

# AFRICA

## **“Civilians still the first victims”**

**Permanence of sexual violence and  
impact of military operations**



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# Introduction

In the wake of a violent civil war, the district of Ituri in the northeast of the Democratic Republic of Congo (DRC), which has a population of 4.6 million, has and continues to be the scene of immense human suffering.

Since 2003, the Médecins Sans Frontières (MSF) medical teams at Bon Marché Hospital in Bunia have borne witness to the situation facing the region's inhabitants and the violence committed against them. By speaking out on several occasions<sup>1</sup> and conducting a number of surveys<sup>2</sup> to assess the nature and impact of this violence on the day-to-day life of the population, Médecins Sans Frontières has unceasingly alerted the international community to the situation

facing people in the region and the difficulties in providing them with humanitarian assistance.

Following the joint deployment of the Congolese army and the MONUC within the peace process, in 2006, the quelling of the conflict brought a marked reduction in the number of wounded admitted to Bon Marché Hospital. Fortunately, in 2007, only a limited number of wounded have required surgical treatment.

However, every day, the MSF teams continue to treat a very high number of victims of sexual assaults committed by both armed people and civilians. Moreover, although the forms of violence described come in various guises, women and children are the main victims.

Other MSF teams have provided emergency medical assistance to populations recently displaced by occasional military operations, such as in Djugu Territory in 2007 or Gety in 2006. In the course of their work, they have witnessed the consequences for civilians of violent episodes linked to fresh outbreaks of fighting.

Given the scale of the phenomenon, MSF considers it necessary to, once again, draw the attention of the various national and international stakeholders involved in resolving the conflict and managing aid in Ituri to the information provided by the victims of violence treated at its facilities.

We think that it is essential to provide a summary of the forms of violence recounted by our patients, and to share this information with the various stakeholders in Ituri and, more broadly, throughout Congo.



<sup>1</sup> Report published in August 2005, MSF, Nothing new in Ituri, the violence continues, and July 2003, MSF, Ituri: Unkept promises? A pretence of protection and inadequate assistance – available at [www.msf.ch](http://www.msf.ch)

<sup>2</sup> High mortality in an internally displaced population in Ituri, L.Ahouat, A.Tamrat, F.Duroch, R.F Grais, V.Brown, *Global Public Health*, October 2006, 1(3): 195-204.



This report does not aim to provide an exhaustive analysis of the humanitarian situation or state of health of the population of Ituri, and is related to the period from 2003 to 2007, with a particular focus on the last two years.

It deliberately centres upon violence of a sexual nature and the consequences of recent military operations, which our medical teams have observed directly during this period. Although these are two distinct issues, they share the fact that they both cause human suffering that prompts the victims to seek help.

**The main findings are as follows:**

- Unfortunately, the pacification process in Ituri has not put an end to all forms of violence, particularly those of a sexual nature.
- More than 7,000 people have been raped in four years, including 2,708 in the last 18 months (January 2006 to July 2007), which illustrates the chronicity of this situation. Most victims of rape are women and girls, although between 2% and 4% of this figure comprises men and boys. The MSF teams are currently seeing a significant increase in child admissions, particularly linked to assaults committed by civilians.
- Hundreds of patients report numerous other forms of violence, acts of cruelty and brutalities. Moreover, around 20% of them report having been abducted.
- Sporadic military operations, performed right until 2007, have resulted in renewed violence against civilians, exacerbating the effects of many years of war. Their consequences will leave a lasting mark on the people of this region.







- Because of fears for their safety, there are still some 150,000 displaced people<sup>3</sup> in Ituri. The theft or destruction of property and land further entrenches this context of instability and impoverishment of communities, leading to fears of secondary violence.
- At certain health facilities, particularly that of Laudjo, a retrospective mortality survey has revealed excess mortality among children under five years of age, as well as a demographic underrepresentation of men between the ages of 30 and 44 years.

The current example of Kivu, where renewed fighting is having dramatic humanitarian consequences for civilians caught in the crossfire, demonstrates the fragility of the peace process in the regions of Eastern DR Congo and the chronic instability that prevails there.

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<sup>3</sup> Source OCHA, July 2007.

### **MSF's medical activities in Ituri**

In May 2003, in the midst of violent fighting between militias, MSF set up the "Bon Marché" hospital in Bunia, to perform emergency surgery linked to the conflict and offer inpatient and outpatient health care for women and children (maternity and paediatrics). Between May 2003 and July 2007, a total of 198,072 outpatient consultations were performed, including 96,874 for children under 5 years of age, which accounted for nearly 50% of all consultations.

During the same period, staff at Bon Marché Hospital admitted 42,405 inpatients, performed more than 24,900 surgical operations and delivered 7,090 babies. Approximately 7,400 patients identified as having been subjected to sexual violence received medical treatment at the hospital.

It should be noted that, in the course of 2006, the team set up a blood bank, which helped

significantly reduce patient mortality within 48 hours of arrival.

The new hospital, which has been operational since May 2007, has 250 beds distributed between seven semi-permanent buildings. MSF employs up to 400 national staff and 18 international staff at the hospital.

Outside of Bunia, the MSF teams have regularly responded to the numerous medical and humanitarian emergencies in Ituri, most often linked to movements of populations fleeing rural combat zones. Examples of such emergencies in the last 18 months are the treatment of displaced victims of violence from July 2006 to May 2007 in Gety, south of Bunia, then from March 2007 to June 2007 in Uwordrama, Waza and Laudjo. MSF provided primary and secondary health care and, in the case of Gety, distributed drinking water that was essential for the survival of the displaced people.

# Method and sources

The figures presented here do not represent all the forms of violence inflicted on people living in these territories, but only those who have been treated at our health facilities, particularly Bon Marché Hospital in Bunia. The period studied is from May 2003 to July 2007<sup>4</sup>, and is particularly related to the patients who have suffered a sexual assault and are forming group 1.

Furthermore, some qualitative information in this report has been taken from a research project

studying the situation at the end of 2005 and the whole of 2006<sup>5</sup>, and patient medical records which have been analysed in depth. A total of 2,695 medical records have been studied; this group of patients is referred to in this report as group (or cohort) 2.

Finally, these figures only reflect the dates of admission to the health care facilities and not the dates of the assaults; some people had to wait several days, or even years, before attending a health centre.



<sup>4</sup> Group 1: 7,482 patients, May 2003 - July 2007.

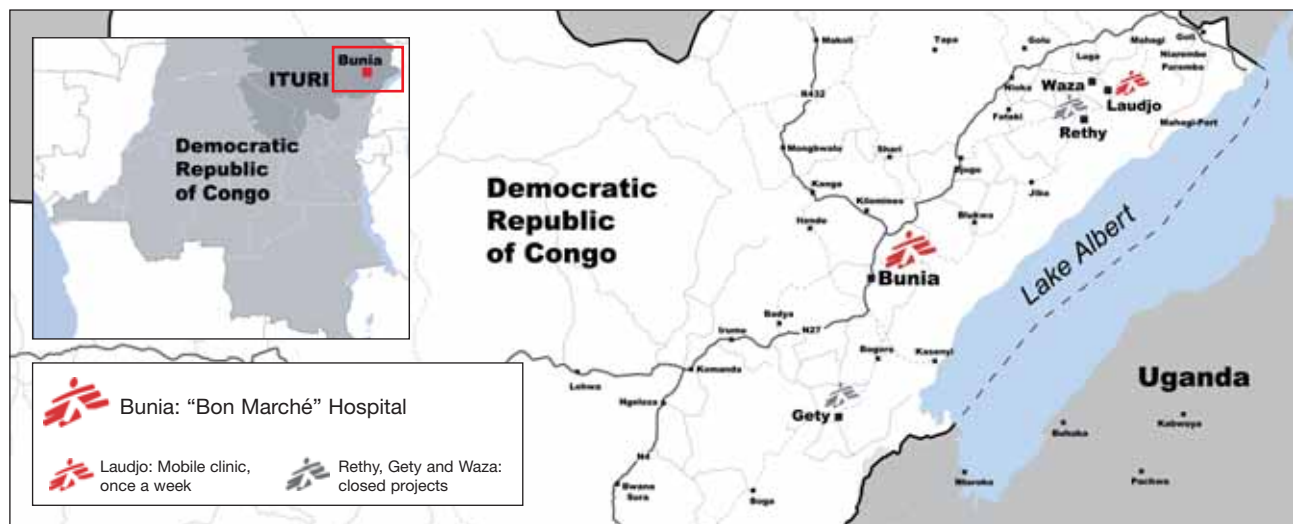
<sup>5</sup> Group 2: 2,695 patients, September 2005 - December 2006, qualitative analysis study.





# Map and brief chronology

## Democratic Republic of Congo



In Ituri, from 2003 to 2007, there were various peaks of armed violence, political instability and peace operations. The succinct chronology below recapitulates the main phases:

### 1. June - September 2003:

Operation Artemis, restoration of relative security in Bunia after the peak of violence from March to July 2003.  
Peak of consultations relating to sexual violence at MSF's Bon Marché Hospital, central Bunia, over the months that followed.

### 2. First half of 2005:

Start of process of demobilising armed factions and deploying of the Forces armées de la République du Congo (FARDC) troops outside of Bunia; fighting and displacement of civilians in Djugu Territory.  
Consultations relating to sexual violence on the rise at Bon Marché Hospital (opening of mobile clinics to treat victims of sexual violence, late 2004; closure in June 2005 following a security incident).

### 3. First half of 2006:

Deployment of FARDC troops in Irumu Territory; fighting and displacement of civilians. Consultations relating to sexual violence on the rise at Bon Marché Hospital (end September, opening of an MSF centre to treat victims of sexual violence in Gety, the main camp for displaced people in the region, which brings down the number of patient referrals to Bon Marché Hospital).

### 4. January - February 2007:

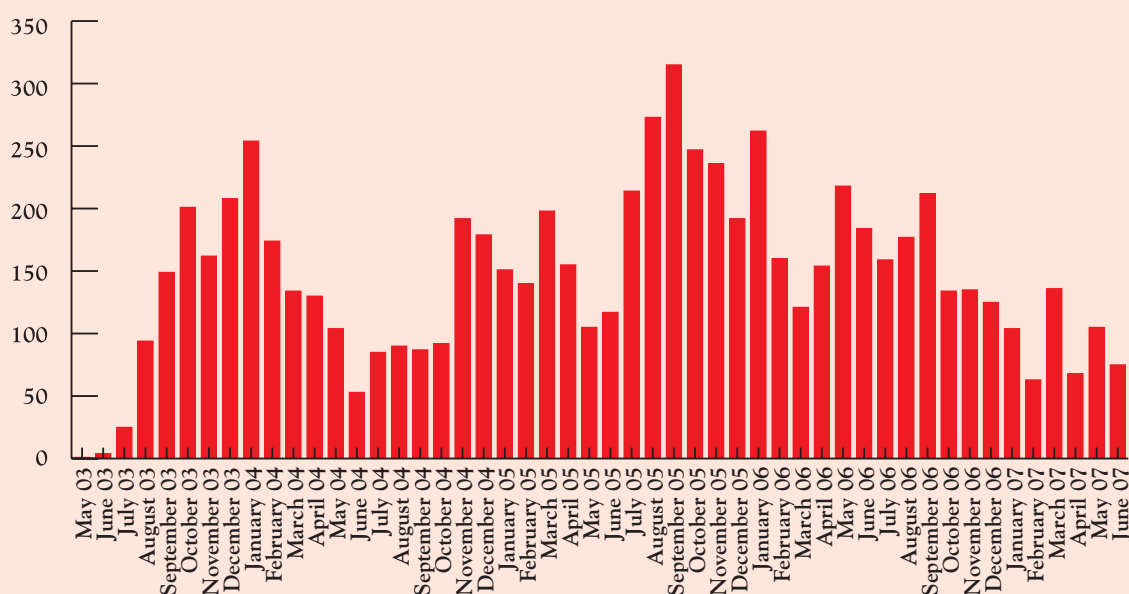
Deployment of FARDC troops to the north of Djugu Territory; fighting and displacements. Slight peak in consultations at Bon Marché Hospital in the weeks that followed (end of March, opening of an MSF centre to treat victims of sexual violence in Waza, where the largest number of displaced people in the region are housed).

# 1

## Rape, sexual violence and associated brutalities: a chronic situation

### a. 50 to 300 patients a month have reported being victim of a sexual assault since MSF began offering medical care in Spring 2003

**Graph 1 – Number of victims of sexual violence, May 2003 - June 2007**  
**Bon Marché Hospital, Bunia, DRC**



From May 2003 to July 2007, 7,482 people reported having been the victim of an individual or gang rape, largely within the context of everyday and domestic activities or during widespread attacks and forced displacement (graph 1). Meanwhile, the number of patients able to undergo prophylactic treatment against the HIV virus<sup>6</sup> remains insufficient, rising from 21% in 2004 to just 36% in 2007. This phenomenon can be partly explained by the following factors: centralisation of care, insecurity, insufficient geographical accessibility to health facilities, a lack of information and fear of stigmatisation.

The table below shows the total number of admissions. The admission peaks are not only the consequence of periods of armed violence, but also, in some cases, the result of information and awareness-raising activities advocating on the consequences and the possibilities of treatment for sexual violence.

**Table 1 – Number of admissions per month to MSF health centres following a sexual assault**

	2003	2004	2005	2006	2007
January		245	151	262	104
February		174	140	160	63
March		134	198	121	136
April		130	155	154	68
May	1	104	105	218	105
June	4	53	117	184	75
July	25	85	214	159	116
August	94	90	273	177	
September	149	87	315	212	
October	201	92	247	134	
November	162	192	236	135	
December	208	179	192	125	
<b>Total</b>	<b>844</b>	<b>1,565</b>	<b>2,365</b>	<b>2,041</b>	<b>667</b>

<sup>6</sup> This treatment consists of administering two antiretroviral drugs for people who are able to attend a health facility within a maximum of three days after the assault.



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In Group 2<sup>7</sup> (2,695 people), we have also found that 9.2% of patients were pregnant at the time of the consultation. 88 women reported having fallen pregnant as a result of the sexual assault. The future of children born of rape is a major concern in a society that has no social services to support their mothers. In the month of July 2007 alone, of a total of 116 patients, 8 said they had become pregnant following a rape.

However, these figures certainly do not reflect the full extent of this phenomenon, since many patients do not report pregnancy resulting from rape or have already had a child under such circumstances.

**Table 2 – Number of women pregnant at time of medical consultation:  
September 2005 - December 2006**

	Number	%
No	2,322	86.2%
Yes	248	9.2%
Don't know	124	4.6%
Total	2,694	100.0%

Furthermore, while many of these acts of violence were committed collectively (two or more attackers) in 2005 and 2006, with 12.1% of patients being raped in the presence of a third party, the number of single assailants has increased in the first part of 2007 (Group 2)<sup>8</sup>.



<sup>7</sup> See Method and Sources, pg. 8.

<sup>8</sup> Data only available for the first seven months of 2007.

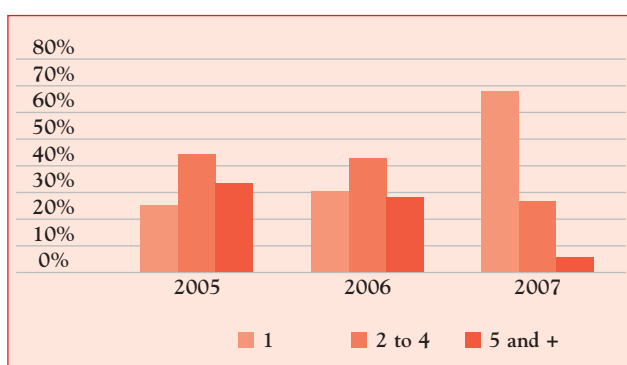
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Violence committed in public like this gives rise to fears of long-term repercussions, particularly in terms of stigmatisation and rejection by the community.

### 16-year-old girl assaulted by a former militiaman, 2007

*"I was on my way to (place X) in Bunia, where my father lives. When I got to (place Y), three boys came out of the bush and dragged me back into the bush. One covered my mouth as two people undressed me. Then the second person held me down while the third raped me vaginally. The three of them took turns on top of me, then two of them asked me if I knew who they were, and I told them I didn't. One of them took me to his uncle's house (place Z), where he raped me every day for two weeks. One of the three boys had some guns, but the one who held me captive had a knife. My father came to get me yesterday and brought me to the health centre."*

**Graph 2 – Number of attackers:  
evolution 2005 - 2007**



### b. From rapes committed by armed forces to civilian violence

In 2006, the main characteristic of these forms of violence was that the perpetrators were armed men. It should be pointed out that the traditional



definition of "soldier" is difficult to apply in this context, mainly because of the great diversity of actors involved in the Ituri conflict: militias, criminals, integrated brigades<sup>9</sup>, regular armed forces and peacekeeping troops. However, the MSF teams are currently observing a significant drop in the age of the patients admitted to our health centres, while the proportion of allegations against civilian assailants is slightly on the rise among the patient cohort.

**Table 3 – Status of aggressors**

	2005	2006	2007*
Civilian	417	428	264
Armed groups (FARDC or militias)	1,859	1,547	260
N/A	67	66	28
Total	2,343	2,041	552

\* Figures from January to June.

Of the sample of 2,695 consultations carried out at Bon Marché Hospital for rape victims who attended the structure between September 2005 and December 2006, 1,973 patients (73.2%, see Table 4) identified their aggressor(s) as belonging to an armed group<sup>10</sup>.

<sup>9</sup> The new brigades of the Congolese armed forces are the result of the incorporation of militias into the army. The brigades which can be posted anywhere in DR Congo are called "brigades brassées" or integrated brigades. "Brigades mixées" or mixed brigades, meanwhile, stay in the "place of origin" of the militias.

<sup>10</sup> Group 2, see Method and sources page 8.





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**Table 4 – Type of aggressor**

	Number	%
Unknown armed man <sup>11</sup>	1,973	73.2%
Unknown civilian	293	10.9%
Known civilian	288	10.7%
Known armed man <sup>12</sup>	76	2.8%
Don't know	65	2.4%
Total	2,695	100.0%

It should also be underlined that, since 2003, patient allegations implicate the majority of the armed groups operating in the region, including both the FARDC<sup>13</sup> and the militias.

Given that the regular Congolese army is unable to protect the region's inhabitants, and may even participate in acts of violence against civilians, the state of insecurity in Ituri will remain permanent for the time being.

### c. Change in the age of patients: violence in the private and domestic spheres?

At present, it is extremely difficult to monitor changes in violence, especially in the private and domestic spheres. However, data from the end of 2005 and the whole of 2006 (Group 2) reveals a link between the age of the victims and the type of attacker.

Acts of violence against children under 9 years of age are mainly committed by civilians known to them, and this trend seems to be continuing in 2007. If we compare the number of rapes committed on victims under 12 years of age, the percentage rises from 5% in 2005 to 6% in 2006 and 18% in 2007.

In the month of July 2007 alone, 80 of the patients seen were under 19 years of age, accounting for 70% of the total patients.

**Table 5 – Type of aggressor/Age of the victim**

	0-9	10-19	20-29	30-39	40+	Total
Known civilian	69	141	47	17	14	288
Unknown civilian	7	104	88	46	48	293
Known armed man	3	40	24	3	6	76
Unknown armed man	3	576	686	382	326	1,973
Don't know	4	22	15	16	8	65
Total	86	883	860	464	402	2,695

Some acts of violence are committed by minors, prompting fears that these phenomena are spreading to all age groups of the population.

**Below is the account of the mother of a child aged 20 months, who was sexually assaulted by a minor during summer 2006:**

*"When I got back from the bush, where I'd been collecting firewood, I found that my little girl Marie wasn't in the house. As her big sister was there, I asked her to look for Marie. My daughter and I went to a neighbour's house where we found the aunt of the little boy who apparently abused my little girl, but she didn't know which way Marie had gone either. When I got near to an area with a lot of grass, I started calling her name; she went silent, but before that I had heard her crying. When I went into the grass, I realised what was going on: the 7-year-old boy was lying on top of my little girl. I called my daughter's name again, and that's when the boy saw me and ran off. His name is X. I shouted that I knew who he was and that he would have some explaining to do. (...) When I got back home (...) we examined my daughter together, and found several scratches on her thighs and legs, as well as some whitish discharge. That evening, I told my husband what had happened. Before Marie went to sleep, she screamed when she was urinating. When the boy's parents arrived, we explained the facts to them, but the boy's mum didn't understand the situation.*

<sup>11</sup> Known and unknown armed men are defined as belonging to an armed faction or the regular Congolese army.

<sup>12</sup> Indicates that the patient knows the armed man personally, rather than identifying the aggressor as belonging to a specific armed group.

<sup>13</sup> Forces armées de la République Démocratique du Congo.

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*That's why we would like a medical certificate, so we can take him to court. That's the third time he's behaved in that way."*

#### **18-year-old girl assaulted by a FARDC soldier, 2007**

*"Around two o'clock in the morning, my husband heard someone pushing against the door. As he sells petrol, he thought it was a customer, but the stranger continued to push against the door. He woke me up and we both got up to go and see; we looked through the curtains and saw that there was still someone at the door. We thought it might be bandits. He continued to push against the door, and we pushed back from inside. From outside, he pushed a knife through the door, the type that soldiers put at the end of their rifles, and said to my husband: "Today is the end of your life; you must die", shooting straight at him. A bullet hit my husband in the neck and came out of his mouth; he fell down*

*and died there and then. When he was pushing against the door, we had called out for help for a long time, but no one had dared come out. When my husband fell down, I opened the door. I saw a FARDC soldier, armed with a rifle, wearing civilian trousers and shirt. He started insulting and intimidating me. He said: "If you refuse to sleep with me, I'll kill you." He roughed me up and raped me vaginally. Once he was satisfied, he asked me for some food; I gave him some rice and saka-saka, then he left. I went and woke up the neighbours, who came out weeping. The FARDC commander also came to see what was going on. The chief had him arrested and now he's in prison in (place X). Yesterday, the military authorities of Bunia came for the inquiry, while the body was there; they sent me here to MSF for emergency treatment. My lower stomach hurts. I'm extremely worried because my husband had some money, but that man stole it all, and now I'm a widow. I want to sue him."*

#### **6-year-old child, assaulted in July 2007 by two known civilians:**

*“It was raining and I was coming back from where I had been playing. When I was nearly home, X and X (names of the attackers) grabbed me. One of them held my arms, the other my legs. They took off my knickers, then they got on top of me to do “something naughty”. I don’t feel very well (she points to her crotch).”*

**The adult accompanying her explains:**  
*“I was giving the child her bath and wanted to wash her crotch. She told me she didn’t feel very well. I asked her why she didn’t feel well (...) This morning, I checked her crotch: there was blood and a liquid coming out of her vagina.”*





# 2

## Associated forms of violence and medical treatment



### a. Individual and collective violence: the example of sexual abuse of men

Between 2% and 4% of victims of rape or sexual abuse that come to our health facilities are men or boys<sup>14</sup>. Some of these acts of violence take place during periods of detention. Patients report being forced to have sexual intercourse with female fighters or female guards, and even other prisoners. Others are raped by other men. The majority of these incidents of violence are committed publicly, in order to humiliate the victim.

The specific nature of this violence risks having a lasting impact on the whole community, as men are not spared from this type of abuse.

Finally, 184 people<sup>15</sup> were admitted to our health facilities as a result of non-sexual violence between the months of September 2005 and December 2006; 22% of them had sustained bullet injuries. These forms of violence are either a consequence of conflicts between armed groups, or are related to acts of delinquency or crime.

#### 23-year-old man

**Date of assault: 2006**

*"I was at home, selling my goods. The X soldiers turned up and went into the kiosk. They intimidated me, saying that it is we, the merchants, who make the militiamen go there. They started stealing my stock, and did the same to my neighbours. Then they set off with us, making us carry the stolen objects. They were based in (place X). When we got there, they started*

<sup>14</sup> Group 1: 7,482 patients, May 2003 - July 2007.

<sup>15</sup> Men and women.

*questioning us. We didn't know what to reply; they got angry and hit us. I've got lash marks on me. The next day, three soldiers took us to the spring to fetch water. There, they told us to wash, but we refused. They whipped us again, until we washed. They suggested sleeping with us; we refused again. They washed us again themselves, then they started raping us. One of them raped me anally twice; two of them raped my friend in the same way; then they took us back. On the third day, they went to the front and we ran away. I've been feeling anxious since that day, and I think about what happened every day; my head starts to hurt and I feel confused. The days following the assault, it hurt*

*to defecate, but that wore off. I'm also suffering from sexual impotence, though I was normal before. I'm really disturbed by what happened."*

#### **b. Acute violence and associated cruelty**

Around ten accounts given in 2006 mentioned extremely serious acts of violence, with patients reporting being forced to drink the blood of other prisoners who have been killed or cook pieces of human flesh. Although the majority of these incidents occurred some time ago – between 2003 and 2005 – the resultant trauma

<sup>16</sup> Cohort 2.

#### **19-year-old woman** **Consultation date: 2006**

*“We had fled the war in (place X) to (place Y). We had fled with my mother and my big sister, to stay with the parish priests; there were lots of people. The fighters came and invaded the parish. They were wearing military uniforms and carried rifles, machetes, knives and arrows. First of all, they killed the two priests in front of us, then some of the people who were with us. They ate their livers and hearts in front of us. My mother and sister ran away, but I was stopped by the fighters. They looted everything that was in the parish. They said that they were looking for hidden weapons. Then, with one of the priests' vehicles, they took us to (place Z), where there were several girls. They locked us in a house and there were several guards at the door. At around 4 pm, their chief started lining up the girls to rape them. I was taken by the chief. He undressed me, physically abused me and raped me, then he sent me to the others. There were lots of them... They raped me until I passed out. A few of us girls agreed to flee here, to Bunia. We ended up at the airport, where I took a plane to (place X). From there, I went to Bunia, a year ago. When I came back, my mother was dead; I now live with my big sister.”*





has led the victims to discuss them years afterwards. For example, one man was forced to have sex with a corpse, while other people were made to cover themselves with faecal matter, or even ingest it. Although these cases of abuse are only an epiphenomenon in relation to other forms of violence, their transgressive and cruel nature is emblematic of the breakdown of social relationships after years of conflict. Social norms have become considerably

weakened, permitting individuals to engage in acts of extreme violence.

**c. Unlawful detention:  
forced labour and exploiting  
people in the economy of conflict**

One patient in five reports having been unlawfully detained for anything from two days to several years. Forced labour and forced sexual



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relations are often corollaries of unlawful detention, highlighting the exploitation of civilians to drive the economy of conflict. In addition to sexual violence and other forms of trauma, many people have witnessed violence against friends and family.

### **38-year-old woman, attacked in summer 2006:**

*"My husband and I were in the field, tending the crops. At around 9 o'clock, we saw four fighters surround us.*

*They were wearing uniforms, and some of them were holding machetes or knives and others had rifles. When he saw them, my husband tried to run away, but after just a few steps, they caught him. He wanted to reason with them, but one of them just shot at him with his rifle; he died straight away. They beat me up, undressed me and wanted to kill me too, but one of them said: "Let's rape her, then she'll be my wife." All four of them raped me, then they took me to (place X) where there were several other women. They sent us to fetch water and made us prepare*

### **24-year-old man raped and detained in 2006**

<sup>66</sup> Towards the end of February, my three friends and I had set off for (place X), to sell our goods. We had already spent two days in (place X), but had not yet sold all our goods. Unfortunately for us, we suddenly saw 32 soldiers who we recognised; they were dressed in army uniforms and were holding rifles. These soldiers took us to their camp, where they mistreated us like their maids, getting us to do domestic chores. During all that time, we were watched over and guarded with weapons. Harder still, each time they took us to the spring, they asked us to wash ourselves and, after that, they raped us by anal penetration. I personally was raped by two people, always anally, and after four days I ran away. My anus hurts and when I go to the toilet, my right leg really hurts. I'm very worried, and I haven't even told my wife what happened to me. <sup>77</sup>

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*their food and wash their clothes. But in the evening, the one who said that I was his wife would come to get me and sleep with me. I had been there for two weeks when, one day, as the other women and I went to get water, I pretended to go and relieve myself in the undergrowth, and ran away to (place X). Two months after the rape, I started to get pains in my lower stomach, itching in my genital area and white discharge in my vagina. I've used lots of indigenous products, but without success; it's thanks to the woman in the village who gives advice about violence that I've come here."*

The severe economic destitution currently facing the different armed groups in Ituri leads to fears that this type of violence, which also affects men, will continue.

Patients report their difficulties in continuing a normal existence after periods of detention marked by sexual abuse and humiliating treatment. Many people underline that it is impossible for them to maintain a satisfying sex life. Signs of sexually transmitted infections among victims of sexual violence are common, and the risk of HIV infection is also high, particularly in cases of gang rape, anal rape or child rape.

### d. The medical consequences treated

The medical treatment protocol for victims of sexual violence at Bon Marché Hospital encompasses both prevention of sexually transmitted diseases (gonorrhoea, chlamydia, syphilis) and prevention of tetanus for all victims. It also includes AIDS prevention for victims attending the hospital within 72 hours of the last assault, prevention of pregnancy as a result of rape (within 5 days of the assault) and a hepatitis B vaccination (within 3 months).

**Table 6 – Number of victims receiving medical treatment**

	2005	2006	2007 (Jan. to July)
STD prophylaxis	2,291	1,809	660
HIV prophylaxis	503	416	221
Emergency contraception	351	300	149
Tetanus vaccination	2,109	2,027	654
Hepatitis B vaccination	998	1,063	418
Pregnancy from rape	n.a.	76	8

The table below shows the symptoms most frequently reported during medical consultations following sexual violence (Group 2). Each patient can give several responses and the percentage per symptom is for the whole of the group studied, i.e. 2,695 people seen at the MSF health centre between September 2005 and December 2006. A large part of this symptomatology indicates psychological disturbance and signs of sexually transmitted infections.

**Table 7**

Symptomatology	Frequency
Pains in the lower stomach, abdomen	57.4%
Disruption of the menstrual cycle: dysmenorrhoea, metrorrhagia	22.5%
Pruritus/genitals	19.7%
Lumbar pain	19.4%
Other	15.4%
Mictalgia: pain when urinating	14.5%
Worrying, feeling anxious or low	13.1%
Loss of appetite	12.1%
Generalised aches	11.8%
No response	11.0%
Insomnia	10.9%
Leucorrhoea: vaginal discharge	10.0%
Pain in the hips, pelvis	7.8%
Headache	5.8%
Pain in the genitals or anus	5.7%
Miscarriage	4.4%
Other psychological or psychosomatic disorders	22.3%

At present, there are few health facilities in Ituri that offer quality health care to carriers of the HIV virus, and it is acknowledged that the rate of seropositivity in armed groups is high, in a context in which rapes have taken place on a massive scale.

# 3

## Physical insecurity and population displacement

### a. Displaced populations in precarious situation due to destruction of property

A survey conducted by Epicentre<sup>17</sup> during late April / early May 2007 reveals that 40% of the population that was in the region before the military “peace” operation carried out from December 2006 to January 2007 in Laudjo is currently unable to return to its land.

Moreover, the military operations carried out in Irumu Territory led to the forced displacement of nearly 100,000 people from March 2006 onwards. Although some began to return to their villages in early 2007, a significant proportion of these displaced people – around 30,000 – have not yet been able to return, in spite of the apparent stabilisation of the security situation. Nearly 14% of the people seen at Bon Marché Hospital in Bunia (Group 2 ) have reported a loss of property due to theft, looting or houses being burnt down. In Laudjo, 84.7% of the population have had their houses looted, 3.3% report total destruction of their homes and nearly 11% have lost livestock.

**Table 8 – Description of damage to property, reported at the Laudjo health facility, Ituri District, DRC, 23 December 2006 - 1 May 2007 (n = 450 families)**

	Total number	Percentage
House looted	381	84.7%
House destroyed	15	3.3%
Damage to livestock	49	10.9%
No violence inflicted	5	1.1%

### b. Chronic insecurity: breaking into homes, assaults during everyday activities

Many people have reported being attacked several times between May 2003 and June 2007, by both

civilians and armed men. At present, the process of displacement put people in great danger due to residual insecurity.

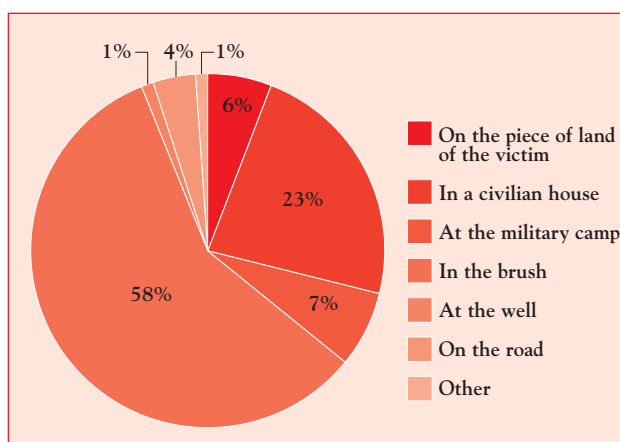
The table below provides a summary of the places where assaults took place, according to the type of assailant (Cohort 2).

**Table 9 – Place of assault/Type of assailant**

	Home	Domest. activ.	Fleeing /displ.	To/from school	Other	Don't know	Total
Known civilian	59	108	3	19	81	18	288
Unknown civilian	16	190	13	13	57	4	293
Known armed man	15	34	6	4	16	1	76
Unknown armed man	243	946	461	28	244	51	1,973
Don't know	5	37	5	2	11	5	65
Total	338	1,315	488	66	409	79	2,695

The correlation between the place of assault and the type of assailant confirms the high level of violence in the private sphere or in domestic activities, a trend which appears to be continuing in 2007. Up to and including 2007, part of the population has reported violence committed within their own homes, by armed men, reflecting a very high degree of insecurity.

**Graph 3 – Places where assaults take place**



<sup>17</sup> Retrospective mortality, violent events and basic needs at the Laudjo health facility, Ituri, Democratic Republic of Congo, December 2006 - April 2007, Francesco Grandesso, Epicentre, June 2007.

<sup>18</sup> See page 8, study of all our patients from September 2005 to December 2006.



Finally, people have reported suffering secondary attacks on the way to our care centres, where they come for medical treatment. The posting of armed men on certain main roads often leads to harassment of patients, with checkpoints becoming obstacles that must be negotiated in order to reach our health facilities.

### **c. Limited access to care**

Although there are a dozen or so health facilities currently offering medical care for victims of sexual violence, residual insecurity in the region and the poor state of the existing health facilities mean that access to care is fragmented, particularly for reconstructive surgery and psychiatric treatment.

Furthermore, the lack of social structures in Ituri makes it difficult to temporarily relocate certain patients to a safe place, particularly victims of

domestic violence. The lack of short-, medium- or long-term accommodation remains a critical problem concerning the physical and psychological protection of this type of population from subsequent violence.

In many cases, the initial assault is exacerbated by additional forms of violence, such as exclusion of the victim from the community or stigmatisation, especially when the rape occurred in public. Unfortunately, for a large number of patients, it is often preferable to keep quiet about an act which may well have severe social consequences and could lead to even greater psychological distress or complete economic destitution.

Finally, the fall in the age of the victims makes it essential to make paediatric versions of medicines, antibiotics and antiretrovirals broadly available, as soon as possible.



**19-year-old woman,  
February 2006**

“I have come because I have permanent pain in my lower stomach, especially during my periods, which I have twice a month (at intervals of 10 to 15 days), and which are extremely painful. My husband and I are not getting on well because I can no longer conceive. My husband has turned nasty. It all stems from the fact that I have been raped three times. Once was when some militiamen attacked the village. The other women and I were trying to get our children out, who were trapped there. We fell into the hands of the assailants who raped us throughout that night and the whole of the next day. On that occasion, I was raped by 14 men. The men were uniformed and armed. That was September 2002. The second time, in April 2003, I came across some members of another militia group, who had come to win back the same village. Three of them raped me. Finally, in July 2003, four soldiers from a third militia group raped me near a refugee site.”

# 4

## Pacification operations in Ituri: civilians are the first victims



Since 23 December 2006, in Djugu Territory, fighting has taken place between the Congolese armed forces and the FNI<sup>19</sup>, throughout the peace operations. Several villages have been completely looted and numerous acts of violence have been reported against civilians.

### **a. Description of violence against civilians**

There has been large-scale displacement in Ituri, with a survey conducted by Epicentre revealing that in the Laudjo region, 12,683 people have

been displaced. In April 2007, 40% of the displaced population was still unable to return home. The same study underlines that during the months of fighting, violence was the main cause of death for people over five years of age (37.5%). For children under the age of five, meanwhile, diarrhoeal diseases were the main cause of death (66%), following a typical pattern of deteriorating health conditions linked to the sudden displacement of large groups of people.

The vast majority of deaths (71.4%) and all deaths caused by violence took place in the

<sup>19</sup> Front des Nationalistes et Intégrationnistes (Nationalist and Integrationist Front).

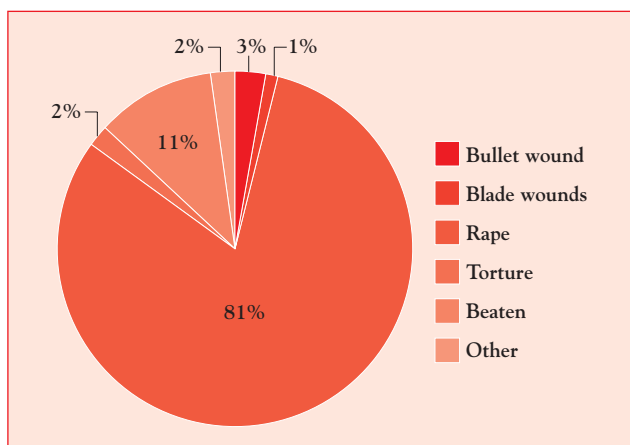
<sup>20</sup> Francesco Grandesso, Retrospective mortality, violent events and basic needs, *Ituri district, Democratic Republic of Congo, December 2006 - April 2007*, Epicentre, June 2007.

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village of origin of the populations. Violence was particularly prevalent between December 2006 and March 2007, with 4.2%<sup>21</sup> of the population reporting having been directly affected.

Once the fighting had come to an end and it was possible to access Djugu Territory, in February 2007, the civilian population began to benefit from medical assistance provided by MSF and other organisations. A permanent medical facility at the Waza site (see map on page 10) and a mobile medical team making regular visits to Laudjo provided specific treatment for victims of violence. These structures assisted a large number of victims in a very short space of time.

**Graph 4 – Nature of violence,  
Waza health facility (n=130 cases)**



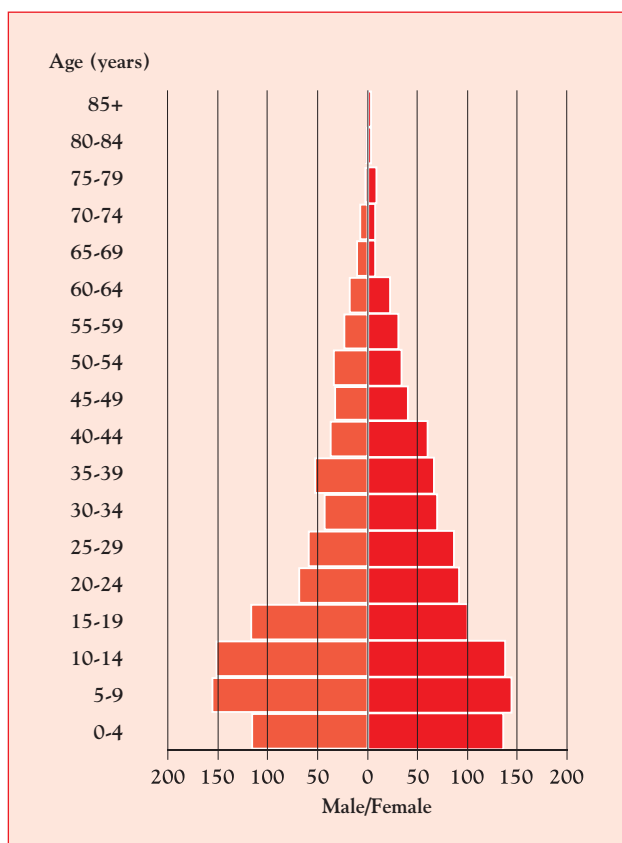
Of the 3,533 people treated by the Waza medical unit between mid-March and the end of May 2007, 130 came following a violent incident. However, in some cases, the assaults concerned had taken place prior to the recent events.

Finally, the study revealed an underrepresentation of certain age groups of the population, highlighting

the demographic impact of the violence, the loss of security experienced by some communities and the lack of access to health care.

### b. Excess mortality among children under five years of age and underrepresentation of young men

**Graph 5 – Age pyramid of the population observed  
(n = 1990), Laudjo health facility, Ituri District,  
DR Congo, April/May 2007**



In a normal demographic situation, there should be between 358 and 398 children under the age of five years in this group of 1,990 people (between 18% and 20% of the population). Graph 5 shows that there are only 252 under fives, accounting

<sup>21</sup> This percentage corresponds to 85 people from a total sample of 2,018. In 80% of cases, these people were beaten. The total population at the Laudjo site at the time of the survey was estimated at 5,900.



**Ituri, Civilians still the first victims I  
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for just 12.7% of the population, when the survey was conducted at the end of April 2007. Compared with the reference figure, a third of children under five years of age is missing.

Furthermore, graph 5 shows a marked underrepresentation of men, particularly between the ages of 30 and 44.

Although it is difficult to formulate hypotheses at this stage, this situation seems particularly worrying and illustrates the extent of the

cumulative effects of several years of conflict on the populations living in certain regions of Ituri. This excess mortality among children is either due to direct violence or the indirect effects of the war, particularly forced displacements following the conflict and the peace process, economic destitution and the lack of access to basic health care, which makes benign diseases highly fatal. Moreover, the underrepresentation of men may also contribute to perpetuating the insecurity of families, with single women often heading the household.



# Summary and conclusions



The nature and intensity of the violence experienced in Ituri and its physical, psychological and economic ramifications will have long-term repercussions, despite a significant reduction in armed clashes. MSF is also concerned about the lowering of the age of the patients attending its health facilities as the result of sexual violence and the high proportion of civilian aggressors.

With regard to the violence perpetrated by the different armed groups, it is the direct responsibility of the Congolese government and the indirect responsibility of the countries that support it to take the necessary measures to reduce the number of incidents and protect the country's citizens. Although the number of rapes committed by armed men went down in 2007, we should remain vigilant, as this drop could simply reflect a reduction in the intensity of military activity rather than an improvement in their behaviour during periods of fighting.

As far as health is concerned, it is still absolutely essential to offer the inhabitants of Ituri comprehensive, adapted medical care: now more than ever, it is crucial for all the partners working in DR Congo to remain mobilised so

that direct aid continues to reach this region. Donors must continue supporting local and national organisations working to help the victims. MSF is seeing many partners scale down or stop their activities due to a lack of funding; this considerably reduces access to care.

The treatments available must be diversified and increased both in terms of quantity and quality; access to antiretroviral drugs, particularly paediatric versions, remains a priority. Social welfare services for children and victims of violence need to be stepped up.

Stigmatizing victims has disastrous effects and considerably hampers medical care: all national and international stakeholders must take action in order to facilitate access to care and the reintegration of victims into their communities.

**To conclude, MSF would like to highlight the following priority points:**

- Violence in Ituri, particularly violence of a sexual nature, is currently a chronic problem within the society, particularly against women and children.

- Military operations linked to the pacification process generate violence that affects civilians: looting, destruction of homes and forced displacement. These forms of violence contribute to reducing the living conditions of many inhabitants of Ituri to a state of mere survival.
- The offer of health care and social services in the region must be improved and decentralised to health centres, to provide comprehensive care for victims of violence. In particular, health practitioners would benefit from receiving training in the national protocol for the treatment of victims of violence and being encouraged to implement it. Access to paediatric versions of medicines and psychosocial care is a priority.
- At the time of writing this report, 150,000 displaced people are still unable to return to their homes and risk being exposed to secondary violence. Because of their economic destitution, these people are particularly vulnerable to the risks of exploitation and attack. They are also dependent on humanitarian assistance, which remains necessary until the conditions for them to return to their villages can be established.
- It is essential for international donors to remain mobilised, to ensure continued aid, and to be attentive to the ongoing humanitarian needs of part of Ituri's population. The care needs of the many victims of the conflict require long-term action.
- Civil society, which is at the origin of many initiatives to help victims of the conflict, needs continued and increased support to develop actions to combat stigma and facilitate the reintegration of people who have been subjected to multiple incidents of violence.











MEDECINS SANS FRONTIERES  
ÄRZTE OHNE GRENZEN