Care-Seeking Behavior by Survivors of Sexual Assault in the Democratic Republic of the Congo

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In February 2008, trained female interviewers collected data on sexual violence and use of medical services following sexual assault from 607 women in the Democratic Republic of the Congo (DRC). Exposure to sexual violence during the DRC's civil war was reported by 17.8% of the women; 4.8% of the women reported exposure to sexual violence after the war. Few sexual-assault survivors accessed timely medical care. Facility assessments showed that this care was rarely available. Clinical care for sexual-assault survivors must be integrated into primary health care for DRC women. (*Am J Public Health.* 2011;101:1054–1055. doi:10.2105/AJPH.2010.300045)

Evidence suggests that gender-based violence, especially sexual violence, increases during times of conflict.[1-3] Sexual violence in conflict can result from breakdowns in normal community organization and be used to systematically weaken populations, accelerate ethnic cleansing, and stake claims to particular territories and peoples.[1]

Since 1996, the Democratic Republic of the Congo (DRC) has been plagued by war, characterized by extreme violence, population displacement, and the collapse of already weak infrastructures.[4,5] Sexual violence continues to be used as a tactic of war in the DRC, and such violence is worsening in terms of severity and number.[6] A range of negative health outcomes are associated with gender-based violence against women, including physical injuries, traumatic fistulas, sexually transmitted infections, unwanted pregnancies, and psychological trauma.[7,8]

It is estimated that fewer than half of Congolese women who experience sexual violence are able to access health centers,[9] and even fewer do so in a timely manner. Lack of access to and awareness of available services were identified as the main barriers to Congolese women receiving timely care.[10]

METHODS

In February 2008, we conducted a multistage cluster sample survey[11] of the villages in the Kasongo health zone. We used Ministry of Health population and household estimates to design the survey. We used probability proportional to size to select 25 clusters, from which 25 households were selected via systematic sampling. Within each household, 1 woman of reproductive age (15–49 years) was selected from among all eligible women, for a sample of 607 women. We asked these women about their exposure to violence by perpetrators outside the family during (1996–2003) and after (2004–present) the civil war. We also asked them what health services they had sought following any exposure to violence. Base sampling weights, inversely proportional to the probability of selection, were applied to the data to reflect the population within Kasongo health zone.

We also collected data from facility assessments of all 21 public health facilities in Kasongo health zone in November 2007.[12] Interviews, observation, and clinical record review were used to assess each facility's general infrastructure, reproductive health services (including services for survivors of sexual violence), and infection-prevention environment.

RESULTS

Sexual violence (defined here as improper sexual comments; being stripped of clothing; unwanted kissing or touching; or being forced to give or receive oral, vaginal, or anal sex) committed by perpetrators outside the family was substantially higher during the conflict, when 17.8% of women reported at least 1 experience of sexual violence, than after the conflict, when 4.8% reported experiencing sexual violence. More than 1 in 20 women (7.3%) reported sexual assault (being forced or coerced by threats to give or receive oral sex or have vaginal or anal sex) during or after the conflict.

Self-reported survivors of sexual assault (n=42) were asked about their care-seeking behavior. The majority of women (58.6%) sought medical treatment, yet fewer than half (46.1%) of those who sought treatment did so within the 72-hour window for postexposure prophylaxis (PEP) for the prevention of HIV transmission, and only 47.4% sought care within the 120-hour window for effective emergency contraception (EC) to prevent unwanted pregnancy. Only 3 of the eligible women said they were offered EC or PEP at the health facility. At the time of the facility assessment, none of the health facilities had PEP or EC in stock, although 1 facility reported having provided EC at least once in the previous 3 months.

DISCUSSION

These data indicate a lack of access to timely, high-quality medical services for survivors of sexual assault in the DRC. Few women accessed medical care following their attack; of those who did, the majority were unable to do so within the necessary time frames to prevent pregnancy and HIV transmission because of barriers of access, culture, and knowledge. Even if a woman did access care in a timely manner, EC and PEP were rarely available at the health facility, as is likely the case in many public health facilities in the DRC. These services constitute a minimum standard of clinical care that must be made available to survivors of sexual assault according to United Nations guidelines,[13] and they should be integrated into primary health care so they are available at all health facilities.

In an effort to address these needs, CARE International and the Reproductive Health Access, Information and Services in Emergencies (RAISE) Initiative have trained health workers to provide clinical care to survivors of sexual assault and have introduced EC and PEP into health facilities in Kasongo. CARE-supported community mobilization activities educate the community about the importance of seeking care early following a sexual assault, to prevent pregnancy or HIV infection. CARE has established a referral system so that sexual

assault survivors who receive medical care can also, if they choose, access psychosocial care, socioeconomic reinsertion opportunities, and legal aid through local partners.

Clinical care for sexual assault must be integrated into primary health care, especially in crisis settings. Once these services are available, the community must be told where to access immediate and anonymous care in case of sexual assault. The DRC government and the international community should ensure that health workers are trained to appropriately respond to survivors and that these services are available to all who need them. The DRC government and the international community should also uphold their commitments to end sexual violence and the impunity with which it is perpetrated against women in the DRC. ■

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Contributors

S.E. Casey and J. Austin participated in study conceptualization and design. S.E. Casey led the implementation of the study. S.E. Casey, M.C. Gallagher, and J. Austin analyzed the data. S.E. Casey and M.C. Gallagher led the writing of the article. J.L. Meyers, B.R. Makanda, M.C. Vinas, and J. Austin contributed to the writing of the article. All authors reviewed and approved the final version of the article.

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Human Participant Protection

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Increased Risk of Suicide Attempts Among Black and Latino Lesbians, Gay Men, and Bisexuals

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Members of racial/ethnic minority groups have a lower lifetime prevalence than have Whites of mental disorders, a risk factor for suicide attempts; paradoxically, however, lesbian, gay, and bisexual (LGB) ethnic minority youths may be at increased risk for suicide attempts relative to White LGB youths. We found that the increased risk of suicide attempts among racial/ethnic minority LGB respondents in our sample relative to White respondents was not explained by excess youth onset of depression and substance abuse or by a higher susceptibility to suicide in the racial/ethnic minority LGB group. (*Am J Public Health.* 2011;101:1055–1059. doi:10.2105/AJPH.2010.300032)

Mood and substance use disorders are known risks for suicide.[1,2] Members of racial/ethnic minority groups have a lower lifetime risk for mental disorders than do Whites,[3–5] but, paradoxically, lesbian, gay, and bisexual (LGB) individuals of racial/ethnic minority backgrounds may be at an increased risk for suicide attempts relative to Whites.[5,6] Lifetime suicide attempt rates in the LGB population range from 10% to 40%,[7–15] compared with 0.4% to 5.1%[2] in the heterosexual population.

According to the minority stress model,[16] the excess prejudice, stigma, and discrimination encountered by sexual minority individuals lead to increased mental health problems in this population and a resulting increased risk of suicide. Explanations for disparities in suicide rates between the LGB and heterosexual populations