workers play a crucial role in helping women who have experienced SGBV. Help with managing worries and shame, regaining happiness, healing and restoration, needs to be professionally addressed. Furthermore, professional assistance needs to be rendered to the women in eastern provinces of DRC who have been thus assaulted as they struggle to deal with everyday life issues. This is needed to enable them to re-order their lives as they move on in the midst of the daunting challenges precipitated by their being victims of SGBV, which was not of their making. The socioeconomic re-integration of assaulted women is very necessary and will help them to navigate the remainder of their lives. To create advantages for and possibilities of employment for these women will help them immensely. This can be achieved through their training and retraining in various professions and skills, according to their intellectual abilities. These actions, if carried out, will most probably fast-track their re-integration into their respective communities and families, from whom they have been isolated for a long time.

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None of the authors have any competing interest.

Paper Context:

The reality of SV in the DRC is well-documented and reported through media, by various NGOs, international institutions and the State. However, there seems to be a gap in research focusing purely on victims. This indicates the necessity that more attention be given to the victims, and makes it clear that healthcare workers have crucial roles to play in helping women who have experienced SGBV. However, there is a need to involve global aid and support to assist the women in DRC.

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