GBV Sub-Cluster
Democratic Republic of Congo

GENDER BASED VIOLENCE SITUATION AND RESPONSE IN THE DEMOCRATIC REPUBLIC OF CONGO (DRC): THE KASAI CRISIS

Introduction

During the last year the spread of conflict in DRC to new geographic areas in the Kasaï region (provinces of Kasaï, Central Kasaï, Eastern Kasaï, Sankuru and Lomami) and Tanganyika province have caused a rapid deterioration of the overall situation. Political unrest, an electoral crisis and a significant socio-economic decline with more than 50 per cent devaluation of the Congolese Francs over the last year further aggravate the current instability. This highly dynamic context made up of a series of acute crises has caused massive population displacements, serious human rights violations *"more horrendous than ever before"* according to Stephen O'Brien's statement to the Emergency Directors of the IASC after his visit to DRC and CAR last July[1].

8.5 people in need of humanitarian assistance in DRC

Image n°1: IDP camp in Kalemie/Tanganyika.
Photo credit @UNFPA/Pascal Banza/2017

In the whole DRC, more than 8.5 million people are in urgent need of humanitarian assistance, including an estimated 4.5 million women and girls whose 425,000 are pregnant. Disaggregating the whole population by age, 5.5 million are estimated to be girls and boys [2]. The country now has greatest internally displaced people (IDPs) in the world: 3.8 million, whose majority is in North Kivu and Central Kasaï. This means that between October 2016 and March 2017 some 8,000 people were displaced daily in DRC. In such a context, women and girls are exposed to many protection risks including various forms of gender-based violence.

1 ERC Note to IASC principals, 7 August 2017
2 These are official data and are taken from the HRP 2017-2019 (January 2017) and Flash appeal for the Kasai, (April 2017). These are likely to be underestimated as for instance the number of IDP has substantially grown up to 3.8 million while strategic documents count up to 3.3 million according to OCHA.

Kasaï crisis

The crisis in Kasaï Region has started in august 2016 as a consequence of a conflict of power among customary chiefs in the territory of Dibaya, in Central Kasaï. A rebellion was created uprising against the central power and the government deployed the national army (FARDC) to contrast this. Military operations had their highest between April and May 2017, causing massive displacements, killings and various human rights violations. The conflict has then engulfed intercommunal violence among the Luba, Pende and Tshokwe ethnic groups, which make the current situation unpredictable.

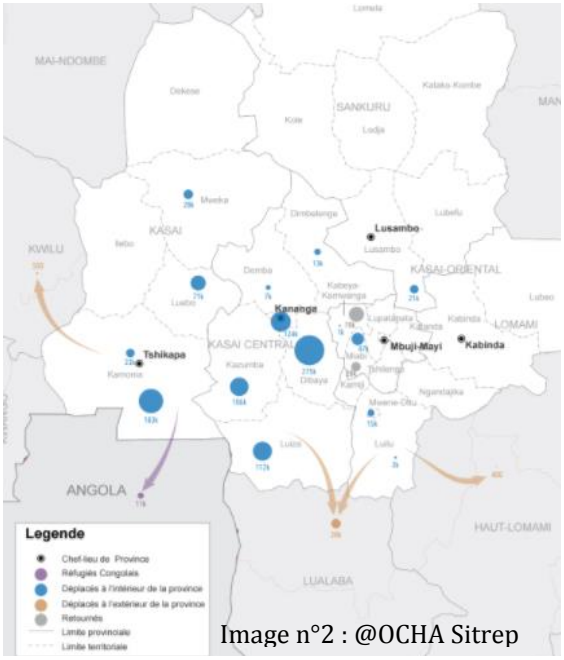

Image n°2 : @OCHA Sitrep

Over the last 12 months, some 1.4 million people have been displaced in the five provinces of the Kasaï region, and 2.8 millions of people are experiencing food insecurity. In addition to protection risks more directly linked to the consequences of the crisis the current food security might lead to negative coping mechanisms adopted by already poor communities. This context further aggravate the risks of sexual exploitation and abuses for women, boys and girls.[3]

1.4 million of displaced persons

Gradual opening of the humanitarian space since end of May 2017 as well as a general respite in the region during the month of July has allowed the GBV sub-cluster to conduct an assessment in Tshikapa (Kasaï), Mbuji Mayi and Miabi (Eastern Kasaï) and Kananga (Central Kasaï). In addition, two GBV sub-cluster members, CARE International and MAGNA conducted two additional multisectorial assessments in Kananga, Miabi and Kabeya-Kamunaga with the *"go and delivery"* methodology which included a special focus on GBV.

[3] OCHA/DR Congo Situation Report n° 11: Complex Emergency in the Kasai Region (11 Augut 2017) and OCHA/DR Congo Situation Report n° 10: Complex Emergency in the Kasai Region (28th July 2017)

Overall GBV situation in the Kasaï region

Secondary data analysis of the overall situation of GBV in the five provinces affected by the crisis underlines three major problems[4].

Child marriages, as 55% of women aged 25-49 got married before getting 18 years old. This is 12% more than the national average[5].
Sexual violence, as 22% of women aged 15-49 experienced sexual violence during the last 12 months and 33% at least once in their lifetime. Both of these data corresponds to 6% more than the national average[6].
Intimate-partner violence, 48% of women aged 25-49 experienced physical or sexual violence by their intimate partner during the last 12 months and 46% during the lifetime. This is respectively 11% and 9% more than the national average[7].

Key findings of the GBV assessments

The **national GBV sub-cluster** conducted a GBV assessment in different phases, following the opening of the humanitarian space to identify the kei needs to ensure a GBV emergency response (GBViE). Data were collected in Kananga (26 May - 05 June), Mbuji-Mayi and Miabi (14 - 21 July) and Tshikapa (21 - 28 July) involving more than 50 GBV actors in the three provinces[8]. More precisely:

- 49 structures offering service provision (21 Central Kasaï, 22 Eastern Kasaï and 6 in Kasaï), including 13 points for medical care, 18 on psychosocial support, 7 for legal aid and 6 for protection and security and 5 with multisectorial services
- 170 persons have been interviewed as key informers on GBV issues (service providers, UN agencies, NGOs)
- 205 of communities affected by the crisis participated in focus groups discussions, this included 12 survivors in social-reinsertion activities in Mbuji Mayi (Eastern Kasaï) as well as 193 IDPs in host families (116 in Kananga in Central Kasaï, and 77 in Miabi in Eastern Kasaï).

Overall, various forms of sexual violence as well as forced and child marriages seems consequence of the instability thought the lens of GBV. Communities said that the greatest obstacle to report sexual violence is that rape might undermine women and girls' chances to get married or cause rejection by the husband. Communities has also the perception of an important increase of early marriages and of sexual violence, in particular as committed by armed men. Informers freely manifested a fear of denunciation of sexual violence when committed by armed men. In focus group

[4] 2d Demographic and Health Survey (DHS II -2013-2014)

[5] DHS II 2013/2014, calculation on data done by UNFPA on July 2017

[6] DHS II 2013/2014, tables A.18.3

[7] DHS II 2013/2014, tables A.18.12

[8] including UN agencies (UNFPA, UNICEF, WHO, IOM and OCHA), I-NGOs (Handicap International, Pathfinder, APSME/ONG, Save the Children) and national NGOs as well as state structures (health, gender and police)

discussions, informers frequently reported about the practice of the kidnapping of young ladies in complicity with community leaders to facilitate forced marriages. Broader discussions on other GBV issues rather than sexual violence and forced marriages were difficult to undertake with the affected population. GBV Sub-cluster members moderating the discussions have not identified other types of GBV issues revealed by communities. By contrast direct observation and protection cluster analysis of the situation showed that women and girls might be exposed to denial of resources by armed men. This shows an evident weak understanding of gender dynamics and root causes of GBV as well as on the identification of risks of GBV. Lastly, a recent study conducted by UNFPA in 6 other provinces of DRC showed that the population make an assimilation between the concept of GBV and of sexual violence. This might be the reality also in the evaluated areas.

Image n°3. Personnes deplacés en famille d'accuil à Kananga @UNFPA/Antoine Banza

Analysing access to service between August 2016 and May 2017: 1.429 incidents of VBG were assisted in service provision locations in Kasaï (162), Central Kasaï (656) and Eastern Kasaï (611). Only 1% of survivors are men and boys. Children represent 68% of survivors of the reported incidents, with adolescent girl aged between 12 and 17 representing the vast majority of them. According to the 6 GBV types of the GBV Information Management System (GBVIMS), the VBG incidents reported in service provision points include 79% of rapes, 11% of sexual aggressions, 4% of physical aggressions and 4% of forced marriages. Denial of resources, opportunities and services and the psycho-emotional violence represent the remaining 2%. Lastly, 34% of alleged perpetrators are armed men, including national security entities and non-state armed actors.

Case management is sectorial and vertical rather than comprehensive, survivor-centred and holistic. Referral pathways, even when established, are partial, inefficient and based on agreements among organizations or structures rather than on a local accessible, updated and available system. Psychosocial response is the weakest sector, with actors limiting their interventions to basic listening and referral. Very few psychosocial collective activities are in place or planned. Medical response is marked by the absence of trained service providers, resulting even in a non-correct application of the national protocol for the clinical management of rape. Despite an acceptable availability of post-rape kits in comparison with number of survivors accessing the health centres within the 72 hours of a rape incident in Kananga, Mbuji-Mayi and Tshikapa, the capacities of health staff on the management of the supply chain is

inadequate. Lastly, medical certificates are not available and the health information system is weakly exploited. Legal assistance is present towards few juridical clinics in Kananga, Mbuji-Mayi and Tshikapa, that difficulty works in the challenging environment of DRC (lack of judges, of training of police officers etc)

On prevention, interventions to mitigate GBV are very limited, and do no go behind outreaching population on GBV service provision. The existing alert systems are not sufficiently GBV-friendly and couldn't identify specific measure to reduce the risk of GBV. The assessment did not identify any other specific activity on prevention, for instance on women economic empowerment or safe spaces. This is surely due to the unique work of GBV identified actors on case-management. National GBV coordination structures are in place at provincial level in Central Kasai and Eastern Kasai but are not aligned with

A GBV sub cluster member, **MAGNA**, conducted a multisectorial rapid assessment from July 3rd to 14th, on GBV, Maternal and Child Health and Nutrition in 5 out of the 6 Health Zones of the city of Kananga. Actors involved included 6 local NGOs, 1 international NGO, 2 UN agencies (WHO and UNICEF), health zones chiefs, services providers in 5 health facilities, National Police (Child Protection and Sexual Violence Prevention Unit), the Provincial Division for Health, the National Program on Reproductive Health and the Provincial Division of Gender. Existing referral system showed among four key actors showed that, since the beginning of the crisis in August 2016 :

- 94 GBV survivors received basic psychological care by a national NGO (FMMDK) in Kananga. Incidents were mainly perpetrated by militaries (52% of alleged perpetrators) and against minors (58% of survivors)
- 261 incidents whose 90% were rape survivors received legal and socio-econimic support by NGO (Lizadeel) in Central Kasai
- 98 survivors of rape (70% in the period August – December 2016) accessed the clinical management of rape at the José Oudney hospital in Kananga. 81% of survivors were aged 13 to 17
- 233 sexual violence incidents (mainly rape) reported by the National Police for the whole Central Kasai. The spike is registered during the last quarter of 2106. 86% of surivivors were minors aged 14 to 17.

MAGNA's finding shows that civil society organisations reported a progressive increase in the number of incidents of sexual violence in the community. On the contrary, the Police noted a decrease in the reporting of cases. This was justified by poor accessibility to protection services due to insecurity as well as by the fear of reprisals in the event of a denunciation. On case management, all actors interviewed by MAGNA agreed on the lack of holistic case management for survivors, as consequence of weak referral mechanisms or absence of integrated services. Only one health facility and few local NGOs in Kananga offer psychological care for GBV survivors. The national protocol is not correctly applied and service does not comply with required confidentiality standards. Psychosocial personnel lack of training on psychosocial support and only provide intake and, sometimes, family mediation. On medical care, health providers were only briefed on clinical management of rape, and years ago and without specific focus on child survivors. Health providers requested reinforced capacities on drugs administration (such as for some components of the post-rape kits) as well as on data collection, analysis and reporting. MAGNA observed that many health facilities were looted and lost medical tools, equipment and drugs. In addition, some health providers, trained over the last years has flee because of the

conflict. Legal assistance and socio-economic reintegration are services even weaker. Lastly, on prevention, MAGNA noted that GBV is a delicate issue in communities, challenged by many cultural barriers. Major mass awareness campaigns on GBV should be held with the community and its leaders, insisting on the life-saving emergency of medical care within the 72h following the rape incident. Capacity building for local civil society actors (CSOs), local NGOs, and national police should also be prioritized. To implement a *"go and delivery"* approach, MAGNA undertook a light intervention in 3 health facilities in Kananga addressing identified GBV needs into its wider maternal and child health response.

CARE International's assessment, carried out in the territories of Miabi and Kabeya Kamanugua in Eastern Kasai between May and June of 2017 confirmed significant needs on the GBV response. 100% of respondents in key informant interviews and focus groups reported cases of rape in their respective villages. Medical personnel in the area confirmed this, reporting that they have received and cared for survivors of rape. Equally concerning is the fact that the reported sexual violence and rape has not only been carried out by armed groups but also by members of the general community. At the time of the assessment, none of the service providers in the area reported having the training necessary to correctly care for and support survivors of sexual violence, and none of the structures visited were equipped with post-rap kits or another necessary medical equipment or drugs to treat sexual violence survivors. CARE International is currently responding in this areas, working closely with UNFPA to provide specialized training for holistic care and support for medical personnel as well as on purchase and positioning of post-rape kits.

Presence of actors and GBViE response in the Kasai region

As of mid-august 2017, the Kasai crisis is still dramatically ignored by GBViE specialized actors and intreventions. NGOs operations are small and scarce and the first emergency actors on the ground such as Handicap International, *Action contre la Faim*, WHO, UNICEF and Save the Children are not always specialized in GBV response or weren't implementing specific GBV programs when the crisis occurred. Also, they were implementing development programs. Moreover, development actors and/or development programs have been the front line responders during of the Kasai crisis, their activities were frequently suspended but the support they provided was crucial. SANRU, a national NGOs, and IMA World Health ensured the availability of post-rape kits in more than 20 affected health zones. Legal clinics with DIFD and Global Fund grants in Kasaï and Central Kasaï supported a minimum documentation of incidents. The American Bar Association (ABA) ensured legal assistance jointly with psychosocial support to GBV survivors in Eastern Kasaï. Save the Children and UNICEF with its partners were conducting regular program on child protection including interventions on GBV.

Since a MIRA conducted by OCHA in January 2017 in Tshikapa, the GBV sectors has been indicated as a top priority by the humanitarian country team, but the first and still solely GBViE programme as of the 19th of August 2017 is a CERF-funded GBV project implemented by UNFPA with Caritas-Congo (Kananga and Luebo). UNICEF, MSF (France, Spain and Belgium), CARE International, MAGNA and Save the Children also undertook key GBViE interventions either into broader child protection or health responses. Handicap International and Oxfam are proactively supporting the GBV integration inside their wider protection programs. Other actors such as UNHCR are

about to open some GBV interventions as well. A GBV sub-cluster covering the Centran Kasaï, Easten Kasaï and Kasaï has been activated on the 10th of August 2017 based in Kananga.

Major challenges identified

- Insufficient presence of specialized GBViE actors (especially for psychosocial and medical care)
- Complicated and time consuming customs procedures that delay the delivery of life-saving medicine and medical equipment
- Capacities of existing responders to ensure a quality, timely, survivors-centred and available mutisectorial GBViE service
- Engagement of other sectors/cluster in mainstreaming of GBV interventions through humanitarian actions in alignment with 2015 IASC GBV Guidelines
- Rapidly put in place prevention measures on sexual exploitation and abuse (SEA) perpetrated by humanitarian actors

Conclusions and GBV Sub-cluster key messages

DRC is a context that has been historically marked by the use of rape as a weapon of war. While the situation has improved in particular on political engagement of national authorities and military justice to fight conflict related to sexual violence committed by national security entities, there is an increase in sexual violence reported in both Kasai region and Tanganyika during the recent crisis.

In conflict affected area, the GBV national database was registering a gradual and continuous decrease of incidents allegedly committed by armed men over the last few years. The pattern of violence in Tanganyika and Kasai is inversing this tendency. Sexual violence during crisis in Tanganyika province and Kasai region should thus keep being a major advocacy priority and area of work for GBV actors in DRC.

The GBV sub-cluster will work on addressing the weakness of the response, but to do so it needs a reinforced presence of GBViE specialized actors for GBV response, aligned to and supporting the national GBV sub-cluster action plan.

Mainstreamed of GBV interventions through humanitarian actions towards 2015 IASC GBV Guidelines represents also a major priority for the mitigation of GBV risks, in particular on the current context of food insecurity.

Lastly, a key priority of the whole humanitarian community in the Kasai region should be the introduction of strong SEA prevention mechanisms inside the humanitarian community in the Kasaian space, in particular on Central Kasai which is the poorest province of the country and where the deterioration of living conditions as consequence of the crisis are already visible.