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Democratic Republic of Congo



Mass rape: Time for remedies

INTRODUCTION

In the course of the armed conflict in eastern Democratic Republic of the Congo (DRC), tens of thousands of women and girls have been victims of systematic rape and sexual assault committed by combatant forces. Women and girls have been attacked in their homes, in the fields or as they go about their daily activities. Many have been raped more than once or have suffered gang rapes. In many cases, women and young girls have been taken as sex slaves by combatants. Rape of men and boys has also taken place. Rape has often been preceded or followed by the deliberate wounding, torture (including torture of sexual nature) or killing of the victim. Rapes have been committed in public and in front of family members, including children. Some women have been raped next to the corpses of family members.

The civilian population of eastern DRC has been the victim of war crimes and grave human rights violations on a daily basis. They have seen combatants from around 20 armed factions fighting for control of the land and its resources. In a context of the collapse of state authority in the east, national and international laws are no longer observed and all the armed factions have perpetrated and continue to perpetrate sexual violence with impunity. Rape has been used deliberately and strategically to attack the fundamental values of the community, to terrorize and humiliate those suspected of supporting an enemy group and to impose the supremacy of one group over another.

In addition to the trauma of rape, survivors' rights are further violated in the aftermath of the rape, deepening their suffering immeasurably. Most women suffering injuries or illnesses caused by the rape – some of them life-threatening - are denied the medical care they need. Because of prejudice, many women are abandoned by their husbands and excluded by their communities, condemning them and their children to extreme poverty. Because of an incapacitated judicial system, there is no justice or redress for the crimes they have endured. Continuing insecurity means that women live in fear of further attacks or reprisals if they speak out against the perpetrators.

This report is a result of research conducted over a year, including through interviews in the DRC with survivors of rape, with local human rights activists, local and international humanitarian organizations, and government and armed group representatives. The interviews were carried out in February and March 2004 in locations in Maniema and North- and South-Kivu provinces, and in May and June 2004 in the Ituri district of Orientale province and the capital, Kinshasa. Survivors of rape were interviewed individually and confidentially. In all cases, Amnesty International has taken measures to protect the identities of the people whose testimonies appear in this report.

Amnesty International (AI) is grateful to the survivors who agreed with great courage to tell their stories, and to the Congolese women's and human rights activists who made this possible. The same degree of courage is demonstrated by the women's daily resolve to challenge the social stigma and exclusion surrounding rape, and by their efforts to demand appropriate medical care for their injuries and justice for the crimes committed against them. But their courage and determination is also matched by despair, because their outspokenness has yet to bring them any significant relief from their suffering.

This report focuses particularly on one of the rape survivors' most pressing needs: access to adequate medical care. In the DRC, a country where millions of civilians are suffering and dying of the injuries and traumas of many years of conflict, the health care infrastructure, already severely under-resourced, has broken down completely in many areas and is unable to offer even the most basic treatment. Across eastern DRC, there is a clear lack of trained doctors, including gynaecologists, obstetricians and other medical personnel. The system of charging for consultations and treatment puts also health care beyond the means of most Congolese.

A new power-sharing government took office in the DRC in July 2003, with considerable international political and financial support. However, the government has so far made little effort to address the suffering of a civilian population traumatized and debilitated by years of warfare, or to advance their human, social and economic rights. The transitional government and international community cannot quickly and comprehensively remedy the immense destruction wrought on the health infrastructure in the east since 1998, but significant progress in this long-term process is now overdue, and both the transitional government and the international donor community should respond to the urgent medical need in the east and the rehabilitation of the health care system as a priority.

AI is urging the DRC government and the international community to implement key measures to facilitate access to medical care for rape survivors and ensure that the rehabilitation of the health care system in the DRC is a priority. Therefore, as an immediate measure, a coordinated emergency medical program in the east for victims of sexual violence must be established. The longer-term restoration of the state health care system should also become a priority and an expert assessment mission should be organised to evaluate the state and needs of the DRC's national health care system and recommend priority areas for its rehabilitation in order to improve its capacity to respond to the medical needs of rape survivors and the Congolese population.

It is also urgent that the other needs of the rape survivors are addressed. The DRC government must take its responsibility in preventing, punishing and eradicating sexual violence, and demonstrate that such behaviour is not tolerated. A coordinated national and international effort to improve security in the east is a priority, including by reinforcing the UN peacekeeping presence in the east and deploying its units to protect women in areas where they are most vulnerable to attack, and by unblocking the stalled national disarmament, demobilization and reintegration (DDR) process. Only by disarming and dispersing the combatant groups, and by introducing integrated, properly trained and accountable government army and police forces, can the Congolese hope to see a significant reduction in the scale of human rights abuses in the east.

The government must also take measures to prevent survivors from being subjected to social and economical exclusion, and facilitate their search for Justice. While many perpetrators of rape remain unidentified, a number are known and many continue to live in the same communities as their victims. The national authorities should take action to ensure that these alleged perpetrators are brought to justice and that the barriers preventing women from lodging judicial complaints against their attackers are removed. Local non-governmental organizations caring for survivors of sexual violence must be supported and protected in their work, and their experience and dedication should be built on in developing national strategies to the rape crisis.

I BACKGROUND: NEITHER WAR NOR PEACE

1. The transitional government: slow progress

In late 2002 and early 2003 a series of international and national peace agreements brought an official end to the wars that have raged in the DRC since August 1996. The agreements provided for the withdrawal of Rwandese and Ugandan government forces from the DRC and the inclusion in a new power-sharing government of most of the Congolese belligerent forces and political parties. This new government took office in July 2003, with the task of leading the country through a transitional period to a situation of stability and national unity that will culminate in national elections, planned for 2005.

The transition is to a large extent sustained by international support and pressure to make it work. This role is exercised inside the country mainly by the United Nations Mission in the DRC, known by its French acronym, MONUC, (*Mission de l'Organisation des Nations Unies en République Démocratique du Congo*), and the International Committee in Support of the Transition, known as CIAT, which brings together the UN Secretary-General's Special Representative for the DRC and the diplomatic representatives of key donor states. MONUC, with around 10,700 personnel, provides a range of services in support of the transition, but its main strength is devoted to peacekeeping operations in eastern DRC. This strength is still woefully insufficient given the size of the country and the complexity of the problems it faces. In the Ituri district and Kivu provinces of eastern DRC, MONUC operates under a Chapter VII mandate, which authorizes peacekeepers to use armed force to protect civilian life.

Without international efforts to keep it going, it is questionable whether the transition would have survived this far. Beset by factionalism and external challenges, the transitional government has failed to make significant progress on issues of fundamental importance to the future stability of the country. Political procrastination and deliberate obstruction are delaying reforms and the efficient functioning of state institutions. This situation is deepening and prolonging the plight of thousands of women and girl victims of rape, who continue to pay the price with their health and dignity.

As the 18-month mark of the transitional government approaches, many major reforms essential to the future stability of the country have barely begun or not begun at all. These include the demobilization of combatants and formation of a new national army (see below), bringing to justice perpetrators of human rights abuses and addressing the urgent needs of the victims, reconciling divided communities, and commencing the reconstruction of the healthcare, educational and justice systems, particularly in the devastated eastern provinces. Laws on a range of issues, including vital and sensitive ones on nationality and the constitutional referendum, have not yet been passed.

Although security has improved locally in some areas, there remains an underlying pattern of instability and sporadic conflict which threatens perennially to reignite into a new war. This is especially so in the east, which by and large remains under the control of different armed groups and militia, some of which have only passing, if any, allegiance to central government. While some locations in the east have recently opened up to international humanitarian operations, others remain or have become newly inaccessible. Rwandan and to a lesser extent Burundian and Ugandan insurgent groups continue to operate in the east of the country. Their presence in the DRC continues to be a source of tension between the states of the region.

Kinshasa, the seat of power for the transition, has seen two apparent coup attempts in the first six months of 2004. Beyond the doubt surrounding their authenticity and true intent, these two incidents have relaunched the debate on the fate of the ex-officers of former President Mobutu who were excluded from the transition and, above all, on the privileged status of the Special Presidential Security Guard (GSSP) in the army and national security structures.¹

In part the political inertia and continuing instability is due to the cumbersome structure of the new government. The result of a Congo-style compromise, the government is led by a president and four vice-presidents (the "1+4 formula"), each of whom heads a political commission into which the government's 36 ministries (distributed between several political parties and "former"² armed groups) are organized. This arrangement is increasingly revealing its limitations, particularly with regard to the functioning of the executive.

Another major brake on progress is the apparent reluctance of some political and military leaders to accept that the benefits of peace and national unity outweigh what they believe might yet be achieved through military victory. This attitude has been encouraged, to an extent, by the neighbouring states of Uganda and Rwanda. Both have continued to support armed political groups or militia in the east of the country, in violation of peace agreements.

All these issues represent deep fault lines running beneath the transition. Unless they can be resolved, they unquestionably carry the seeds of future armed conflict. And the longer the country remains destabilized, the more the conditions of insecurity which favour a return to widespread violence predominate. In the meantime, in a space which is neither war nor peace, the civilian population remains prey to horrifying violence and the daily denial of their basic human rights.

2. Disarmament and demobilization: a stalled process

The disarmament, demobilization and reintegration (DDR) into civilian life of combatants and the formation of a new national army, which will include components of all the major Congolese belligerent forces, should be among the major priorities of the new government and of the international community. It is estimated that up to 200,000 combatants will require demobilization, while the new army will total around 80,000 to 100,000 soldiers.

¹ The first attempted coup d'état was attributed to Mbutist officers of the former *Forces armées zairoises* (FAZ), Zairian Armed Forces, who had fled to neighbouring Congo-Brazzaville at the time of Mobutu's fall in 1997. These soldiers – believed to number around 3,000 – have been excluded from considerations on the reform of the army. They constitute a force which could prove an asset or a threat to the transition. The second attempted coup d'état was reportedly the work of an officer of the GSSP, Major Eric Lenge.

² "Former" being their formal designation since entering the transitional process, although in reality the armed groups have maintained and even reinforced their military capability, pending integration into a new national army.

These twin processes are essential to bringing security to the DRC. The national DDR programme is backed by the World Bank and other international institutions. However, progress has been painfully slow. The government has appointed military commanders drawn from the different forces, to the country's 10 military regions, and a national DDR planning and coordination body has been established, but the merger of the different military forces has not taken place and no coordinated demobilization has begun³.

As a consequence, the armed groups have retained control over their combatants, and still control large areas that in reality escape the authority of central government. Their combatants in many cases respect only their former chains of command, rejecting the authority of senior officers appointed by the government. This impasse is tightening the screw of insecurity in the east, where tensions between the different forces remain palpable. In many locations parallel civil and political administrations exist: one bearing allegiance to the central government, the other to the armed group locally in control. In these circumstances, the capacity of the armed groups for disruption and criminal behaviour is undiminished. All armed groups are still recruiting and using children as combatants, and all continue to commit rapes and other forms of sexual violence with impunity.

Moreover, there is no clearly-defined plan for the demobilization of unofficial forces and militia in the east. So-called "Local Defence Forces" maintained by the governor of North-Kivu province, Eugène Serufuli Ngayabaseka, for example, is believed to regroup thousands of combatants, including many children. These forces, which have also committed numerous human rights abuses, pose a serious threat to the civilian population and will continue to do so, even if the DDR and integration of other forces finally do take place.

The demobilization and repatriation of foreign insurgents in eastern DRC, which is overseen by MONUC, has seen somewhat greater progress, although this programme relies on voluntary disarmament and results have therefore been piecemeal and localised. Thousands of such combatants, notably from Rwanda but also from Burundi and Uganda, remain on DRC soil. These groups, too, continue to commit atrocities including killings and rapes.

3. The situation in the east: chronic insecurity and desperate humanitarian need

The civilian population of eastern DRC has borne the brunt of the human rights and humanitarian catastrophe unleashed by the war. It is estimated that since 1998, more than three million Congolese have died through direct violence or from preventable diseases and starvation brought about by the insecurity, displacement and lack of access to humanitarian or medical care⁴. Worst affected are the provinces of North-Kivu, South-Kivu and Maniema and large parts of the provinces of Orientale (notably the Ituri district), Kasai Oriental and Katanga. In these areas, the people have suffered unlawful killings, rape, torture, arbitrary arrests, forced displacement, arson and looting by armed groups on a routine basis. Agricultural land in many areas has been laid waste or ransacked by combatants, deepening food insecurity. In many localities hospitals, health centres and schools have been destroyed or looted.

Despite the official end to the war and the inauguration of the transitional government, the humanitarian needs in these provinces have been increasing. Throughout large areas of the east people are lacking even the most

³ Another version of the DDR process, known as the Disarmament and Community Reinsertion (DCR) programme, is designed to meet the specific needs of Ituri district. It will involve around 15,000 combatants, including 6,200 children. It was officially launched on 1 September 2004. When AI delegates visited the region in June 2004, combatants and militias encountered by AI knew little or nothing of the programme and its objectives. As elsewhere in the country, the delay in getting operations off the ground exposes the Ituri region to new security threats.

⁴ International Rescue Committee report, *Mortality in the DRC: Results from a nationwide survey*, conducted from September-November 2002, published in April 2003.

basic services for health and food security. By August 2003, the UN estimated that 3.4 million Congolese were internally displaced as a result of armed conflict, the majority in eastern DRC. A large proportion of this displaced population was – and remains – cut off from humanitarian aid, through a combination of insecurity, inaccessible terrain and dilapidated roads. While many state health facilities have been able to reopen, they often lack basic infrastructure such as doors, windows and furniture, as well as essential medical equipment.

The human cost of this situation is shocking. It is estimated that fewer than 30 per cent of Congolese have access to even basic health care. The countrywide malnutrition rate is around 16 per cent, rising to up to 30 per cent in areas of the east, with 13 per cent classed as severe malnutrition. It is believed that over one million children aged under five suffer from acute malnutrition, and that one in every five Congolese children do not live to see their fifth birthday⁵.

This situation often worsens towards the interior of the country. Maniema, for example, far from the national borders and of limited strategic importance, was largely cut off from the rest of the country during the armed conflict and experienced extreme privation. Only now is an accurate picture of the suffering in that province beginning to emerge, although much of the province has yet to be accessed by humanitarian agencies. In May 2004 the UN Office for the Coordination of Humanitarian Affairs (OCHA) estimated that at least 1.5 million people in the province were starving and suffering from endemic diseases, and that aid granted to the displaced population in the province was "insignificant".⁶

Continuing armed conflict and insecurity

Although the levels of conflict in eastern DRC have diminished since the signing of the peace agreements, violence has continued. In many areas the violence is now sporadic and localised, but in other cases has been more extensive and threatened to reignite widespread armed conflict in the east. The most serious episode to date was triggered in early June 2004 when dissident RCD-Goma⁷ forces, opposed to the transitional government, took control of the strategic city of Bukavu, the capital of South-Kivu province, on the border with Rwanda. More than 100 civilians were unlawfully killed in the ensuing days, and many rapes were reportedly committed by the renegade forces (see for example the testimony of Edith, p.23). Government loyalist force retook the city within a few days, but the larger part of the dissident RCD-Goma force remained intact and continues to destabilise the region.

The dissidents claimed to be acting in defence of the minority Congolese Tutsi population (from which ethnic group most RCD-Goma political and military leaders originate), and ethnic divisions in the region have since become more inflamed. On 13 August 2004, more than 150 Congolese Tutsi refugees, mainly women and children, were massacred in a refugee camp in Gatumba, Burundi, close to the DRC border, by combatants that had reportedly crossed over from the DRC. A Burundian armed group, the FNL, claimed responsibility for the atrocity, although the Rwandan and Burundian governments alleged that Congolese and Rwandan armed groups based in DRC were also involved.

Relations between the DRC and Rwandan governments deteriorated sharply in the wake of the June 2004 crisis. Rwanda has threatened to re-enter the DRC in force to protect Congolese Tutsi and eliminate the Rwandan FDLR insurgent group. Serious divisions within the RCD-Goma and between the RCD-Goma and the rest of the

⁵ DRC UN Consolidated Appeal 2004, UN OCHA, November 2003

⁶ IRIN 18 May 2004: "DRC: Maniema residents in need of extensive humanitarian aid, OCHA says"

⁷ For this and other acronyms, please consult the glossary.

transitional government (of which it forms a major part) also appeared, to the point where in the days following the Gatumba massacre the RCD-Goma temporarily suspended its involvement in the transitional government.

In Ituri, where the armed conflict took a profoundly ethnic dimension, about 10 different armed groups are active, none of which are professionally structured or coordinated, and most of which have been formed on ethnic bases. None of the armed groups is involved in the transition process, a fact that has aggravated insecurity. Since December 2003, these armed groups have also suffered internal crises which have led to the implosion of the most influential of them, notably the UPC and, to a lesser extent, the FNI. As a result an increasingly brutal intra-communal rivalry has now been added to the inter-ethnic clashes with which people had previously become familiar.

Following mass killings in the district in May 2003, a sizeable MONUC Ituri brigade has been stationed in the major town in the region, Bunia, and has progressively deployed to other areas of Ituri. Although this MONUC brigade has succeeded in introducing greater calm and stability in the district, it still struggles to contain the violence, which continues sporadically. The last phase of MONUC's anticipated deployment, in Aru and Mongbwalu, which will represent a decisive step for pacification and political settlement in the region, still remains to be fully implemented.

Deep uncertainty surrounds the future in Ituri. In May 2004, the transitional government made the leaders of armed groups in Ituri sign a document undertaking to make a positive contribution to the implementation and success of DRC. But one month after this undertaking had been signed, the leader of one of the most influential armed groups in Ituri denounced it despite having signed it, saying *"this is not the first document, nor will it be the last. What counts is its applicability. We would like to point out that the document was imposed on those who signed it, but peace can never be imposed."*⁸

The uncontrolled flow of arms

Much of the violence in eastern DRC is underpinned by the widespread availability of small arms. Despite the imposition of a UN arms embargo on the Kivus and Ituri in July 2003, it is believed that new supplies continue to reach the region. The UN appointed a group of technical experts to monitor states' compliance with the embargo. In July 2004 the Group of experts' report revealed that direct and indirect assistance, which included the supply of arms and ammunition, was still being provided to armed groups operating in Ituri, the Kivu provinces and other parts of the DRC by neighbouring countries and from within the DRC. The report concluded that "This on-going assistance... continues to threaten the fragility of the TG [Transitional Government] and, if unchecked, could lend itself to renewed outbreak of hostilities and further jeopardize regional stability."⁹ In particular, the report accused the Government of Rwanda of directly aiding the May/June 2004 insurrection by renegade RCD-Goma forces in the Kivus, and that Rwanda also exerted "a degree of command and control" over these forces.

II "LIMITLESS DEMANDS": THE LOT OF WOMEN IN CONGOLESE SOCIETY

⁸ AI interview with Floribert Njabu, President of the FNI/FRPI, July 2004, published in "La Colombe" newspaper May-June 2004. FNI/FRPI as a group, has signed the engagement act. However, Njabu him-self was not in Kinshasa for the ceremony. He was represented by his deputy and his chief of staff.

⁹ Report of the Group of Experts on the Democratic Republic of Congo. UN Document S/2004/551, 15 July 2004.

"When you lift the stone of sexual violence, you will find another stone of the treatment of women more generally, which is effectively slavery. Women do everything: they walk miles for food or water, they care for the children, they cook, they clean, they cultivate the land and they earn the family income... That is the female condition in the Congo. If it is to change, the women themselves need first to conceive of change and then demand it."

-- Expatriate woman psychologist working in DRC, interviewed by AI

There is a direct link between discrimination practised against women in general and the exacerbated violence inflicted on women in times of war. The fact that women in the DRC are considered to be second-class citizens is closely related to the violence inflicted on them and to the discriminatory absence of appropriate measures on the part of the State to combat such violence.

Before the war, women suffered economic, social, cultural and political discrimination. The situation for women has deteriorated since the start of the armed conflict. Widows or rape survivors fare even worse than the rest of the female population. According to one Congolese activist, "in some traditions, for example, women who have lost their husbands are, as widows, considered to be the property of the husband's family. In this way, they often become victims of sexual violence from members of his family."

The law

The legal system discriminates against women on different levels. For example, under Article 448 of the Family Code (*Code de la famille*), while unmarried women over the age of 18 are treated as equal before the law, a married woman who wishes to take a case to court must first ask her husband's permission¹⁰.

The law criminalizing consensual sex out-side marriage, termed as adultery, is also applied differently to husband and wife. Article 467 sub-section 4 of the Family Code lays down a term of imprisonment of six months to a year and a fine for a married women committing adultery. A husband, however, will only face the same punishment if behaviour covered by this law is found to be of an "offensive character" (*caractère injurieux*) (Article 467, paragraph 2).

Article 352 of the same Code provides for different ages of marriage for men and women: women/girls need only be aged 15 or over, men have to be aged 18 or above. Given the very high number of forced marriages, human rights organizations are campaigning for the law to be changed in favour of an equal age of marriage for both sexes.

According to article 490 paragraph 2 of the Family Code, whatever the marriage settlement, the management of the wealth is entrusted to the husband.

These are among examples of a number of discriminatory provisions in Congolese legislation. Congolese human rights organizations have been campaigning since 2002 for reform of the discriminatory articles of the Family Code. The NGOs produced a model draft law, which they submitted to the Commission for Reform of Congolese law (*Commission de reform de droit congolais*) for consideration. The Commission, however, appears to have made no progress in taking reform of this law forward.

¹⁰ Similarly, until October 2002, when the Labour Law (*Code du travail*) was amended, women had to ask their husband's permission before applying for a job.

Custom

In many areas of the DRC, custom predominates in gender relations, even when this is in contradiction to national law. Many Congolese women do not know of the rights and protections available under the law. Throughout the country, many marriages are not registered and therefore wives cannot claim the rights in the Family Code. This is compounded by years of armed conflict in the east, which has seen the disappearance or many civil and judicial structures and further eroded standards of protection for women.

Customary law varies among the multitude of ethnic groups in DRC, but it is generally highly discriminatory towards women. Customs on inheritance and property ownership mean that women often cannot inherit anything from their husbands. They are often not permitted to own property or the land they cultivate, independently of men, which puts them in a situation of dependence on their male relatives and in-laws. In many traditions, women are considered as little more than "possessions" of a man, to be exchanged for a dowry or summarily divorced, which affects her status and economic self-sufficiency in society. Cultural discrimination also goes as far as restricting women's decision-making power and therefore their choices in matters of sexuality and family planning. For example, many Congolese women are expected to seek their husband's permission to obtain contraception.

In Congolese society, where virginity is considered essential for any young woman about to marry and a fundamental quality in a girl of marriageable age, rape and infertility are likely to limit a young woman's options for the future. A young unmarried girl who has been raped will find it difficult to find a husband. The victim's family may feel ashamed, or may be concerned that they will not receive the dowry and material possessions a marriage is expected to bring to the family. According to a Congolese activist, "sexual violence and rape used to be taboo, and virginity and respect for women were values that were highly respected. This stems from the fact that in certain traditions, at the time of marriage, the woman's virginity was a means of obtaining the maximum dowry for the girl's family."

The level of literacy among women is considerably lower than among men. Congolese culture encourages women to stay at home to look after the family and their access to education is very limited. This is demonstrated by the very high level of illiteracy among women, which is estimated at 46 per cent compared to only 17.5 per cent among men.¹¹ On average, 44 per cent of women (as opposed to 22 per cent of men) have "no income and are therefore incapable of accessing the opportunities they need".¹² Given that education is not free of charge, many families give priority to sending boys to school. According to UNIFEM, of 12 million children of school age in the DRC, more than 6 million do not go to school, 75 per cent complete their basic education and only 19 per cent of girls have access to secondary education.¹³

Political representation

Women are extremely underrepresented in leadership positions, in particular. Despite the fact that women account for a very high percentage of the victims of war, that the socio-economic consequences of the conflict rest on their shoulders and that their efforts for the protection of human rights and reconciliation make them essential players in the reconstruction of the country, very few women were present at the peace negotiations or in the Inter-Congolese Dialogue, a forum which underpinned peace negotiations and whose role was to help

¹¹ United Nations Population Fund: Recommendations by the Executive Director-Assistance to the Government of the DRC, DP/FPA/COD/2, 26 November 2001.

¹² Interim Poverty Reduction Strategy Paper and Joint IDA-IMF staff assessment, Report No. 24216, May 2002.

¹³ Progress on the World's Women 2002, volume 1, "Women War Peace", The Independent Experts' Assessment on the Impact of Armed Conflict on Women and Women's role in Peace-building, Elisabeth Rehn and Ellen Johnson Sirleaf, 2002.

define the country's future. Today, women head six of the transitional government's 36 ministries, with only two women Vice-Ministers and only three women among the 120 members of the Senate.

In 2000, the Human Rights Committee called on the DRC to "take the necessary steps to increase women's participation, without discrimination, in political and social life, in accordance with article 3 of the Covenant".¹⁴ UN Resolution 1325 (2000) addresses gender issues in situations of armed conflict and post-conflict as well as the participation of women. It includes, *inter alia*, a requirement on all actors to involve women in all the implementation mechanisms of peace agreements and to "ensure the protection of and respect for human rights of women and girls, particularly as they relate to the constitution, the electoral system, the police and the judiciary" (paragraph 8(c)).

The failure to comprehensively include women in national post-conflict planning and peace-building is even more unjustifiable given the considerable strength of women's civil society organizations and collectives in DRC. Women have organized themselves politically to demand greater participation in the transition process, and have cooperated in an extraordinary manner to protect human rights and provide care for victims. Today, women's organizations and a handful of male human rights activists are almost alone in campaigning and providing effective care for the victims of sexual violence at the local level, and to date they provide almost the entire indigenous Congolese response to the rape crisis in eastern DRC. Their successes, which are described in Chapter VII of this report, have been accomplished without support from the DRC government or international community.

III RAPE: A WEAPON OF WAR

"In peacetime, the demands on Congolese women are limitless; but in this war, the most insane fantasies have found their expression. When seven soldiers rape a woman or little girl, and thrust a knife or fire shots into her vagina, for them the woman is no longer a human being, she is an object. And since there are no longer any laws or rules, combatants pour out their anger and their madness on to women and little girls."

- Congolese doctor in eastern DRC specialising in the treatment of rape victims

1. The scale of the rape crisis in eastern DRC

The victims of sexual violence committed in the course of the DRC armed conflict are believed to number tens of thousands. Establishing exact figures, however, is difficult. The lack of security in many regions, the inaccessibility of some locations and the physical or material inability of some victims to travel, make it very difficult to obtain clear data. Some regions of the country are not covered by humanitarian agencies or national and international NGOs, and cases of sexual violence in such places have not been documented. Fear of reprisals by the perpetrators and the risk of being rejected by their families or stigmatized by the community also frequently prevent victims from coming forward. Survivors who seek medical assistance may present themselves for treatment days, months or even years after the rape, making it difficult to establish the current reality.

In conversation with AI delegates, experienced UN and international humanitarian NGO staff were unanimous that they had never come across as many victims of rape in a conflict situation as they had in DRC. They were unanimous, too, in believing that many more victims are still to be identified. Around 40,000 cases have been

¹⁴ UN Doc. CCPR/C/79/Add.118, 27 March 2000.

reported by the joint initiative to combat sexual violence against women and children¹⁵, that is to say, 25,000 cases in South-Kivu, 11,350 cases in Maniema, 1,625 cases in Goma, the capital of North-Kivu, and 3,250 cases in Kalemie, Katanga province¹⁶. These figures are only partial and represent only those women who have been able to seek assistance. It can be assumed that the actual number of victims suffering the consequences of rape is much higher than these estimates.

One aspect of the prevalence of rape by combatants in eastern DRC is the high number of women who have been raped more than once, at different times, by different forces. **Odile**, from the Mahagi region of Ituri, for example, was raped first in April 2003 by an RCD-ML soldier, again in June 2003 by two members of the UPC, and finally in September 2003 by another combatant from an unidentified force. She was pregnant from this last rape, she said, when interviewed by AI. The last rape occurred as she was making her way back to her home village after being thrown out by her husband because of the second rape. Unable to work fully because of health problems following the rapes, already responsible for the care of two children, and entirely dependent on a cousin for her food and lodging, she was deeply worried her children's future and her own.

2. The perpetrators

All the armed forces involved in the DRC conflict have committed rape and sexual violence, including government armed forces of DRC, Rwanda, Burundi and Uganda. In Ituri in June 2004, for example, AI met **Yvonne**, a 17-year-old who was abducted along with nine other girls by Ugandan government soldiers while they were collecting water from a spring near Bunia in early 2003. The girls pleaded to be released, but were taken to a military camp where they were kept forcibly as "wives" by the soldiers. Yvonne was held for four months before escaping with another girl. She now has a one-year-old girl who she says was born from one of the rapes she suffered in the camp.

However, most allegations of sexual violence centre on the host of less well-controlled and disciplined armed groups in DRC. These include notably, but not exclusively, the Congolese *mayi-mayi*, RCD-Goma, MLC, RCD-ML, UPC, FNI and FAPC armed groups, and the Rwandan FDLR and Burundian FDD or FNL armed groups¹⁷. The MLC is also accused of committing widespread and systematic rape in the Central African Republic (CAR) during a military incursion in late 2002. These allegations will be the subject of a forthcoming Amnesty International report on the CAR.

The victims' identification of their attackers sometimes needs to be treated with considerable caution. Due to fear of reprisals, many survivors refuse to identify correctly the armed group to which their attackers belong, particularly when this armed group still controls the territory in which they live. Some identifications are based on the language reportedly spoken by the rapist, which itself can be wrongly identified or can be misleading, since many combatants speak more than one language. Moreover, many Congolese use "Rwandan" to mean RCD-Goma forces or anyone they consider to be of Congolese Tutsi or rwandophone origin, and "FDD" is commonly applied to all Burundian combatants, including combatants from another Burundian armed group active in eastern DRC, the FNL. For this reason we have substituted "FDD" with "Burundian insurgent group" in

¹⁵ *Sexual violence against women and children in DRC: a joint initiative with a view to prevention and to meet the needs of victims*, Kinshasa, November 2003. This "joint initiative" comprises a number of international non-governmental organizations and UN agencies in DRC involved in work on sexual violence and with rape survivors in eastern DRC. In November 2003 the joint initiative submitted a proposal – in effect a draft national plan of action – to halt sexual violence in the east and respond to the needs of survivors, based on a series of interlinked projects during a period of two years. The proposal is currently before UN senior officials and other bilateral and multilateral partners to the DRC.

¹⁶ Recorded cases have been registered by national and international NGOs and UN agencies.

¹⁷ See glossary of acronyms for further descriptions of these groups.

the testimonies below and have used the word "reportedly" or "allegedly" in connection with most other identifications.

3. Sexual violence in armed conflict: motivating factors

Combatants in DRC may have many different and sometimes overlapping motivating reasons for committing sexual violence. One common element, however, is that rapes take place because the forces committing them can do so with almost absolute impunity. Rapists only rarely face any legal or disciplinary repercussions. Many combatants appear to regard rape as a "spoil" of war. Sexual violence is also commonly accompanied by the systematic destruction of the victims' economic means of livelihood by looting of property and setting fire to homes.

Superstition and fetishism is a further motivation of some combatants, many of whom reportedly believe that having sexual relations with a pre-pubescent child or a post-menopausal woman will make them immune from disease, including HIV/AIDS, or will cure them if they already have HIV, and will be protected from injury or death during combat, or will be strengthened in other ways. **Sange** is a former child combatant who enlisted with the *mayi-mayi* at age 10 but was later captured and incorporated into the RCD-Goma forces. She told AI that: *"At night the other soldiers raped me. They came almost every night. They said that the more they raped me, the more they would be men, and the higher up the ranks they would rise."*

However, beyond individual motivation, rape appears frequently to have been used as a deliberate strategy of warfare in the DRC, perpetrated in some cases at least with the encouragement or at the behest of commanding officers¹⁸. Armed groups have sought through sexual violence to destabilise the forces opposing them by terrorizing and humiliating the men, women and children of the community from which they believe their adversaries originate. Rape is also used by way of reprisal against individuals, families or communities. This has on occasion led to armed groups committing abuses against and raping members of their own community. The rapists have also sought to attack the fundamental values and social fabric of the community, principally through maximizing the humiliation and debasement of the victim and witnesses. Many cases feature the rapes of mother and daughters in front of their family, of mass rapes, rapes in public, or forcing victims to have sex with family members. Almost unbelievable brutality or cruelty often accompanies the rapes.

Sexual violence has a clear ethnic dimension in some cases and areas of DRC, with combatants purposefully singling out their victims from among an "opposing" ethnic group. This is especially so in the Ituri, where inter-ethnic violence extends also to sexual violence, and where numerous women have been targeted for rape solely because they are of Hema, Lendu or other ethnicity. In the Kivus, too, a number of rapes may be attributable to ethnic divisions. A number of abuses, including rapes, committed by dissident RCD-Goma forces in Bukavu in early June 2004, for example, were reportedly accompanied by statements in which rapists said they were avenging perceived abuses committed against Congolese Tutsi civilians. Government loyalist forces also reportedly committed rapes of Banyamulenge woman, apparently in reprisal, when they retook control of the city.

Rapes are known to have been ordered by military commanders or others in positions of authority in the armed factions, sometimes at gunpoint. According to a 15-year-old child soldier, **Albert**, recruited by the RCD-Goma:

¹⁸ It has also been widely alleged, although without clear evidence, that some commanders have deliberately ordered soldiers they know to be infected with HIV to attempt to infect civilians through rape.

After capturing a village what happened is that they would give us chanvre [cannabis] and force us to kill people to toughen us up. Sometimes they brought us women and girls to rape. The commanding officers didn't justify why they did that. Every time they captured somewhere, they would get the kadogos [child soldiers] to do these things in front of the adult soldiers, as if it was a show, in order to humiliate the people of the village. The scene held no interest for us, but they would beat us if we refused. The unlucky ones were shot and would die – they killed kadogos like that when they refused to obey.

Combatants also commit rape to secure control, through fear and intimidation, over the population of the territory they want to occupy, with the ultimate aim of gaining access or maintaining control over territories that are rich in natural resources such as diamonds, gold and coltan. For example, troops belonging to the FAPC and the FNI had jointly controlled the goldmines at Mongbwalu in Ituri. However, this joint "management agreement" broke down at the beginning of 2004, giving rise to violent fighting between the two forces for control of the most lucrative mines. During the fighting, which lasted several days, all forces committed serious human rights abuses. Houses were burned down and looted and many women and girls were raped. **Selina**, a young girl of 12, was raped by a group of FNI soldiers as she fled the fighting in search of refuge. While she was being attacked, she lost track of six of her friends and two of her sisters who had been with her. She found her sisters, **Lara** and **Valerie**, 13 and 14 respectively, three days later in a nearby village. Both had been raped, allegedly by FAPC soldiers: her other friends are missing. Selina has pain in her lower abdomen and has never been seen by a doctor.

4. Allegations of sexual violence by MONUC personnel

MONUC personnel have also been accused of sexual abuse and exploitation. In May 2004, serious allegations of sexual exploitation of women and girls by civilian and military MONUC personnel in Bunia, Ituri were made public. The allegations included instances of rape and prostitution of minors. The victims were mainly women and girls at camps for internally displaced persons. MONUC launched an investigation into these abuses, followed by an investigation by the UN Office of Internal Oversight Services, which in September 2004 had yet to finalize its report.

The Head of MONUC in Bunia was quoted as saying that "there is a kind of impunity here that we have to end"¹⁹. In fact, the UN personnel are not subject in principle to criminal jurisdiction in the host country. Civilian personnel working in a UN peacekeeping mission can only be prosecuted for crimes committed in connection with their official duties if the UN Secretary General waives the immunity enjoyed by the alleged perpetrator, paving the way for action by the judicial authorities of the host country. In the case of UN military members of national contingents, their immunity from criminal prosecution in the host country is absolute; they can only be prosecuted in their home countries.

In August 2004, the Secretary General reported to the Security Council²⁰ on the investigations in course and announced that "any civilian staff member found to be responsible for misconduct will be strictly disciplined". Members of the military contingents found responsible would be repatriated. The UN Department of Peacekeeping Operations has also indicated that it has urged troop contributing countries to ensure that the "necessary disciplinary follow-up action is taken once the formal investigations are completed". To deter the occurrence of abuses in the future, MONUC announced the establishment of a "rapid response action plan",

¹⁹ Agence France Presse (AFP), "UN mission in DR Congo vows truth, punishment in sex abuse scandal", 30 May 2004.

²⁰ Third special report of the Secretary-General on the United Nations Organization Mission in the Democratic Republic of the Congo - S/2004/650 - 16 August 2004.

which would focus on investigation, deterrence, the creation of an emergency task force, and the launching of an extensive public relations and information campaign.

In spite of these announcements, MONUC's public image has been seriously tarnished by the allegations. The effective impunity enjoyed by the UN peacekeeping personnel in these situations is surpassed only by the vulnerability and lack of redress available to the victims. The UN should not only complete the investigations as soon as possible, identify and sanction the perpetrators as appropriate and without delay, but also address the needs of the survivors and ensure reparations are made.

5. National legal instruments relating to sexual violence – further reforms needed

Rape is a crime in the DRC and is punishable under the Congolese penal code and the military penal code. Rape was not previously mentioned in the military code, but article 169, paragraph 7 of the new code of 18 November 2002 states that rape, only when one of these acts is perpetrated during a general or systematic attack against the republic or the civilian population (which effectively means that individual cases of rape or one-off cases of sexual slavery are not going to be punished by this code) sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization or any other of sexual violence of comparable gravity are considered crimes against humanity and punishable by death.²¹

In the penal code, Rape is defined as forced sexual penetration and an indecent act as sexual assault with no penetration. Article 170 of the Penal Code provides that rape is punishable by five to 20 years' imprisonment. If the victim dies, the guilty party may be sentenced to death or life imprisonment. Serious impairment to the health of the victim (including pregnancy resulting from rape, or infection with a serious and painful disease) is punishable by between 12 months' and 10 years' imprisonment. However, the penal code does not define "rape" and there is no clarification on what consent is. In this sense, the current definition of rape does not include penetration of the vagina or anus using an object, or the insertion of the penis into the anus without consent. Moreover, the rape of a man is not included in the legal definition of rape. Congolese law describes forced anal sex by one man on another man as indecent assault and not rape.

The penal code should define rape and other crimes of sexual violence in a way that is consistent with evolving international law. The definition of rape in national law should reflect the most advanced international principles, including some of the better aspects of recent jurisprudence. In particular, the elements of the crime of rape should include: (i) a physical invasion of a sexual nature;²² (ii) the lack of consent of the victim.²³ It is a matter of concern that some states have used a narrower definition of rape in their implementing legislation.

Some national NGOs have begun a campaign to press the government for legislative reforms on sexual violence and to promote greater judicial assistance to victims. The proposal is to increase the minimum sentence of five years for rape, as well as an increase in the sentence for rape with aggravating circumstances, such as gang rape, the young age of the victim, physical and mental vulnerability of victim, pregnancy resulting from rape of

²¹ AI is opposed to the application of death sentences or the carrying out of the death penalty in all circumstances, considering it to be a violation of the right to life, recognized by Article 3 of the Universal Declaration of Human Rights (UDHR), and the ultimate cruel, inhumane and degrading punishment contrary to the prohibition in Article 5 of the UDHR, whether committed in time of peace or war.

²² See ICTR, Trial Chamber, *Prosecutor v. Akayesu*, Case No. ICTR-96-4, Judgment, 2 September 1998, para. 688. AI believes that this approach is preferable to the more restrictive one, adopted by the ICTY jurisprudence and partially incorporated in the Elements of Crimes.

²³ See *Prosecutor v. Kunarac et al.*, Case No. IT-96-23, Judgment, Appeals Chamber, 12 June 2002, paras. 127 and 128. Amnesty International is concerned that the more restrictive approach adopted in this respect in the Elements of Crimes does not take into account the central factor of the victim's free and voluntary consent.

the victim. However, Amnesty International urges that legislative reform of the definitions of rape and other crimes of sexual violence must go further to make them consistent with international law and standards and that the death penalty be abolished for such crimes.

IV "IT MAKES NO DIFFERENCE": THE INDISCRIMINATE USE OF RAPE BY ARMED FORCES

All levels of the population in eastern DRC are affected by sexual violence. Survivors hail from all ethnic groups, all social strata and all age groups,²⁴ from rural and urban districts. Those raped may be seriously ill, physically or mentally disabled or pregnant. In some areas, rapes of men and boys are common. In the words of one rapist (see Bernadette's story, p.21), "*It makes no difference*".

Women and girls are attacked on the roads, in the fields or inside their homes. Attacks also take place as children walk to and from school or as families walk to attend church. In many areas, women and girls cannot walk alone or even in groups, for fear of attack, and often no longer go to the market or to fetch water. If other family members protest or try to protect the woman, they are killed or beaten. Rape is also often followed by looting of household possessions or goods women are carrying. After raping them, combatants will occasionally force the victims to carry the looted property.

The country's immense internally displaced population constitutes another at-risk group, forced to live in makeshift camps or empty homes, or condemned to live in the forest, without shelter, food, water or clothing. Lacking security entirely, they are frequent targets for sexual assault. The widespread breakdown in family structures in eastern DRC caused by the armed conflict is leaving more and more children vulnerable to attack.

1. The young and the old

AI has documented cases of rapes of girls aged under 10 and of women aged 70 and over. Among the youngest survivors of rape known to Amnesty International is **Uzele**, a five-year-old girl who was tending a fire outside her home in the Mahagi area of Ituri in March 2004 while her parents were out working in the fields. She was raped by a passing FAPC combatant. **Odette**, a girl of six, was raped on the afternoon of 27 December 2003 in the city of Kindu in Maniema province, by a *mayi-mayi* combatant as she played in front of her home. The man dragged her into the grounds of the local school where he raped her. After the attack, Odette fainted. After hours of searching, her parents found her lying on the ground behind the school at around midnight, still unconscious and bleeding profusely. In March 2004 she was still in hospital, having undergone surgery for a fistula²⁵. According to her mother and the nurses, Odette suffers nightmares, cries constantly and has difficulty in speaking.

Among the elderly women survivors interviewed by Amnesty International is **Stephanie** aged 72 from Maniema province. In September 2003 she was abducted by a *mayi-mayi* group and held for three months. She told AI: "*Every day I was raped by up to three men. When we tried to refuse, they would beat us. They also pushed*

²⁴ One study, however, has estimated that around 75 per cent of victims are under 30. See Study of the Causes and Consequences of Sexual Violence against women and girls in southern Kivu, Democratic Republic of Congo, Preliminary Conclusions (*Réseau des Femmes pour la Défense des droits et la Paix* (RFDP), *Réseau des Femmes pour le Développement Associatif* (RFDA), International Alert, New York, 11 March 2004).

²⁵ A fistula is an opening caused by a loss of tissue from the wall of the vagina leaving it connected to the bladder and/or the rectum.

wooden sticks into my vagina. Now I have a prolapsed uterus. They treated us all the in same way, whatever our age. I used to say to them 'I'm old, kill me and let the others go'. They released me when my brother sent them a nanny-goat. The others are still there, though."

2. Those incapable of fleeing from their attackers

Women who are ill, disabled or pregnant, and therefore without the capacity to flee from their attackers, are routinely subjected to sexual violence. **Bernadette**, aged 40, fell seriously ill after being raped for the first time in October 2002. *"Since there are no medicines at the local health centre, I had to walk to the town for treatment. On the road I was stopped by two soldiers. I told them I was sick and on my way to get medical treatment because I had been raped. But one of them said 'It makes no difference' and they threw me to the ground, there on the road, and raped me again. Since then I can't sleep. I keep reliving the images of what happened and I'm afraid it might happen to me again..."*

Bernadette eventually received medical care from an international organization but continues to experience intense stomach pains. "Sometimes bleeding from my period lasts an entire month", she told AI. Her rapists took all her possessions: she and her children are currently impoverished and displaced in one of the major towns of South-Kivu province.

Juliane is 22 years' old from the Fizi region of South-Kivu province. She was born with a hip problem and is only able to move about with difficulty. One day in September 2001, soldiers attacked her village. "The entire population fled into the forest but because of my leg, I couldn't leave. Three soldiers came into my hut and raped me, one after the other. After that, another group of three soldiers came and raped me. After I was raped, my disability became worse and now, I can't look after my three-year-old. As the community looks down on us, we hide away."

In July 2003, **Carla** was returning from the fields; as she approached her home, she discovered the body of her young brother, who had been murdered. As she stood over the body, three *mayi-mayi* tied her up and beat her. After that, all three raped her before taking her to a camp in the forest for four days:

There were lots of women and girls there, some women even as old as 70. They called these old women 'young girls'. I managed to run away. But I was five months' pregnant when they raped me and as I escaped through the forest, I felt very sharp pains in my stomach. I stopped near a village, and there I lost my baby. People helped me with water and bathed me with Longosso leaves. When I arrived in my village, my husband accused me of having aborted my baby intentionally. I still have pain in my abdomen and back, because I did not receive any treatment. And every time I feel the pain, it reminds me of what happened, and of the baby I lost.

3. Men and boys

Today I can't work. I have to keep a cloth over my genitals like a woman. Only hot water seems to calm the pain. My wife looks after everything now, and I'm beginning to lose hope. I feel I have no future.

- 50-year-old man, raped and stabbed in his genitals by combatants in 2002

A hitherto unreported aspect of sexual violence is the large number of men who are also victims of sexual violence²⁶. Some men have been subjected to rape in the presence of their wives or children. Although male rape is reported much less frequently than the rape of women, one Congolese activist noted that *"the rape of men is much more frequent than you might think. However, it is very difficult for the victims to speak out and condemn the violence to which they have been subjected."*

Joachim is a fisherman from near Baraka in Fizi territory. He is 46 years' old and married with eight children.

Several months ago, when I was on my way into the hills to sell fish, my friend and I ran into some Burundian insurgents on the road. There were a lot of them; they threw us to the ground and raped us. They stole everything from us, even our clothes, and left us naked on the road. When we arrived at a village along the route, some people gave us clothes to wear. At home, members of our family collected money to pay for us to go to Uvira for treatment. But since then, I've had pains in my lower body. The soldiers stole everything from us, so I have no equipment for either fishing or selling fish and I can't pay for my children to go to school now. I feel that people in the community look down on me. When I talk to other men, they look at me as if I'm worthless now.

Polidor is 40 and comes from Kazimia in South-Kivu. He is married with four children. Late one evening in January 2003 his village was raided by soldiers he identified as belonging to a Burundian insurgent group: *"My wife and I were in bed when the soldiers knocked on the door, saying that the man of the house had to come outside. So I hid. The soldiers came in and threatened to rape my wife. So I came out of hiding and tried to stop them, but there were too many of them, and they beat me up, and even broke my leg. Then they held me down, and raped my wife, who was six months' pregnant, in front of me and the children. Then they raped me. While they were doing that they kept saying 'you're no longer a man, you are going to become one of our women'. My leg and foot still hurt. I'm not able to have sexual relations any more. My wife gave birth, but our child is physically ill, and the nurse said it could be because of the rape and the torture. We received some treatment at the Kazimia health centre, but they have no medicines there. So I came to Baraka for treatment. My wife is still too weak to make the journey"*

4. Gang rape and collective rapes

Systematic gang rape is committed by the majority of the armed groups. Rape may be committed by a group numbering up to twenty. These rapes are often also committed in front of the victim's children, family or community, adding terribly to the stigmatisation suffered in the wake of rape.

Edith, aged 16, and her sisters **Jeanette**, aged 22, and **Francine**, aged 20, were raped by up to 20 soldiers of the dissident RCD-Goma force that took control of the city of Bukavu in early June 2004. The rapes took place in their house, which also had a small shop in front, from the evening of 2 June to early the next morning.

²⁶ Male rape appears to be especially prevalent in the Fizi territory of South Kivu province, where Burundian and Rwandan armed groups appear to be the main perpetrators, although, as noted above, survivors are sometimes reluctant to reveal the true perpetrators for fear of reprisals. Members of the Burundian FDD or FNL and the Rwandan FDLR have on occasion joined with *mayi-mayi* attacks in this region.

That evening, we could see them sitting with their vehicle in front of our house. The electricity in the town had been cut off and as soon as it got dark, they came in. They looted everything, and took it away in a truck. Then they asked us how old we all were. They only took the youngest – my mother and eldest sister were not touched. Jeanette was raped by seven soldiers in the storeroom, Francine by eight soldiers in the shop. They put me in the bathroom. I fought with five of the soldiers when they tried to make my brothers watch me being raped. But they beat me so hard. They tore off my clothes. It was the first time I'd had sexual relations. When I bled the soldier hit me in the face because he said I had "dirtied" him. At some point my mother and brothers were brought in to watch. When one group had finished, another group came in. I just lay there, without moving. It lasted all night.

Edith has since received some medical care for her injuries, but she still suffers pain and infection. "Every time I have a doctor's appointment, it brings back the memories". Her two sisters have since fled Bukavu.

Eki is 50 years' old. She and her family had already been displaced by the armed conflict and were living in the village of Nemba in South-Kivu province. "One night, in February 2003, while my husband was out fishing, five soldiers came into the house. I screamed as loud as I could, but nobody came to save me. The soldiers wanted money and when I told them that I had no money, they slapped me and threw me to the ground. They said they would rape me as I had no money. And there, in front of the children, two soldiers each held one of my legs, another slapped my face while a fourth soldier raped me. The fifth soldier ran after the children. After the rape, we left the house because the soldiers set it on fire. When my husband returned, he accused me of being an FDD woman, and abandoned me, leaving me alone with the children."

In some cases, attempts are made by combatants to force victims have sexual relations with members of their family: sons with their mother, or brother with sister. **Teresa** was alone with her three children in a village near Kindu in Maniema. "When the *mayi-mayi* came into our house, they tried to take hold of me so that they could rape me. My eldest son, who is 16, tried to stop them. They took hold of him by the arm and pushed him against me and for about an hour tried to force him to have sex with me. There were a lot of them, and it was difficult for us to resist them. My other two children looked on, crying..."

Collective rapes of a number of women together are also common. Such rapes are particularly committed against rural populations. Commonly groups attack a village, killing civilian men and boys and raping women and girls, before making off with the community's cattle, tools or clothing and sometimes setting fire to the houses.

Marie is 28, and comes from Baraka in southern Kivu. She was pregnant when she was raped by Burundian combatants in late 2003: *I was on my way to Ubwari to sell some fish. I was with five other women, and when we arrived at Mwayenga there were six soldiers hiding in the bushes. They seized and raped us all at the same time. Although we shouted for help, the soldiers went from one woman to the other and were very violent... I was three months pregnant, but after I was raped, I miscarried. I still have pains in my abdomen, I don't know whether it's as a result of the miscarriage, or the soldiers kicking me... My health is not good and I'm worried. I don't know how my children will survive if I die."*

5. Abduction and sexual enslavement

Women of all ages, including young girls and elderly women, are the victims of sexual slavery. Abductions and enslavement are generally committed by armed groups operating in and moving through rural areas. These

women and girls are abducted and become the “property” of one or more combatants, to whom they have to provide sexual services and perform other domestic duties such as cooking, collecting wood or working in the fields. Women are held captive for anything from a number of days to several months or years, being subjected to repeated rape by one or a number of men.

Rachel is 17. She comes from Masisi in North-Kivu, but is from Rwanda originally:

In 2002, I was abducted by an interahamwe soldier. When I arrived at their camp, they took away all my clothes, just to humiliate me. As I was naked, I had to find animal skins to cover myself. I had to live in the bush with them. The combatants kept lots of girls and women like me. Almost every day, I was raped by soldiers. They said they would make babies with the women and girls from Rwanda, so that rwandophones would be in the majority in Masisi. I did become pregnant and, when I was about to give birth, I was lucky that there were some older Congolese mothers there to help me; they prepared herbal medicine, but I almost died. My baby is still sick.

Caroline is 15 years old and lives in Kindu, Maniema province. In July 2003 she was taken by a *mayi-mayi* group, who tortured and raped her over two months.

I was on my way to the fields with my mother. The soldiers took us to Lubao. There, they tied us up, gave my mother 50 lashes of the whip and then put her in another house. They bound me hand and foot, too, and gave me 80 lashes. The next day, they took us to the riverside, pushed a tree branch into our backs and dropped us into the water. Each morning, noon and evening, they would put us all in the same house, force us to lie on the ground and then they would rape us, all in the same room. While they were doing this, they were hitting and kicking us in the stomach, back and face. My mother's hand was broken; it is still swollen and she can't use it. My buttocks are still painful and I can't use my arm any more. There were twelve soldiers and they raped us every evening. They gave us nothing to eat or drink and we had to drink whatever water we could find on the ground.

One day, we ran away, but two mayi-mayi caught us and took us back to Lubao. They tortured us for several weeks and raped us. In August, we managed to run away, but when we arrived [home], everything had been looted and the house had been burned down. Before, I was a student and had friends, but now we have no home, nothing, so I can't study any more. When we walk along the street, people look down on us. The community despises us. I will never forget that I have been raped.

Floriane is 21. She was abducted from the forest and held in captivity by the FDLR for three years, from 2001 to 2004. *“It was terrible. They used to beat me on my arms with an iron bar, just like an animal. I can't move my arm now. As we were considered sex slaves, sometimes as many as five soldiers would rape me, and I became pregnant. It was a very difficult birth, because I gave birth in the bush. The soldiers wouldn't let me go and the very day I gave birth, several soldiers raped me.”*

Florence is 28-years' old. In September 2003 she was travelling through the Rusizi plain towards Uvira, South-Kivu, in a minibus. The vehicle was stopped by FDLR combatants who ordered everyone out. Six women, including herself, were taken off into the hills “for the commander”, but the soldiers took turns in raping them first. When they were presented to the commander, he made the first choice, and then other officers followed with their selections. She was held by the group for two months and raped repeatedly. *“When they tired of me,*

I was put in a "cachot" [detention room], for the use of the cachot guards. I stayed there for 7 weeks, fed only on beans. The water was filthy. We were treated differently from women who were followers of the soldiers, but these other women risked death if they helped us. Most difficult was to be raped daily by different men, and to be kept for two months practically naked, wearing knickers only." In the cachot Florence fell ill and was bleeding constantly. Her family eventually managed to arrange a payment to set her free. Before her abduction she was a successful businesswoman, *"but now I can do nothing, my children suffer"*.

Women abducted by foreign combatant forces, and any children born during their enslavement, are frequently abandoned when the combatants leave, surrender or are repatriated. Congolese women and girls have also reportedly been forced to move as "wives" with combatants repatriated to Rwanda or Burundi. However, MONUC officials responsible for repatriation of foreign combatants asserted to AI in June 2004 that repatriation is voluntary and families must provide evidence of their common desire to return before repatriation can take place.

The situation for hundreds of Congolese women in Uganda who were taken by Ugandan government soldiers (see for example the case of Yvonne, above p. 15) is a cause for concern. Fleeing atrocities and at times threatened by the soldiers, many of these Congolese women had no choice but to follow Ugandan government soldiers when they withdrew from the DRC in 2002 and 2003. Many have had children with these Ugandan soldiers or were transferred to military units unknown to the women. Once on Ugandan territory, they were abandoned, because their partners went back to their families. With no protection, no shelter and no means of subsistence, these women are in Uganda without any legal status. The Ugandan government has not taken any steps to resolve the issue and many women have been forced into prostitution as a means of survival. Between 2002 and January 2004, at least 20 of these women have died of a variety of diseases and more than five are said to have starved to death.

6. Girls used as soldiers

In the DRC, thousands of girls are also enlisted into armed groups, either as child combatants or as "wives" of combatants²⁷. Many of these girls have been tortured, ill-treated or imprisoned after rejecting the sexual advances of their superiors. To avoid such treatment, for many girls it becomes routine to cede to these sexual advances, although they do so unwillingly. Others are forced to give in to the pressure exerted by senior military officers in exchange for favours such as food.²⁸

Rose is 14 years' old. She was recruited by the *mayi-mayi* in South-Kivu when she was 11. She survived battles in which her friends, including other girl child combatants, were killed. At night she was raped by her commander. *"He said that by having sex with me, he would be protected on the battlefield."* She fell pregnant from one of these rapes and gave birth in the forest. But after eight months the baby boy fell ill and, with no treatment other than "traditional" medicines concocted from herbs and leaves, he died. Afterwards, Rose fled to the shelter of a local child rights' organization, which helped her return to her family and civilian life.

Local and international NGOs attempt to intervene with the armed groups to secure the release of these child soldiers. Following an intervention that led to the release of 36 girl soldiers, mostly aged around 14 or 15, in

²⁷ A child soldier is any person under 18 years of age who is part of any kind of regular or irregular armed force or armed group in any capacity, including but not limited to cooks, porters, messengers and anyone accompanying such groups, other than family members. The definition includes girls recruited for sexual purposes and for forced marriage. It does not, therefore, only refer to a child who is carrying or has carried arms.

²⁸ Amnesty International, *DRC: Children at war*, September 2003, AI Index: AFR 62/034/2003.

early 2004, one Congolese activist reported that 17 of the girls were found to be HIV positive, two were pregnant and eight had miscarried in the bush. **Nathalie**, a 14-year-old, was one of these 36 girls. When she was 12, she and her mother were raped by FDLR combatants. At the age of 13, she was persuaded that, in order to avenge her mother, she should enlist in the RCD-Goma local defence forces (LDF). In the LDF, Nathalie was raped regularly by three to five soldiers and fell pregnant. She wanted to have an abortion, but since this is illegal in DRC and she feared imprisonment, she later tried to commit suicide.

7. Killings and torture

Rape is generally accompanied by beatings and threats, and in many cases other extreme acts of torture are also used. Some women have had a rifle, a knife, a sharpened piece of wood, glass or rusty nails, stones, sand or peppers inserted into their vaginas, causing serious physical injury and suffering. Others have been deliberately shot during or after rape, sometimes in their genitals.

Christine was 24 years' old and on her way to attend a family funeral in June 2000 when she was pushed off the road and into some bushes by a soldier believed to be from the RCD-Goma. The man raped her and then fired several rounds from his automatic rifle into her vagina. The shots destroyed large parts of her vagina, uterus and bladder. She lay for around three hours in the bush, bleeding heavily and passing in and out of consciousness, before help came. She later underwent four operations to reconstruct her reproductive organs, but these did not fully succeed and she was left incontinent, was abandoned by her husband and thrown out of her lodgings "because of the smell". One final operation, in February 2002, was successful and she has since begun to recover her life and resume education²⁹. But she retains a deep fear of returning to her home area where the attack took place and "when I think about what happened, it hurts me to my core".

Sophie was 19 when several RCD-Goma soldiers arrived while she was at home in a town in South-Kivu province. *"They broke the door down. When I saw them coming, I tried to hide, but the soldiers were stronger than me and they caught me. After they had raped me several times in my house, I tried to escape to get help. Just then, one of the soldiers shot me in my arm."* Sophie and her family fled to neighbouring Burundi, where her injured arm had to be amputated. *"I'm 23 now and I can't tend the crops, I don't know how I'm going to survive. What I'd like is a prosthetic arm. Then I wouldn't be ashamed of having been raped, nor would I have to try to hide the fact that my arm is missing and I could help my family to survive financially."*

Eliza is a widow who lives with her children. On 14 April 2002 three combatants forced their way into her home: *"They pushed open the door of my house and asked me for money. I didn't have any, so they threw me to the ground and one soldier started to rape me. My 10 year old daughter was present, looking on. When they saw her, two soldiers took hold of her to rape her. I tried to stop them, but they shot me. I did all I could to stop them, to protect her, but they raped my little girl all the same."*

Rape ends in some cases with the killing of victims. **Nadine** is 42 years old. She was on her way to the fields with her three daughters, aged 12, 15 and 20, when *mayi-mayi* combatants from Kabambe attacked them and took them to their camp in the forest. There Nadine was separated from her daughters. *"It was very difficult. Every day they raped the women morning, noon and night and they beat us all the time. But the worst thing was when I heard that after they had split us up, my daughters had tried to resist being raped and one of the*

²⁹ In July 2004 she passed her national diploma and now intends to study to become a doctor because "I've known so many women who were raped but who have had no help at all."

soldiers slit their throats, all three of them. I don't think I can go on living after that. My husband is still angry with me, he has disowned me and says that it is my fault."

In some cases combatants shoot dead the victims' husbands, sons or other family members before committing rape next to the corpses of their loved ones. **Marguerite** is 40 years old and a widow. She said to AI that in October 2002, two members of a Burundian insurgent group, forced their way into her house at night and raped her. *"They took me in front of my children and began to rape me. Frédéric, my eight-year-old son, was very frightened and began to cry and shout. The soldiers turned round, as they were raping me, and shot him dead ... Before leaving, they set fire to the house."*

Nadège is a young woman who lives in Ubwari, South-Kivu. *"At the end of 2002, I was in my house when two soldiers came. They got hold of me and began to rape me. I started shouting and my brother came to my aid. When he came into the house, one of the soldiers shot and killed him. His wife arrived a few minutes later and when she began to cry the same soldier shot and killed her, too. Now I look after my brother's and sister-in-law's children. They have both been killed because of me. I am very ill, and I worry who will look after the children if something happens to me."*

V SURVIVING RAPE: THE URGENT NEED FOR MEDICAL CARE

"Before the conflict, the distribution of drugs to health centres and hospitals was done much more regularly. The transitional government, with the support of the international community, must now make it a priority to restructure the Congolese health service. The population must no longer be allowed to die for lack of basic drugs."

– Congolese doctor working for an international humanitarian NGO in DRC

1. Rape: physical and psychological trauma

Physical injuries

The brutality of rape frequently causes serious physical injuries that require long-term and complex treatment. Many survivors of rape endure uterine prolapses (the descent of the uterus into the vagina or beyond), vesico-vaginal or recto-vaginal fistulas and other injuries to the reproductive system or rectum, often accompanied by internal and external bleeding or discharge. Fistulas result in urinary or faecal incontinence, a condition that is difficult to hide from public knowledge, adding to the distress of the victim. Other injuries such as a broken pelvis, which occur if extreme force is used during rape, are relatively common. Long-term sexual health problems are also prevalent in many cases, including infertility and difficulties in maintaining normal sexual relations, for physical or psychological reasons. Menstrual periods may last longer, be accompanied by severe pains, or may disappear.

Many such injuries generally require long-term treatment. The surgical reconstruction of sexual organs in particular may entail several relatively expensive operations. In current circumstances in DRC, however, few women have access to proper treatment due to the lack of functioning health centres and hospitals, equipped with the appropriate drugs, materials and trained personnel. In the entire country only two hospitals, run or heavily supported by international humanitarian NGOs, currently have the capacity and ability to provide surgery for rape survivors, and are only able to treat a small proportion of those in need.

Reproductive health

In addition to the physical injuries and infections suffered by the victims, women who become pregnant after being raped sometimes lose their lives as a result of complications at birth, although these complications could be easily treated if appropriate care was available. Infant and maternal mortality rates in the DRC are amongst the highest in the world³⁰. The dangers of childbirth apply to all Congolese women, although it should be noted that young girl victims of rape, whose bodies are not sufficiently developed to bear children, are particularly vulnerable.

Abortion is illegal in the DRC except in cases of certified medical emergencies, when a doctor considers that the pregnancy could be fatal for the mother. However, this exception does not include cases of pregnancy as a result of rape, or adolescent pregnancy under circumstances which are not considered life-threatening. The current Penal Code imposes a sentence of minimum 5 years for attempted or actual abortion³¹. Many women, including some rape survivors, have been imprisoned for this offence. In this context, many young girls and women seek abortions outside the formal health system with the help of traditional "doctors" or "midwives", often in dangerously unhygienic conditions and using unsafe practices and equipment. Limited discussion about a possible reform of the abortion law has been discussed in the DRC parliament, but very few observers believe reform stands much chance of success due to the likely opposition of the majority on the grounds of religious belief or sexual morality. The government itself does not seem to be in favour of reform of the law.³²

HIV/AIDS and STIs

Judith, aged 25, was raped by 10 combatants in December 2002. Since the rape she has become very ill and fears that she has contracted HIV/AIDS. *"I have constant stomach problems and diarrhoea. It's as if my legs don't work any more, and I know I'm losing weight"*. She worries immensely that she no longer has menstrual periods, and thinks this is why she gets such painful cramps in her stomach. But she wants people to remember her story. *"They should know this, they should see me"*.

Since the beginning of the conflict, one of the greatest concerns has been the massive increase in the prevalence of sexually transmitted infections (STIs) in the provinces most affected by rape. These STIs include syphilis, gonorrhoea and HIV/AIDS. Destruction of genital tissue caused by the violence associated with rape or gang rape, greatly increases the chances of the rapists transmitting STIs to the victim. According to health experts, women are more likely than men to acquire HIV because they are physiologically more vulnerable, which explains why HIV rates are generally higher among women than men. Unlike most other diseases, AIDS affects adults of child-bearing age particularly, leaving the very young with no one to care for them.³³

³⁰ Progress on the World's Women 2002, volume 1, "Women War Peace", The Independent Experts' Assessment on the Impact of Armed Conflict on Women and Women's role in Peace-building, Elisabeth Rehn and Ellen Johnson Sirleaf, 2002.

³¹ Amnesty International has not adopted a position on whether or not women have a right to choose to terminate unwanted pregnancies: a movement-wide consultation on AI's position on reproductive rights is currently under way. Official bodies that interpret human rights treaties are increasingly indicating support for the position that, where it is legal, abortion should be safe and accessible and further that it should be permitted in cases where pregnancy is life-threatening or has resulted from rape or incest. International human rights bodies have also urged states to decriminalize abortion, noting a correlation between high maternal mortality rates due to unsafe abortions and restrictive abortion laws. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, adopted in July 2003 but not yet in force, is the first human rights standard to include an explicit right of access to abortion "in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus"(Article 14.2(c)).

³² Interview with a member of the transitional government. Kinshasa June 2004

³³ "No Excuses", Christian Aid, 2001, Oxfam, 6 August 2001, p.28.

Accurate statistics on the true rate of HIV prevalence in eastern DRC are unavailable in the current context. According to the director of the *Programme national de lutte contre le sida* (PNLS), National Aids Programme³⁴, the HIV prevalence rate may have reached 20-22% in the eastern provinces.³⁵ Figures obtained by AI from the few reliable health treatment programmes in the east indicate that between 20 and 30 per cent of the patients they test, many of them rape survivors, are seropositive. Some specialists believe the rate may be even higher. All agree, however, that the situation is rapidly getting worse. One international specialist told AI that "the rate is not only high, it is probably one of the highest in the world, and what's more it is in full expansion". Another noted that the probable rate "makes us afraid, makes everyone afraid. It will destroy a large part of the population". According to the PNLS, the HIV/AIDS epidemic could threaten more than half of the population within the next ten years.³⁶

Psychological trauma

The psychological consequences for victims of sexual violence include emotional effects such as depression, post-traumatic stress disorder, shock, intense feelings of terror, rage and shame, loss of self-esteem, self-blame, memory loss, nightmares and daytime "flashbacks" to the rape. Physical symptoms include headaches, nausea, stomach pains, rashes, sexual dysfunction, sleeplessness and fatigue. Many of these symptoms overlap. Feelings of fear, anger and anxiety may show themselves in crying, laughing or extreme agitation; equally many women may seem to be apathetic or indifferent. These effects commonly last for years. Therapeutic support and treatment is virtually non-existent in the DRC, except for the informal counselling provided by local Congolese women's associations dealing with the rape crisis and a very small number of international NGO psychologists. The mental health problems suffered by victims are also aggravated by their fear of being repudiated by their husband or rejected by their family and community. Fear of having acquired STIs, HIV/AIDS and unwanted pregnancy also intensifies the trauma.

2. The unavailability of health care

It is usually very difficult, and often impossible, for rape victims to obtain adequate medical care. The DRC's health care infrastructure, always severely under-resourced, has broken down completely in many areas with the advent of war, either having been destroyed or looted by combatants or become obsolete or neglected, with unhygienic conditions and no water or electricity supply. Professional psychotherapeutic care is almost entirely non-existent. Without the presence of international medical and humanitarian NGOs in the east, who provide their own health care programmes or heavily assist the state health facilities to enable them to provide at least a minimum service, the provision of organized medical care in the east would have collapsed entirely long ago.

With the collapse of the health sector, outbreaks of once virtually eradicated rare diseases have re-occurred. The DRC is host to one of the world's widest assortments of infectious diseases, including polio, hemorrhagic fevers, monkey pox, measles, chickenpox, meningitis, pertussis, leprosy and HIV/AIDS³⁷.

In 2001, at the height of the armed conflict, it was estimated that over 70 % of the Congolese population lacked access to any formal health care at all.³⁸ In the same vein, the DRC's Ministry of Health estimates that

³⁴ *Programme national de lutte contre le sida* (PNLS), National Aids Programme, Plan Strategique National de Lutte contre le VIH/SIDA/MST, PSN, (1999-2008), with the financial support of the European Union, September 2003.

³⁵ DRC: Assistance against HIV under preparation, IRIN, Kinshasa, 9 December, 2003.

³⁶ *Programme national de lutte contre le sida* (PNLS), National Aids Programme report.

³⁷ USAID, Health and Family Planning Overview, July 2002.

³⁸ WHO/UNICEF Joint Mission, DRC, (18-29 June 2001).

less than 30% of the country's health zones³⁹ are operational, and some health experts estimate it is more like 15%.⁴⁰ In February 2004, of 14 health zones in South-Kivu, one of the provinces worst affected by the conflict, 10 were still in a "state of ruins", according to the state *Médecin Inspecteur de Province* (MIP), Provincial Medical Inspector⁴¹. The prevention and vaccination system covers less than 1% of the population outside the city of Bukavu. The strain on the remaining functioning zones – which often cover the larger urban centres -- has also become much worse: health centres in these zones sometimes carry out 3,000 consultations or more per month, when their capacity is for around 600.

For the survivors of sexual violence, the near impossibility of receiving decent medical treatment for the illnesses or injuries brought on by rape represents yet a further violation of their rights. The insecurity that persists in some parts of the east does still make it very difficult to address all these needs. However, in other areas that have seen a significant improvement in the security situation, it is possible to begin now to restore the healthcare infrastructure. This should be a priority of the transitional government and the international community. Responding to the health needs of the civilian population of the east, especially, and rebuilding state provision of basic health care is an essential base and springboard for the future social and economic development of this ravaged society.

Lack of material resources

The health service lacks adequate material, logistical and financial resources. In some cases, roofs, windows, doors and beds are missing from hospitals and health centres. Land transport infrastructure has been in a state of collapse for several decades and most ordinary people can only travel by walking. Some basic drugs and medical equipment are difficult to come by, and government supplies of drugs are subject to unexplained ruptures or blockages⁴². Food and blankets have to be supplied by the patients or their families, who are also required to pay for consultations and treatment. The inaccessibility of health care makes the population depend on local traditional forms of medicine, such as plants, including for the treatment of sexual violence, or to unscrupulous pharmacies that offer unidentified drugs that often aggravate the illness.

The minimum initial services package (MISP) for reproductive health services, considered to be the basic standard of care in emergency situation for internally-displaced women is not available in the DRC⁴³.

Basic means to sterilize medical instruments are also wanting in some areas. Most health centres and hospitals lack syringes and gloves, and have poor hygiene. At a visit to Walungu general hospital, in South-Kivu province, AI delegates witnessed dirty water being mixed with food supplement in powder form, destined for the maternity ward. "Is it drinkable?" asked one of the delegates. "More or less," replied the nurse. The hospital, like most others in the east, lacks decent sterilising equipment. It has no clean water or electricity supply.

Health centre staff, mainly nurses, do not usually have the resources to test for, identify and treat STIs. Some health centres have stocks of basic drugs supplied by international NGOs or religious organizations. Health

³⁹ A typical health zone comprises around 60 health centres, generally staffed by only a nurse, and one or sometimes two hospitals.

⁴⁰ Ministry of Health (2001). Integrated anti HIV/AIDS plan. Support to health sub-sector.2002-2004.

⁴¹ AI interview February 2004. The worst affected health zones are Bunyakiri, Kabare, Shabunda, Walungu, Kaziba, Lemera, Mwengi, Uvira, Nundu and Fizi.

⁴² AI interviews with medical health professionals, eastern DRC, February and June 2004.

⁴³ See *Reproductive Health in Refugee Situations : an Inter-Agency Manual*, (WHO, UNFPA, and UNHCR) which prescribes the Minimum Initial Services Package (MISP) for reproductive health as a set of priority activities designed to prevent excess neonatal and maternal morbidity and mortality ; reduce HIV transmission ; prevent and manage the consequences of sexual violence, and plan for comprehensive reproductive health services. The MISP includes equipment and supplies to complement a set of priority activities that must be implemented in the early stages of an emergency.

centres that are not supported by such organizations have none or very few stocks required for basic health treatment, let alone the complications that may result from rape.

Lack of human resources

"This is an enormous responsibility for a gynaecologist working on his or her own. An entire team of gynaecologists is required for this work. But few doctors want to do this work because they know they will not be paid. Many of them are just not interested anyway, because rape is a problem for poor women."

- Surgeon providing reconstructive surgery to rape survivors

Throughout eastern DRC, there is a clear lack of trained doctors, including gynaecologists, obstetricians and other medical personnel. These are longstanding problems. Before the 1998 war, the DRC only had 2,056 doctors for a population of 50 million, and 930 of these doctors were in Kinshasa.⁴⁴ However, many essential health care personnel have since been dispersed by the armed conflict. Others that remain, enormously dedicated, are overworked, rely on their impoverished communities for sporadic salary payments, and have not received training or other professional support in years.

In 2004, only two towns, Goma and Bukavu, had a hospital with one or two gynaecologists, medical equipment and human resources capable of treating, including through surgery, the serious physical injuries caused by rape⁴⁵. Both hospitals are overwhelmed and hundreds of women are on waiting lists for treatment. Many of those admitted to these two hospitals require complex surgery and sometimes the reconstruction of their genital organs.

State hospitals are generally unable to offer this kind of surgery, through want of training as much as of material resources. In Kindu, Maniema province, the hospital has treated female victims of sexual violence since August 2003, but only once did the doctor there attempt to repair a vesico-vaginal fistula. The operation did not work.⁴⁶

About 70 per cent of the population lives in rural areas. Staff in rural health centres are often inadequately trained, and usually untrained in how to treat STIs⁴⁷. It is also very difficult to get doctors and nurses to work in rural and isolated regions. Doctors and nurses are neither paid nor supported by the government, and they usually stay in the urban centres, or prefer to work abroad. The lack of a salary and support from the government creates a secondary barrier to health care for victims, who find themselves having to pay all the fees for their treatment, and often cannot afford it.

Three universities in the DRC have major faculties of medicine – Kinshasa, Kisangani and Lubumbashi. In the provinces of North- and South-Kivu, two universities have been established, which take students from the east of the country. However, once they have completed their studies, the doctors have no incentive to work in the Congolese state system, and even less in the state hospitals in the east, because they receive no salary. All the health personnel interviewed by AI in the east expressed a wish to see training programmes introduced to produce qualified personnel capable of helping victims in rural areas, and strengthening their own medical teams.

⁴⁴ OCHA DRC (2001), Study on mortality trends, levels and causes in Kinshasa.

⁴⁵ These hospitals are Doctors on Call for Service (DOCS), an international medical NGO, in Goma and Panzi hospital in Bukavu, which is subsidised by international medical NGOs

⁴⁶ AI interview, Kindu, March 2004.

⁴⁷ AI interviews, health centre nurses in various locations in eastern DRC, 2004.

3. Inaccessibility of health care

Physical Accessibility

Survivors of sexual violence are often unable to obtain access to the already limited and poor health facilities that are dispersed sparsely over a wide geographical area. For victims who live in rural areas, especially, access is often still impossible, because they are too ill to travel or because they live too far away to get to a health centre. Victims living in remote regions might have to walk for between four and seven days to reach a hospital. Roads and bridges are often in severe disrepair. The insecurity that reigns in certain regions also prevents victims from being able to travel to health centres. In Ituri, for example, efforts to assist survivors of sexual violence medically are mainly focused on Bunia, the capital, and the geographical coverage required to meet primary health care needs in the affected regions is far from being attained. MSF estimates that it only provides care for 5 % of the victims affected by sexual violence in Ituri⁴⁸.

Outside the larger towns, access to emergency health care can only be offered to a handful of victims. Health facilities in these areas are woefully ill-equipped to be able to deal with the needs of patients, and the number of patients that come for treatment is very much greater than they are able to care for. On 17 June 2004, when Amnesty International representatives were visiting Mahagi 49, an international NGO was taking a dozen women who had been raped by militiamen to their first medical consultation. It was a cross-section of women and girls who, until then, had had absolutely no support or medical and psychosocial care. Some of them had become pregnant after being raped. They were taken in a lorry to the "hôpital de référence" at Logo, near Ndrele, a small town located more than 40km from the centre of Mahagi. They stayed there all day without food. When they returned to Mahagi in the afternoon, most of them were exhausted and weak. They had been seen by a doctor but not treated. They had to return to Logo the next day without any certainty that they would receive treatment.

Economic Accessibility – Health Care Charges

While patients continue to pay for services, and the health service is little more than a conduit to feed health worker's families, no amount of medical supplies, training campaigns or coordination will increase access to health care, nor reduce avoidable mortality.

- WHO/UNICEF Joint Mission, DRC, June 2001

The provision of state health care in DRC is based on a cost-recovery system, in which the population is expected to pay for consultations and treatment. Free treatment is in some cases available for people classed as indigent, but this concession requires certification by local authorities which is sometimes difficult to obtain. Aside from the fact that a major segment of the population could be considered as indigent, the right to indigent care is also not widely known or publicized.

By and large, costs imposed are beyond what is affordable to the majority of Congolese. The vast majority of Congo's 50 million people live on around 20 US cents per person per day, and eat less than two thirds of the calories needed to maintain health⁵⁰. Nundu general hospital in South-Kivu, which at the time of AI's visit had no doctor, charges 400 Congolese Francs (FC) or about \$1 for out-patient care, 750 FC (slightly less than \$2) for child admissions and 950 FC (nearly \$2.50) for adult admissions. The near-by Swima health centre charges

⁴⁸ Médecins sans frontières, Section Opérationnelle Suisse Bunia/Ituri, Rapport Annuelle d'activités Mai-Décembre 2003

⁴⁹ Mahagi is a town with 50,000 inhabitants and the administrative centre of Mahagi, one of the five territories in Ituri district.

⁵⁰ WHO/UNICEF Joint Mission, DRC, (18-29 June 2001).

100 FC (\$0.25) for all consultations. A similar situation applies in Ituri, where a consultation with a doctor (without treatment) will cost around \$1.50 or with a nurse around \$0.50. For most people, accessing health care is therefore either entirely unaffordable or involves making unacceptable choices between, for example, health and children's education (where fees are also demanded) or sale of essential family assets such as livestock.

With the humanitarian crisis in the DRC, international medical NGOs providing emergency humanitarian assistance, provide some health care. In cases where these NGOs maintain their own temporary facilities, such as with MSF, they generally succeed provide such assistance free of charge. However, where NGOs collaborate with the state health system, agreements with the state generally maintain, at the government's insistence, a system of at least nominal charging for consultation and treatment. This is so in the case of health care programmes that have been established by international NGOs for the care of rape survivors, where NGOs such as AMI (Association Modeste et Innocente) or Malteser contribute to a large part of the health care costs, thereby reducing charges imposed on patients. While this has improved access to essential treatment for survivors, it has also led to the emergence of a shadow system, where women who are not rape victims but who are nevertheless in need of emergency care are either forced to claim they have been raped or rely on doctors' discretion to register them as rape victims.

4. "It makes us afraid; it makes everyone afraid": the emerging HIV/AIDS pandemic in DRC

"HIV/AIDS has highlighted the differential access of drugs between rich and poor in such dramatic fashion that over the course of the past several years, treating the millions of people living in poor parts of the world with anti-retroviral drugs went from being seemingly beyond the scope of possibility to a universally accepted moral imperative."

-- Statement at World Health Assembly on Transmission of AIDS in Medical Settings, Physicians for Human Rights, May 23, 2003.

In the DRC, it is estimated that there are several million people living with HIV/AIDS, and a considerable effort will be needed to provide care and treatment for even a small part of this number. Care and treatment for people living with HIV/AIDS are practically non-existent in the country. In addition to the fact that most health centres in the east are not operational, life-prolonging anti-retroviral drugs are almost entirely inexistent and treatment is not generally available for opportunist infections that co-exist with HIV/AIDS. Most health staff have received no training or information on AIDS. People who are sick are referred to their families for care, although they are often rejected by family members because of the stigma attached to the disease⁵¹.

Screening

All rape victims say they are afraid that they may have contracted an STI or HIV, but it is very difficult to know the proportion of victims who are HIV-positive because there is no policy for general systematic voluntary

⁵¹ AI has noted the severe consequences of a lack of medical support for rape survivors living with HIV/AIDS in a number of contexts. See for example *Rwanda: "Marked for Death", Rape survivors living with HIV/AIDS* (AI Index AFR 47/007/2004, April 2004) and *Sudan, Darfur: Rape as a weapon of war, sexual violence and its consequences* (AI Index AFR 54/076/2004, July 2004)

testing. Although they may screen for HIV and other infections before blood transfusions and surgery, international humanitarian organizations operating in the east, refuse to undertake general screening programmes. They consider that testing without the possibility of treatment for HIV is unethical, or because they are unable to ensure the necessary psychological support for those found to have HIV, or because they believe they are not in a position to rigorously detect “false positives” or “false negatives”⁵².

People can obtain HIV tests from a variety of Congolese state, private or charitable health facilities, but the tests are often accompanied by only cursory counselling or advice (or sometimes none at all) to those who test positive. Many people choose not to be tested, because they know that they risk being rejected if they are found to be HIV positive. On the other hand, victims of rape know that reintegration with their family could be easier if they are tested and found not to have the virus. The DRC government does however encourage local and international NGOs to carry out HIV screening. They argue that a person who knows she is HIV positive will care for herself and protect her partner better. According to the state’s regional health representative, the *Médecin Inspecteur de Province* (MIP), Provincial Medical Inspector, for South-Kivu, “even if there are no drugs, testing can help to stop the virus spreading.” This view is also echoed by many Congolese, including activists working with rape survivors, who argue that knowledge of HIV status will lead to changed and safer behaviour.

Blood used in transfusions is often not tested for virus infections or compatibility of blood groups, and a syringe used for blood transfusions could be used for a year. According to UNIFEM, no more than eight per cent of blood used in transfusions is tested for HIV/AIDS, because either the infrastructure has been destroyed or the resources are not available⁵³. According to the National AIDS Programme, 80 per cent of health centres in the DRC do not test blood prior to using it for transfusions.⁵⁴ This severely increases the risk of spreading HIV/AIDS.

Treatment

The malfunctioning of the health service means that it is practically impossible for victims who have been infected with HIV/AIDS to obtain basic drugs including antibiotics. Post-exposure prophylaxis (PEP) against HIV/AIDS, which appear to offer protection if offered to rape victims within 72 hours of the rape, is only available from international organizations in the cities.

Life-prolonging anti-retrovirals to treat HIV/AIDS are not generally available to the general public or are available only in major cities at a prohibitive cost. To AI’s knowledge, there is only one experimental programme in the east of the country, run by Médecins sans frontières (MSF) in Bukavu, which provides anti-retroviral drugs. This program has a target to treat a total of 150 people by 2005. (Another MSF programme in Kinshasa, the DRC capital, has an eventual target of treating 800 people.) MSF in Bukavu also runs an STI clinic, treating around 300 people every month, provides HIV tests, with psychological support for HIV positive patients, and treats opportunist infections.

However, anti-retrovirals are still very expensive and, with the exception of some programmes run by international NGOs, there is hardly any infrastructure in place that could ensure monitoring of prescriptions and the administration of the drug to patients. It is in this context that Pharmakina, a Congolese (although internationally-owned) pharmaceutical company, plans to begin local production of anti-retrovirals in the DRC,

⁵² False positives and negatives indicate test results which incorrectly indicate that the tested person is HIV-positive or HIV-negative respectively. The false positives and negatives occur because the test process is not 100% specific for the virus and in a small fraction of tests the outcome is incorrect.

⁵³ Progress on the World’s Women 2002, volume 1, “Women War Peace”, The Independent Experts’ Assessment on the Impact of Armed Conflict on Women and Women’s role in Peace-building, Elisabeth Rehn and Ellen Johnson Sirleaf, 2002, p.36.

⁵⁴ Assessment of Reproductive Health in the DRC, JSI Research and Training Institute, July 2002.

which would bring down their cost. These lower cost anti-retrovirals produced by Pharmakina could be bought locally by international NGOs.⁵⁵ Private companies providing health care for their employees will also be able to buy the drugs from Pharmakina at a cost price⁵⁶.

For the moment, generic treatment costs \$29 per month, which is not affordable for a vast proportion of the population. However, even if the cost of treatment comes down, treatment will remain unaffordable to most people in need, unless subsidised by the international community and the government.

Opportunistic infections

While there is presently little prospect of significant greater anti-retroviral provision in eastern DRC, considerable progress could be made in the treatment of opportunistic diseases, notably tuberculosis (TB), which often co-exist with HIV. It is believed that TB affects up to one third of HIV sufferers in DRC and is in many cases the principal killer disease. However, it is relatively easy and cheap to treat. Treatment of opportunistic infections can prolong and improve the quality of life of people with HIV/AIDS.

While treatment of TB⁵⁷ can be less restrictive for patients than treatment for HIV, international organizations find it impossible to import drugs to treat the disease. Only the government is authorized to import drugs to treat tuberculosis, as part of the national tuberculosis treatment programme. Government health services are therefore responsible for ensuring the effective distribution of government stocks of drugs for the treatment of TB. This distribution, however, has been woefully inefficient and subject to unexplained blockages and delays, typically for months at a time.

According to medical experts in the DRC, ruptures of stock threaten the successful treatment of TB. Treatment takes place in two phases and involves taking tablets every day for two months, and then one tablet a day for six months. If there is an interruption to the treatment for more than two weeks during the first phase, or an interruption of more than one month in the second phase, the treatment has to begin again. Moreover, such interruptions in treatment may result in the patient developing resistance to it, making the disease even more difficult, if not impossible, to treat further.

5. The DRC Government's response to the rape and HIV/AIDS crises

We had thought that it was because their attention was focused on political questions in a situation that was so difficult that it was impossible to formulate an adequate response; but now we are in a period of pacification of the country, we would have thought it was time to talk about sexual violence against women.

-- UNAIDS officer in Kinshasa, interviewed by AI in June 2004

Most members of the DRC transitional government have displayed indifference to sexual violence and mass rape in eastern DRC and, beyond some isolated public condemnations, has shown no sign of taking action to prevent sexual violence or of making care and redress for survivors a priority. Nor are the authorities taking meaningful measures to address the related issue of a burgeoning HIV/AIDS crisis in the country.

⁵⁵ Some international NGOs plan to organize a network of mobile clinics, with a voluntary screening centre, a laboratory, a medical care unit and treatment for STIs and opportunist infections.

⁵⁶ *Drug company in battered Congo helps fight AIDS*, Reuters, 14 September 2004.

⁵⁷ TB treatment typically lasts from six to 12 months. It is essential that the drug treatment regimen is followed which is why the WHO has recommended the DOTS (Directly Observed Treatment Short course) protocol, whereby the health personnel observe the administration of the medicine.

Insufficient resources and the fact that the country is still balanced between war and peace are often used as excuses by the government to justify its inaction on these issues. Questioned by Amnesty International on the government's weak commitment on care for survivors of sexual violence, the deputy health minister claimed that this was due to the lack of resources and the complex configuration of the government. He clearly indicated that his ministry will limit its work to caring for victims if and when it is able to, and that the government "cannot establish a global policy on rape because rape is an isolated phenomenon and is not an epidemic or disease like cholera"⁵⁸.

This is far from an acceptable response. The government's position is not only due to a lack of resources. It also indicates an absence of political will at the highest level. The transitional government's lack of interest is clearly visible in the medical priorities it has established for 2004. The policy analysis section of the Ministry of Health's action plan for 2004, which has been approved by donor countries and institutions, acknowledges that violence against women has been one of the major consequences of the armed conflict. Specific objective 6 of the action plan is care for the victims of sexual violence in the target zones for the rest of the year.⁵⁹ However, less than 0.1% of the government's health budget for national health programme has been allocated for the care of the victims of sexual violence. This amount is scandalously inadequate and testifies to the government's lack of concern for the suffering of the victims affected by sexual violence.

In March 2004, a framework plan to halt sexual violence in the east and respond to the needs of survivors was presented by a joint initiative of NGOs and UN agencies in the DRC (see footnote 15 above). The plan estimates that more than US\$ 30 million will be needed to comprehensively address the issue. To date, there has been no further progress on taking the plan forward, reportedly chiefly because of objections to the likely cost. Referring to the joint initiative, a UNICEF official still hopes that "this synergy of efforts offers the advantage of helping to convince the government to get more involved in this struggle."⁶⁰

A national committee to prevent violence against women and children created by the Ministry of Health is virtually inoperative and does not have the resources required to make a determined attempt to deal with this scourge. A national programme⁶¹ managed by the Ministry of Health has been adopted to coordinate the response to HIV/AIDS, but the country still suffers from the lack of a comprehensive national vision on how to tackle the issue. The government has an AIDS prevention fund but only a tiny part of this is allocated to treatment which, in fact, is the element most needed by rape victims. The larger part of the fund is dedicated to secure blood transfusion and to AIDS prevention programmes. The national AIDS programme has so far had little impact in the east of the country.

VI OTHER RIGHTS DENIED: SOCIAL REJECTION, ECONOMIC EXCLUSION, DEPRIVED OF JUSTICE

In addition to the impossibility of obtaining medical care, rape survivors also commonly suffer rejection by their communities and abandonment by their husbands. Many women rape survivors are left as the sole carers of themselves and their children, generally cut off, because of social exclusion, from their former economic means of survival and often displaced. Many are vulnerable to further attack or to reprisals. For survivors, obtaining

⁵⁸ AI interview with the deputy Minister of Health, Kinshasa, June 2004.

⁵⁹ Ministry of Health Action Plan, 2004.

⁶⁰ AI, interview with UNICEF, Kinshasa, June 2004

⁶¹ The PNLS (Programme National de Lutte contre le SIDA) is the only one functional existing government programme in the DRC

justice and redress is also not possible. These represent yet further violations of their rights and add considerably to their suffering.

1. Stigmatization, rejection and social exclusion

"Please tell them that rape is not adultery" – Congolese rape survivor

Rape survivors typically encounter widespread discrimination and rejection by their communities, including insults and threats. Large numbers of survivors have been summarily abandoned by their husbands and left as sole carers of their children. Social and familial rejection also carries enormous economic consequences for the victims, who are thereby excluded from their homes and cut off from means of livelihood. In many communities in eastern DRC, rape remains a taboo subject, despite the fact that many women and men have experienced rape and other forms of sexual violence personally or among the people they know.

Rejection appears to stem largely from moralistic attitudes that the women themselves at some level being "responsible" for what happened to them. They are often viewed as shameful or "dirty" because of the type of violence that has been used against them. Women and girls who survive rape are sometimes accused of not having resisted enough, of having somehow consented to sex or of having cooperated with their attackers. Children who are born from the rape, can also face severe discrimination and are often referred to as "the child of the enemy". Fear of rejection and social isolation prevents many survivors from seeking help or speaking out.

The widespread fear of HIV/AIDS in eastern DRC also contributes to the stigmatisation of rape survivors and their children, as well as of others suspected of carrying the illness. According to a human rights activist in Uvira, "even if victims have not been contaminated, but go to hospital and are sent home without drugs, the people in the community still think that they have been infected. They point at victims and call them SIWA (AIDS) DAWA (without drugs).

In some areas of eastern DRC, the climate of stigmatisation and exclusion is slowly improving. In some locations this is because rapes have been so extensive that virtually no family has been left untouched. In other locations, the large number of male rapes has alleviated the traditionally harsh community attitudes towards rape survivors. Community awareness and family intervention programmes run by local women's or human rights organizations are also beginning to bear fruit in some areas of the east. Many rape survivors themselves are also increasingly outspoken about their experiences and ready to challenge openly discriminatory attitudes they face. However, no governmental or international programmes have been initiated to combat discrimination against rape survivors or their children, or against HIV/AIDS sufferers. In this aspect of the rape crisis in eastern DRC, as in all others, community and survivor groups are left entirely to their own activism and resources to improve the situation.

Estelle, a girl of 12 who was raped by a combatant in a manioc field in February 2004, for example, can no longer face attending school. She told AI: *"I don't feel brave enough to go. The other girls in the neighbourhood make fun of me. They call me the little girl who sleeps with soldiers in the forest. I try to hide."* When her mother initially sought medical help for Estelle from the local hospital, *"the doctor said that since this man had had sex with me, I was no longer normal like the other girls"*. She subsequently received rather more sympathetic medical care, but still suffers intense pains.

Pauline is 40. She comes from a rural area in South-Kivu. *"It was in June 2002, towards midnight, I heard the crackle of gunfire all around the village. My husband fled. As I was trying to escape with my children, seven soldiers broke down the door to my house, threw me down to the ground and raped me. I lost consciousness till the next day. I was married, but my husband abandoned our three children and me. He said I was contaminated by disease and he was afraid of me. He got married again, to a young girl. When I walk, I have to hold my abdomen with my skirt, because it hurts so much. I cannot walk very far now and as the soldiers took everything, I can hardly manage to look after my children."*

When women become pregnant after being raped, their children generally endure the same humiliation and rejection as their mother. Sometimes the mother herself repudiates the child and in some cases may abandon the child, leaving it to die. Children born in these circumstances, and their mothers, need medical and psychological care and economic and social support, but society prefers not to acknowledge these needs. Only a handful of local or church or other non-governmental organizations try to support and look after the children who are born as a result of sexual violence or children who are orphaned or abandoned through the effects of war or disease.

Sylvie, a young woman of 22, from a rural area of South-Kivu, was raped in late 2002 by 10 combatants who also killed her husband in front of her. Sylvie fell pregnant from the rape. *"Today, when I walk with my baby, the people in the community say that I am the enemy's woman, and that the child belongs to the enemy. Sometimes, when I look at my child, I cry, because I remember what happened. I am alone. What I find upsetting is that nobody will come near my baby; everybody says he is cursed. And the baby is frightened because the neighbours are always shouting at him."*

Rejection by family and community often forces rape survivors to move to another village or town, or seek refuge among the displaced populations where their plight is not known. Sometimes they are forced to flee into the forest. **Josephine** is 29. In April 2003, she and her friend **Miriam** were raped at gunpoint by three RCD-Goma soldiers as they walked to their fields near Walungu, in South-Kivu. In October 2003, Josephine was raped again, this time in her home, by another RCD-Goma soldier who gagged her to prevent her from screaming. She became pregnant after this rape and in March 2004, when she told her story to AI, she was close to despair. *"In the community, they made such fun of me that I had to leave the village and live in the forest. Today, the only thing that I can think about is that I want an abortion. I am hungry, I have no clothes and no soap. I don't have any money to pay for medical care. It would be better if I died with the baby in my womb."*

2. Sexual violence: extending poverty

When women are raped, this affects their own sense of self-respect, but also their status and their place in the community. Already at a disadvantage in peace times because of their gender, thousands of women who have been raped during the war are now marginalized and isolated, excluded from society and the economy.

In the DRC, women are generally responsible for feeding the family and for a multitude other tasks. They grow the crops, conduct local trade in consumer products and basic goods, collect the wood and water, feed livestock and look after the children. These responsibilities have become more burdensome since the conflict began. The war has caused high infection and death rates, increasing the workload for surviving women, who must manage the household and support their community while looking after orphan children. Women have become the heads of many households in the east after the departure or death of their menfolk. For victims of sexual violence, it is a daily struggle to ensure the survival of their children.

Agricultural workers and traders who have been raped often find it impossible to continue their activities because the rapists steal their work tools and because they have been physically and psychologically weakened by the injuries and trauma caused by the rape. Agricultural workers dare not return to the fields and traders are afraid of setting out on the road to sell their goods because they fear being raped again.

Victims who have sometimes lost all their possessions ask local NGOs for help. In many cases, their homes have been destroyed or thoroughly looted and they have no clothes or food. In other cases their penury is attributable to expulsion by their families or communities. Local NGOs and international humanitarian organizations sometimes provide them with food, clothes and other essentials such as cooking or agricultural equipment, but this assistance is neither systematic nor sufficient, and is only a very temporary support.

Unable to make a living in the professions they previously held, women are sometimes left little choice but to resort to prostitution in order to ensure the survival of their family. The increase in poverty, the break up of many families, and forced displacement have made prostitution as a means of generating income more common and led many girls of an increasingly younger age to offer their services for money. "In Kivu, you can now find very young girls who sell sex in the bars or near the market for less than US\$ 1", says a human rights activist in Bukavu. "Moreover, they run a serious risk of contracting AIDS, because it is generally unthinkable for a Congolese woman to ask a man to use a condom. She would risk being beaten up or raped."

3. Deprived of justice

"I wish that these soldiers could be put in prison. If they were arrested, then I would have peace."

- 12 year old Béatrice, raped in the fields.

Despite the frightening prevalence of sexual violence in the DRC, hardly any of the perpetrators have had to answer for their crimes. To AI's knowledge, few perpetrators have been brought to justice and no senior officer has been prosecuted or disciplined for a rape committed by either himself or one of the soldiers under his command. Only a handful of cases of rape have been referred to the military courts⁶². In Ituri, courts have dealt with a small number of rape cases, including rape committed by civilians. However, these cases are far below the incidence of rape and do not reflect the extent of crimes committed against women. This situation of almost total impunity encourages further rapes, because perpetrators know they will almost certainly enjoy impunity.

The war has turned eastern DRC into a widely lawless region, characterized by the almost total degeneration of the Congolese judicial system. In most provinces, civil courts do not function properly, and in many areas there are no judicial personnel, lawyers, civilian police officers or detectives. Judicial institutions are starved of financial resources and even of basic legal texts, including national legal codes. Judicial personnel have not been paid for several years and have no incentive to carry out their duties. Magistrates have rarely had any training in international law and human rights. Office materials and stationery are in short supply and buildings, including prisons and detention facilities, are dilapidated. Major escapes of prisoners take place regularly. The

⁶² On 14 June 2003, the Bukavu *Conseil de guerre* (Council of War) sentenced an RCD-Goma soldier to 20 years' imprisonment for the rape of an eight-year-old girl in Kabare, South-Kivu. The complaint was lodged by the South-Kivu Coalition against Sexual Violence. The unique nature of the case was that the plaintiff's lawyers based their case on the provisions against sexual violence in national and international legal instruments. AI hopes that this case and the sentence imposed might yet form a precedent and example for other legal actions on behalf of rape victims. So far, it has not, despite the best efforts of Congolese human rights activists.

judiciary is widely unindependent throughout the country, controlled or influenced by the political and military authorities, including the *de facto* authority of armed groups.

Many rape survivors do wish to pursue legal action against the perpetrators. Many survivors know the names of their attackers and where they are based. A number of women reported to AI that they still see their rapist in the street. But their wish to see their attackers brought before the courts is effectively blocked by the inadequate functioning of the justice system and, in this context, very few victims have the confidence in the judicial system to lodge a legal complaint.

Victims face other obstacles to pursuing their right to an effective remedy, including financial ones. Victims are obliged to pay for the cost of summons and proceedings, but the high costs involved are beyond the reach of the majority of Congolese. Costs can be waived for indigent victims, but most of the population is unaware of this and the practice is discouraged by judicial staff, who depend for their salaries on payments made by plaintiffs.

In the meantime, those in Congolese society who are adamant that justice must one day be done and redress provided to the survivors of rape continue to document cases of rape and to report these to the judicial authorities. As an activist in Goma, North-Kivu remarked, *"if some of the perpetrators were brought to justice at national or international levels, it would serve as a deterrent and prevent others from committing these acts. That is why we document cases, so that one day, the perpetrators of these crimes can be brought to justice, either in the Congolese courts or at the International Criminal Court."*

Amnesty International is calling on the DRC government and international donors to place the reconstruction and reform of the justice system among the major priorities of the transition. The organization has called on the government to adopt, in close consultation with civil society, the ICC, the United Nations High Commissioner for Human Rights, other intergovernmental organization and states, an action plan to rebuild, step by step, the national judicial system so that it eventually will be able to conduct fair criminal proceedings throughout the entire country with effective civil reparations proceedings and without the death penalty. While this will undoubtedly be a long-term process, an important start can be made, including by taking action now to end impunity for perpetrators of rape and by removing financial and other obstacles that rape survivors encounter in seeking justice before the courts.

The investigation recently commenced in the DRC by the International Criminal Court (ICC), which will have a likely initial focus on atrocities committed in the Ituri region and may include rape cases, could also send an important signal that rapists can no longer expect to escape justice. Action by the ICC may also encourage greater domestic legal action against perpetrators.

4. Lack of protection for survivors

The total absence of protection for victims and witnesses is another factor impeding justice for rape survivors. In the current political and military context, victims are not protected by the Congolese authorities or by the MONUC peacekeeping force and there is an urgent need for stronger protection mechanisms on the ground. Women have no protection against any combatant wanting to intimidate them into remaining silent or to commit further violence against them. Fear of reprisals prevents many victims of sexual violence from reporting the crime and seeking justice and redress.

Many victims continue to live in the same communities and in perpetual fear of their assailants, whom they see regularly. On 20 November 2003 **Mireille**, aged 12, was abducted by a lieutenant of the RCD-Goma armed

group and held at his private residence for a week, during which time she was repeatedly raped. After a two day search, Mireille's mother discovered where her daughter was and contacted the military authorities. A Congolese NGO paid for an investigation into the case. Mireille was released and the lieutenant was arrested. After reportedly confessing, he was taken to the local military prison. A few days later, he was released, on the understanding that he would not leave the area, and that he would appear before the competent jurisdiction when required. *"What is horrible for me", said Mireille, "is to have been raped, yet today when I walk in the street, I can see my assailant, and sometimes I can see in his eyes that he is making fun of me."*

Marie from Kindu in Maniema province, is 14 years' old. In October 2003 she was abducted by *mayi-mayi* combatants then tortured and raped: *"I had just set out along the railway track for the fields, when some mayi-mayi soldiers took me and forced me into the forest. They wanted me to stand guard to watch out for their enemies. One day, the leader gave the order that I should be given 150 lashes. After that, when my back and buttocks had been torn to shreds and bleeding, three soldiers raped me. I couldn't walk after that. Even today I'm still very frightened, because I know who my assailants are."*

VII. LEADING BY EXAMPLE: NGO RESPONSES TO THE RAPE CRISIS

"The NGOs do all they can to help the victims, but still it's like a drop of water... We need a national programme, properly coordinated and funded." - Woman activist, Baraka, South-Kivu

The desperate circumstances in which tens of thousands of victims of sexual violence find themselves, the number and diversity of their needs, present an immediate emergency and a long-term challenge which should involve all levels of Congolese society as well as the international donor community. However, to date, only non-governmental organizations and a handful of Congolese doctors and nurses have provided rape survivors with care and support. This response is clearly inadequate when the extent of the survivors' needs is taken into consideration.

A number of Congolese women's, human rights, church and development organizations have mobilized themselves to respond to the needs of survivors. In AI's view, these initiatives – all of which have proved successful in their own right at the local level – represent models which could and should be adopted and implemented by the DRC government and international donors in a systematic national response to the crisis.

Some of these local initiatives are supported materially by international NGOs (INGOs), many of which also have their own programmes of medical or humanitarian assistance to rape survivors. This support, although generally modest is essential to sustaining some NGOs in their core programmes of work. The NGOs have also sought to pool their efforts and expertise through the formation of collectives, "platforms" or "synergies". In North-Kivu, South-Kivu and Maniema, for example, local and international organizations have organized a "Synergie en Faveur des Femmes Victimes de Violences Sexuelles" / Synergy for Women Victims of Sexual Violence." This cooperation involves local and international organizations, MONUC, UN agencies, religious groups and public health structures who pool their expertise and coordinate their activities when dealing with victims of sexual violence. Other smaller collectives also exist at local levels. The main NGO actors in Bunia have also achieved a good degree of coordination and organized a clear division of responsibilities. Such coordination does not yet exist in other parts of Ituri.

Rare are the Congolese NGOs who have the necessary professional and technical skills or the material resources to enable them to fully achieve their aims. They lack sufficient money to pay their workers' salaries; they lack phones, transport, office furniture and stationery. They do not have enough basic supplies such as food, clothing, cooking equipment and soap to provide to rape survivors who seek refuge in their centres. UN agencies and some other international organizations organise training courses on sexual violence, but most local organizations still lack the specialized training they need to increase their capacity to intervene. NGO staff also fall victim to the stress and isolation of their work. Activists whose daily work involves listening to the experiences of rape survivors admit to feeling deeply traumatized themselves, but there is little they can expect in the way of organized support and counselling.

The NGOs also work in conditions of danger. In most areas the local political and military authorities are hostile to the activities of the NGOs, which they fear may expose their involvement in human rights abuses. The activists are frequently called in by the authorities for questioning or to settle so-called "administrative matters" that are in reality thinly disguised acts of intimidation; their offices are subject to unannounced visits by security officials. In some cases, women activists have been explicitly threatened at gunpoint, often as they travel through isolated rural areas to visit rape survivors. Some NGOs are forced to take elaborate security measures, including storing their records in another town or city, to protect rape victims and themselves. If and when armed conflict resurges in their area, as in the recent violence in Bukavu, the NGO offices are typically the first in line for looting by combatants, while the activists themselves are forced to go into hiding for fear of being killed or otherwise abused.

NGOs representatives with whom Amnesty International met, whether in Maniema, the Kivu provinces or Ituri, have developed remarkably similar strategies to caring for rape survivors and their children, which typically involve identifying rape survivors in the community, helping them access the medical care they need, and providing them with counselling, legal, social or socio-economic support. AI believes that the efforts of these NGOs should be actively supported by the DRC government and international community, and that greater governmental measures should be taken to enable them to work free from harassment and the threat of violence.

Identification and documentation

To identify rape survivors and document cases, NGO activists visit local communities, subject to being able to afford transportation, or maintain networks of women, known as "*femmes de référence*" or "*femmes de vigilance*", in the different communities who can be contacted after rape and who provide initial counselling and advice to the victim.

Medical assistance

NGOs refer survivors to local medical facilities and will often accompany them for support during treatment. Often the NGO or the local umbrella network of NGOs has agreements with charitable health centres and hospitals to provide free health care, or has secured international NGO funding for medical care, at least to a certain level, when referral is to the state health facility. In some places, however, where the only medical facility is a state health centre or hospital which does not receive international NGO assistance and is unwilling to forego charges, the NGOs are forced to pay the costs themselves. In practice, this means that many women do not receive treatment. A smaller number of NGOs are able to employ a nurse to provide basic medical treatment and drugs, when available.

Psychosocial care

Several NGOs run refuge and counselling centres, known as *maisons d'écoute* or *d'accueil* ("listening centres"), for rape survivors. Many of these are "drop in" centres, where survivors can come to talk through their problems with activists and receive mutual support from fellow survivors. It is rare that the women activists have received any training in counselling, and all NGOs involved in this work expressed to Amnesty International their wish to receive greater outside training from professional counsellors. Some centres also offer accommodation for a small number of women, as well as food, clothes and basic needs such as soap, if and when the NGO has enough money.

Legal assistance

Where the survivor wishes to pursue legal action, the NGOs provide support advice and sometimes engage local lawyers on their behalf. A number of cases have been filed with local prosecutors, but because of the deficiencies of the state judicial system, very few cases have made it to trial. Protection for the witnesses is also a major concern, and many NGOs express wish for greater measures by the government and MONUC peacekeeping force to protect women who are willing to launch legal action.

Economic and social support

Many NGOs enable rape survivors to restart economic or agricultural activities, a practice which not only provides them with a livelihood but also helps them to recover their social status and self-worth. These projects can take the form of donations to individual victims of agricultural implements or seeds or of vocational training. One NGO in the Fizi/Baraka area of South-Kivu, for example, established a restaurant run by rape survivors, although the restaurant was later looted and destroyed by combatants. A religious order in Uvira provides a centre where up to 20 rape survivors abandoned by their families live and learn sewing, dress-making, cookery and other activities that will help them earn an income. The order has also established a school for the children of these victims of sexual violence and other abandoned children.

Other projects give micro-credit assistance, in which the survivor is loaned a small amount of money to enable her to build business, for example by purchasing vegetables from an outlying market and selling these on in order to make a profit. In some cases, the economic assistance is on the basis of a loan of US \$5 to be repaid in instalments, which is then used to support another rape survivor. Those benefiting from such programmes are often encouraged to meet regularly to exchange advice about marketing and to give each other support.

Geraldine from Walungu in South Kivu was raped and her house burned down by combatants in January 2003. She was abandoned by her family, who called her "dirty", and she was forced to flee to Bukavu with her six children. Eventually she was accepted for a micro-credit program and received the \$5 start-up loan. She told AI: *"I took this money to Mudaha market, 17 km from town, and bought several bunches of bananas at 500 FC per bunch, which I then resell for 600 FC at the central market in Bukavu. I therefore make a profit of 100 FC on each bunch, half of which I can save. Every Wednesday, we have a meeting. There are about 30 in each group and it is very good to be able to meet and to give each other advice... it encourages us. When I do my trade, I feel like a woman again and a good mother because I can feed my children."*

Fighting discrimination and social exclusion

A number of NGOs have developed mediation programmes in which they work with families and local communities to try to prevent the abandonment of rape survivors and children, or to reunite families torn apart by rape. Usually this involves education, addressing the cultural discrimination and taboos surrounding rape, and tackling fears that the family might have, for example, about STIs including HIV/AIDS, that may result from the rape. More widely, most NGOs are involved in public campaigning to stop sexual violence, raise awareness about the plight of survivors and end their social exclusion. Human rights NGOs also work to promote greater public awareness about women's rights. In such campaigning, local radio is used to good effect.

In another example, in South-Kivu province a coalition of commercial enterprises and public institutions has adopted a rights-based HIV/AIDS policy designed to eliminate discrimination against HIV sufferers from the workplace. The coalition strives to ensure that HIV positive workers do not encounter discrimination, undertakes awareness-raising amongst employees, trains individual employees to act as educators on the issue, and pays certain medical costs for HIV/AIDS and other STI sufferers among their workforce.

VIII CONCLUSION AND RECOMMENDATIONS

1. Conclusion

The scale of rape in eastern DRC represents a humanitarian and human rights crisis requiring both an immediate and a long term response. Tens of thousands of survivors are today suffering and dying needlessly. An organized and comprehensive response must be developed to respond to the various needs of those survivors.

As demonstrated in this report, the impossibility for the survivors to access decent medical care is a further violation of their rights. Amnesty International is therefore urging the DRC government and international donor community to establish an emergency programme for the medical and psychological care of survivors. Also in the immediate term, Amnesty International urges the DRC's Ministry of Health to urgently review its system for distributing government stocks of drugs to health facilities in the east, with a view to eliminating blockages or ruptures in the provision of essential medicines, notably for the treatment of Tuberculosis, and to remove restrictions on the import of these drugs by international medical NGOs. Efficient distribution of medication would undoubtedly save or prolong many lives, including of HIV sufferers.

The longer-term restoration of the state health care system must also become a priority. Amnesty International recommends that an assessment mission, composed of mixed DRC and international medical experts and health care managers, be formed as quickly as possible to evaluate the needs of the DRC's national health care system. The findings of this assessment mission should form the basis of a joint national and international plan, with dedicated international donor assistance, for the priority reconstruction of the DRC's health system. The assessment should include a review of the application of the cost recovery system to essential medical services, which according to international standards should be affordable for all Congolese.

So far, despite these obligations, the DRC government and the international community have been far too slow in fulfilling their obligations to protect the human right to health for survivors and the Congolese population by planning, funding and beginning to implement programmes to provide comprehensive prevention, treatment

and care. Unless such programmes are put in place, by the time elections take place in the DRC thousands more people will have died as a result of the appalling state of the health care system.

Amnesty International urges the transitional government to undertake these obligations urgently, and to use all available resources, including those provided through international cooperation and assistance. It is also particularly incumbent on donor countries, and others in a position to assist the transitional government, to offer sufficient assistance to allow the realisation of, at least the minimum essential levels of health care, and the right to health of particularly vulnerable individuals such as rape survivors who are suffering from the aftermath of years of conflicts in the DRC.

AI believes that the initiatives developed by local NGOs to assist rape survivors deserve greater recognition, support and expansion. AI also believes that a culture of genuine participation and consultation with women's organizations and civil society on major policy issues (especially those that touch the lives of women) needs to be encouraged at all levels of Congolese national, regional and local decision-making.

2. Recommendations

A. To the DRC Transitional Government

i) Meet the health care needs of survivors of sexual violence and make the rehabilitation of the national health care system a priority:

- In collaboration with the donor community, create an emergency medical programme to provide essential medical care to rape survivors. This response could take the form of mobile health teams trained and equipped to treat rape survivors. Such mobile teams should also contribute to the training of nurses and medical staff in rural and urban centres.
- In collaboration with the donor community, support and contribute to an international or mixed international/national assessment mission to evaluate the needs of the DRC's national health care system. The findings of this assessment mission should form the basis of a joint national and international plan, with dedicated international donor assistance, for the priority reconstruction of the DRC's health system.
- Ensure adequate supply of essential drugs, technical aid and material in the health centres of the country, including in the rural health centres.
- Remove restrictions on the importation of drugs by international medical NGOs to treat tuberculosis and ensure that government stocks of these drugs are supplied without interruption to health facilities, especially in the east.
- Ensure implementation of the minimum initial services package (MISP) for reproductive health services, considered to be the basic standard of care in emergency situation for internally-displaced women is not available in the DRC.
- Support the training and professional training of medical staff, including gynaecologists and nurses, and prevent corruption by ensuring prompt and adequate payment of medical staff salaries.

ii) Ensure a coordinated national and international response for the care of victims of sexual violence :

- Establish a systematic and comprehensive program of care for survivors of sexual violence, by coordinating a global and comprehensive approach with governmental, national and international initiatives involved in supporting victims of sexual violence. This should be done in full consultation with

Congolese and international non-governmental organizations already providing medical, legal, social and economic programs for the care and rehabilitation of victims.

iii) Condemn and prevent sexual violence against women:

- Publicly denounce sexual violence, whenever and wherever it occurs.
- Issue clear instructions to all armed forces to refrain from all forms of sexual violence.
- Carry out a systematic and complete screening of all personnel aspiring to belong to the FARDC and ensure that they are clean of allegations of serious human rights abuse including rape.
- Suspend from duty and exclude from positions in the new integrated armed forces anyone implicated in violence against women pending investigation. Ensure that the reform of the new army and the security sector is carried out in compliance with international standards that promote respect for women's right.
- Train all forces of the integrated national government army and police on the rights of civilians to protection, including the prohibition of sexual violence, and to respect and abide by international human rights and humanitarian law, taking into account the fact that most rape cases documented by Amnesty International have been committed by combatants.
- Ensure that the FARDC and the national police enforce a strict code of conduct that draws lessons from the current situation and provide a framework for its effective implementation.
- Use its influence over the armed groups to release all women kept as sex slaves.

iv) End impunity for violence against women:

- Ensure that laws, rules, regulations and military orders prohibit violence against women and provide for appropriate punishments for perpetrators. National legislation should conform with international law and definitions of offences, including the definition of rape as contained in the Rome Statute of the International Criminal Court (ICC).
- Take greater action to end impunity for the perpetrators of rape and enable victims of sexual violence to obtain full redress before the courts, as part of the wider reform and reconstruction of the national justice system
- Train lawyers, magistrates, judicial police officers and other judicial personnel and equip the courts so that the legal authorities can start to document cases of sexual violence and initiate legal action in favour of the victims.
- Develop mechanisms within the investigation and judicial processes to ensure the full protection of victims and witnesses from intimidation and reprisals.
- In regard to the ICC, enact effective implementing legislation for the Rome Statute of the International Criminal Court (Rome Statute) and to provide the fullest possible assistance to the ICC in the protection of victims, witnesses and ICC investigators, in sharing and safeguarding evidence, and protecting its sources when doing investigations and in arresting and surrendering persons indicted by the ICC without delay.

v) Act to end discrimination against rape survivors and HIV sufferers, and against women more generally:

- Put in place public awareness and social/economic assistance programmes to effectively combat the exclusion from communities of rape survivors and/or HIV sufferers, and facilitate their reintegration into the community. Such programs should build on those already developed at the local level by women's, human rights' and humanitarian organizations.
- Implement fully the UN Declaration on the Elimination of Violence against Women, Security Council resolution 1325 on women, peace and security; and other relevant standards.
- Guarantee women's equal rights to land, housing and control of property.
- Abolish laws that discriminate against women

- Prohibit discrimination on the grounds of gender, sexual orientation and marital status.
 - Support initiatives to reinforce the status of women in Congolese law, institutions and society.
- vi) Provide victims of sexual violence with social and economic options:**
- In collaboration with the donor community, develop income generating activities, through the granting of micro-credit and agricultural tools, in cooperation with local NGOs.
 - Establish mechanisms to assess the effectiveness of such programs and review their functioning where and when necessary.
- vii) Ensure human rights defenders and local NGOs working on women's rights can carry out their work without fear:**
- Enable them to operate freely and investigate violence against women.
 - Protect women human rights defenders from violence, including gender-based violence.
 - Create a climate that enables them to speak out, publicly against violence and support their work and provide resources to support them.
 - Use political influence, as well as human and material resources, to support programs to promote the activities and reinforce the capacities of local NGOs assisting victims of sexual violence in the DRC, and provide support for local human rights defenders.
- B To the DRC Transitional Government and the governments of Rwanda and Uganda, as well as other governments worldwide**
- i) Stop supporting armed groups responsible for violence against women:**
- Publicly condemn all forms of violence against women committed by such armed groups.
 - End the provision of any logistical, financial or military assistance to governments or armed groups responsible for violence against women and use their influence over armed groups to stop further abuses.
- ii) End the misuse of arms to perpetrate violence against women:**
- Respect fully the UN arms embargo and halt all arms transfers and supplies of military, security and police equipment or training to armed groups in eastern DRC.
 - Stop the manufacture, transfer and use of landmines and ratify, implement and monitor the 1997 Mine Ban Treaty.
- C To MONUC and states contributing personnel to MONUC:**
- i) Assist in the provision of greater medical care for rape survivors:**
- MONUC medical facilities should assist local health structures and international medical and humanitarian NGOs in providing treatment to rape survivors. MONUC medical facilities should be open to rape survivors in need of emergency care.
- ii) Provide greater protection for women and girls from sexual violence:**
- Interpret MONUC's protection mandate broadly to include the protection of women and girls from sexual violence.

- Actively patrol areas where violence against women is most likely, for example roads and major footpaths on market days, major trade routes and agricultural land bordering hills or forests where armed groups are known to operate.
- Employ staff with the expertise and capacity to protect women and girls from violence, including the monitoring and investigating allegations.

iii) Help combat impunity for sexual violence:

- Where access is possible, carry out investigations and publish reports on the incidence of rape and action taken to prevent it.
- MONUC DDRRR units facilitating the voluntary repatriation of foreign combatants should be aware that combatants and their commanders may have been responsible for serious human rights abuses, including rapes. Every effort should therefore be made in the DDRRR process to collect intelligence on the formation and command structures of foreign armed group units, their areas of operation in the DRC, and the personal histories, identification and home addresses of foreign combatants, in the event that combatants or their commanders are one day indicted by Congolese or international judicial authorities.
- In the operation of DDRRR, reinforce significantly measures and actions that encourage a gender based approach to DDRRR and ensure that the specific needs of women and girls going through the process are met.
- Investigate and suspend from duty any member of MONUC suspected of being responsible for violence against women. Make public the outcome of the investigations into sexual exploitation and abuse by MONUC peacekeeping personnel. Ensure that victims receive adequate reparations and redress.
- Countries contributing military or civilian personnel to MONUC should ensure that any allegations of sexual violence against their personnel are investigated and that the alleged perpetrators are brought to justice before national courts and appropriate reparations provided to the victims.

D To the UN Security Council, UN member states and the international donor community

i) Encourage the DRC transitional government to make medical care of rape survivors and the reconstruction of the national health care system a priority:

- In collaboration with the DRC transitional government, contribute to an international or mixed international/national assessment mission to evaluate the needs of the DRC's national health care system. The findings of this assessment mission should form the basis of a joint national and international plan, with dedicated international donor assistance, for the priority reconstruction of the DRC's health system.
- Collaborate with the DRC transitional government to create an emergency medical programme to provide essential medical care, free of charge, to rape survivors in both rural and urban areas of eastern DRC. This response could take the form of mobile health teams trained and equipped to treat rape survivors for the range of physical and psychological injuries they suffer. Such mobile teams could also contribute to the training of nurses and medical staff in rural and urban centres.
- Assist the DRC transitional government in ensuring the flow of drugs, technical aid and material in the health centres of the country, including in the rural health centres.
- Collaborate with the DRC transitional government in supporting the training and formation of medical staff, through deployment of international medical staff, provision of scholarship and financial support for training and university studies, student exchanges, and provision of adequate salaries for medical staff.

ii) Ensure a coordinated national and international response for the care of victims of sexual violence:

- Assist the DRC transitional government to establish a systematic and comprehensive program of care for survivors of sexual violence, by coordinating a global and comprehensive approach with governmental, national and international initiatives involved in supporting victims of sexual violence. This should be done in full consultation with Congolese and international non-governmental organizations already providing medical, legal, social and economic programs for the care and rehabilitation of victims.
- iii) Support local initiatives:**
- Use political influence, as well as human and material resources to support programs to promote the activities and reinforce the capacities of local NGOs assisting victims of sexual violence in the DRC, and provide support for local human rights defenders.
- iv) Prevent sexual violence by UN personnel in DRC:**
- Take all necessary measures to ensure that allegations of sexual violence by civilian or military UN personnel in DRC are investigated and sanctioned, and that reparations are made to the victims.
 - Ensure that UN personnel are trained and operate in compliance with the SG Bulletin on special measures for protection from sexual exploitation and abuse and the MONUC Code of Conduct.
 - Ensure full respect of the UN SG bulletin on special measures for protection from sexual exploitation and abuse, MONUC's code of conduct and in general the UN policy of "zero tolerance" for those abuses.

APPENDIX 1: INTERNATIONAL LEGAL INSTRUMENTS ON SEXUAL VIOLENCE

In 1993, the Vienna Declaration and Programme of Action held that “Violations of the human rights of women in situations of armed conflict are violations of the fundamental principles of international human rights and humanitarian law. All violations of this kind, including in particular murder, systematic rape, sexual slavery, and forced pregnancy, require a particularly effective response”.⁶³

The DRC is a state party to the following international treaties of relevance to the issues it currently faces regarding sexual violence, its prevention and the medical and judicial response to it:

- UN Convention on the Elimination of all Forms of Discrimination against Women (1979)
- International Covenant on Civil and Political Rights (1966)
- International Covenant on Economic, Social and Cultural Rights (1966)
- UN Convention against Torture and Other Cruel and Inhuman and Degrading Treatment or Punishment (1984)
- African [Banjul] Charter on Human and Peoples’ Rights (1981)
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (2003)

Several other authoritative documents – resolutions, declarations and international conference outcome documents – also speak to the obligations of the DRC and the international community for promoting, protecting and fulfilling those rights that relate to the prevention and elimination of and response to sexual violence in the DRC.

a. International human rights law on sexual violence

Under the universal system of human rights protection, violence against women and girls constitutes both a violation of their human rights that prevents them from enjoying fundamental rights and freedoms⁶⁴ and a form of discrimination⁶⁵ which all states have an obligation to eradicate.⁶⁶ Article 2 of the **Declaration on the Elimination of Violence against Women**⁶⁷ states that violence against women “shall be understood to encompass, but not be limited to” physical, sexual and psychological violence “(a)...occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation; (b)... occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere, trafficking in women and forced prostitution; and (c) ...perpetrated or condoned by the State, wherever it occurs”.⁶⁸ According to former **UN Special Rapporteur on Violence against Women**, Radhika Coomaraswamy, rape as the ultimate violent and

⁶³ Section 3, para. 38, [www.unhcr.ch/huridocda/huridoca.nsf/\(Symbol\)/A.CONF.157.23.En](http://www.unhcr.ch/huridocda/huridoca.nsf/(Symbol)/A.CONF.157.23.En), see also Beijing Platform for Action, Fourth World Conference on Women (1995), paras. 114 and 131, <http://www.un.org/womenwatch/daw/beijing/platform/violence.htm>.

⁶⁴ Beijing Platform for Action, Fourth World Conference on Women (1995), para. 112

⁶⁵ “[...] violence against women is a manifestation of historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and to the prevention of the full advancement of women, and ... one of the crucial social mechanisms by which women are forced into a subordinate position compared with men”.

Declaration on the Elimination of Violence against Women, A/RES/48/104, 23 February 1994. See also CEDAW General Recommendation 19 (Violence against Women), UN Doc. A/47/38, 29 January 1992, para. 7.

⁶⁶ CEDAW General Recommendation 19 (Violence against Women), UN Doc. A/47/38, 29 January 1992, para. 24; Beijing Platform for Action, Fourth World Conference on Women (1995), para. 112-130.

⁶⁷ See footnote 65.

⁶⁸ Article 2.

degrading act of sexual violence constitutes "an intrusion into the most private and intimate parts of a woman's body, as well as an assault on the core of her self".⁶⁹

General Recommendation 19, adopted by the Committee on the Elimination of Discrimination against Women (CEDAW) in 1992⁷⁰, confirmed that the definition of discrimination against women contained in article 1 of the **Convention on the Elimination of All Forms of Discrimination against Women** included violence against women.⁷¹ **General Recommendation 19** states that "[w]ars, armed conflicts and the occupation of territories often lead to increased prostitution, trafficking in women and sexual assault of women, which require specific protective and punitive measures".⁷² The DRC has signed and ratified the Women's Rights Convention and its optional protocol.

In its concluding observations on the DRC in 2000⁷³, CEDAW noted the DRC's "economic, social and political problems related to the war, which have had a negative impact on the whole population, particularly on girls and women, who are often victims of rape and gender-based violence, and on most refugees and displaced persons, who are experiencing great hardship". It voiced its concern regarding "the persistence of prejudices and stereotyped behaviours with respect to the role of women and men in the family and society, based on the idea of male superiority and the consequent subordination of women to men". The Committee encouraged the government "to find the necessary resources to entrench the principle of gender equality, particularly ensuring the equal participation of women and men at all levels of decision-making". It furthermore urged the government to enact legislation prohibiting "traditional customs and practices, which are in violation of women's fundamental rights, such as dowry, the levirate, polygamy, forced marriage and female genital mutilation".

With regard to sexual violence, the Committee professed itself "gravely concerned about the reports of women who were raped, assaulted or severely tortured during the war [... and] about the situation of refugee and displaced women suffering from the consequences of war and at the psychological and mental trauma experienced by women and girls as a result of the forced conscription of children". It recommended the adoption of "specific and structural measures, including legislation to protect women from such acts and provide to women victims of violence psychosocial support and socio-economic integration measures" and the introduction of "awareness-raising measures to emphasize the importance of maintaining human rights standards in times of war".

Under the International Covenant on Civil and Political Rights, states are obliged not to violate women's human rights and to protect them from attacks on their rights by other actors in times of peace and war. The ICCPR contains specific obligations for States parties to respect the right to freedom from torture and the right not to be arbitrarily deprived of life; these are recognised under international law as non-derogable. In its General Comment 28 on Equality between Men and Women⁷⁴, the Human Rights Committee calls on states to "inform the Committee of all measures taken during these situations to protect women from rape, abduction and other forms of gender-based violence".

⁶⁹ Report to the UN Commission on Human Rights, UN Doc. E/CN.4/1997/47, 12 February 1997, para. 19.

⁷⁰ See footnote 65.

⁷¹ "The Convention in article 1 defines discrimination against women. The definition of discrimination includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty. Gender-based violence may breach specific provisions of the Convention, regardless of whether those provisions expressly mention violence", para. 6.

⁷² Para.16

⁷³ UN Doc. A/55/38, paras.194-238, 1 February 2000.

⁷⁴ UN Doc. CCPR/C/21/Rev.1/Add.10, 29 March 2000

In its most current set of Concluding Observations on the DRC in 2000⁷⁵, the **Human Rights Committee** expressed grave concern "at the rape of women and the perpetration of other forms of violence against them by armed men" and called on the government to "give women the necessary protection and assistance, ensure the reintegration of rape victims and do everything possible to identify and prosecute the perpetrators of these crimes."

In accordance with Article 19 of the International Convention on the Rights of the Child, the DRC is obliged to protect children against, "all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse".

The **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa**⁷⁶ requires governments to eliminate all forms of gender-based discrimination and violence. The protocol is robust and innovative in its definitions and recommendations. It provides for women to have equal access to justice and equal protection before the law, the right of access to adequate food and drinking water, and the right to education and economic, social and cultural rights, without discrimination. The protocol also guarantees widow's rights, including the right not to be subjected to any cruel, humiliating or degrading treatment, the right to guardianship, and the right to an equitable share in the inheritance of the husband's property. The DRC is a signatory of the Protocol but has not yet ratified it.

In accordance with Article 4 on the rights to life, integrity and security of the person, States Parties to the Protocol are obliged to adopt appropriate and effective measures to:

- a) enact and enforce laws to prohibit all forms of violence against women including unwanted or forced sex whether the violence takes place in private or public;
- b) adopt such other legislative, administrative, social and economic measures as may be necessary to ensure the prevention, punishment and eradication of all forms of violence against women;
- c) identify the causes and consequences of violence against women and take appropriate measures to prevent and eliminate such violence;
- d) actively promote peace education through curricula and social communication in order to eradicate elements in traditional and cultural beliefs, practices and stereotypes which legitimise and exacerbate the persistence and tolerance of violence against women;
- e) punish the perpetrators of violence against women and implement programmes for the rehabilitation of women victims;
- f) establish mechanisms and accessible services for effective information, rehabilitation and reparation for victims of violence against women;
- g) prevent and condemn trafficking in women, prosecute the perpetrators of such trafficking and protect those women most at risk; ...
- i) provide adequate budgetary and other resources for the implementation and monitoring of actions aimed at preventing and eradicating violence against women;

The State's duty to exercise due diligence

Under international law, as well as having a duty to respect the human rights of women and girls, the state also has a duty to protect their rights in the face of acts of gender-based violence wherever they occur and whether

⁷⁵ UN Doc. CCPR/C/79/Add.118, 27 March 2000.

⁷⁶ The protocol is not yet in force. The DRC signed the document on 9 September 1999.

or not those responsible are acting on the state's behalf. This obligation is not confined to ensuring that such acts are established as criminal offences in law but requires the state to adopt measures to prevent, punish and eradicate them.

The obligation to exercise *due diligence* is explicitly included in various instruments and documents relating to human rights protection.⁷⁷ In general, it refers to the degree of effort a state must make to comply with its duty to protect people from abuse. As far as the prohibition of discrimination against women is concerned, the duty to exercise due diligence requires the state to implement, immediately and without delay, a policy to combat violence that has its roots in the lack of equality between men and women.

According to the United Nations Special Rapporteur on Violence against Women, "a state can be held complicit where it fails systematically to provide protection from private actors who deprive any person of his/her human rights".⁷⁸

Exercising due diligence means adopting effective measures to prevent abuses, investigating them when they take place, prosecuting the alleged perpetrators and ensuring that they are brought to justice and given a fair trial, as well as ensuring that appropriate reparations are made to the victim. As well as ensuring that women who have suffered any form of violence have access to justice, the state must also ensure that the law effectively addresses their needs.

b. International humanitarian law on sexual violence

Under international humanitarian law applicable in time of armed conflict, all parties involved are answerable for any acts which contravene treaty-based or customary law. Rape and other forms of sexual abuse are prohibited under Common Article 3 of the **Geneva Conventions** which applies to both international and non-international armed conflicts: "To this end the following acts are and shall remain prohibited at any time and in any place whatsoever (...) (a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; (...) (c) outrages upon personal dignity, in particular, humiliating and degrading treatment; (...)". **Additional Protocol II** – which DRC acceded to on 12 December 2002– and which applies to non-international armed conflicts prohibits: "violence to life, health and physical or mental well-being of persons, in particular murder as well as cruel treatment such as torture, mutilation or any form of corporal punishment; collective punishments; taking of hostages; acts of terrorism; outrages upon personal dignity, in particular humiliating and degrading treatment, rape, enforced prostitution and any form of indecent assault; slavery and the slave trade in all its forms; pillage; [and] threats to commit any of the foregoing acts" (Article 4).

States parties to the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003)** incur specific obligations under Article 11 regarding the protection of women in armed conflicts:

- 1) States Parties undertake to respect and ensure respect for the rules of international humanitarian law applicable in armed conflict situations which affect the population, particularly women.

⁷⁷ In terms of jurisprudence, the most authoritative precedent is to be found in the inter-American system. In its judgment in the case of *Velásquez Rodríguez*, the Inter-American Court said that states parties have an obligation to guarantee the free and full exercise of the rights recognized by the Convention to all persons subject to their jurisdiction and that, as a consequence of that obligation, states must prevent, investigate and punish any violation of the rights recognized by the Convention.

⁷⁸ United Nations document E/CN.4/1996/53, para. 32.

2) States Parties shall, in accordance with the obligations incumbent upon them under the international humanitarian law, protect civilians including women, irrespective of the population to which they belong, in the event of armed conflict.

3) States Parties undertake to protect asylum seeking women, refugees, returnees and internally displaced persons, against all forms of violence, rape and other forms of sexual exploitation, and to ensure that such acts are considered war crimes, genocide and/or crimes against humanity and that their perpetrators are brought to justice before a competent criminal jurisdiction.

4) States Parties shall take all necessary measures to ensure that no child, especially girls under 18 years of age, take a direct part in hostilities and that no child is recruited as a soldier.

c. International criminal law on sexual violence

Some types of violence against women and girls can be classified as genocide,⁷⁹ crimes against humanity or war crimes, all of which are acknowledged under international criminal law to be among the most serious crimes.

The **Rome Statute of the International Criminal Court (ICC)** has sought to ensure that women who are the victims of crimes under international law have access to justice. The Rome Statute of the International Criminal Court (Statute of Rome) has been ratified by the DRC but has not yet been implemented into national legislation. The ICC can exercise its jurisdiction with respect to genocide, crimes against humanity and war crimes when states are unable or unwilling genuinely to investigate or prosecute such crimes. Although both men and women can be victims of most of these crimes, some forms especially or overwhelmingly affect women and girls.

The following offences are among those classified as crimes against humanity under Article 7 (1)(g) of the Rome Statute: rape, sexual slavery, enforced prostitution, enforced sterilization, and any other form of sexual violence of comparable gravity. The same article also expressly recognizes that enslavement includes the trafficking of women. Article 7(1)(h) provides that the persecution of any identifiable group or collectivity on gender grounds, when committed in connection with any crime for which the Court has jurisdiction, constitutes a crime against humanity. . The Elements of Crimes, which are designed to assist the ICC in the interpretation and application of the Rome Statute, includes [“forced penetration, using objects”] in its definition of rape.⁸⁰

However, the definitions of rape and other crimes of sexual violence in international law have evolved considerably since the adoption of the Rome Statute and the Elements of Crimes. The penal code should define rape and other crimes of sexual violence in a way that is consistent with evolving international law.

Furthermore, under international law rape is also considered to amount to torture when it is perpetrated by agents of the state. The State can also be held accountable for acts of rape perpetrated by private actors, if it has failed to exercise due diligence to prevent, punish or redress the crime. International law permits, and in

⁷⁹ It is now firmly accepted that violence against women can be used as a means to commit genocide. Although women were not among the four groups expressly protected by the Convention on the Prevention and Punishment of the Crime of Genocide (Genocide Convention) of 1948, certain types of attacks on women belonging to one of the four protected groups (national, ethnic, racial and religious), when committed with the intent to destroy such groups, in whole or in part, can amount to genocide. See *Prosecutor v. Akayesu*, Judgment, Case No. ICTR-96-4, Trial Chamber, 2 September 1998, paras. 508, 706, 731-734 ; *aff'd*, Appeals Chamber, 1 June 2001.

⁸⁰ PCNICC/2000/1/Add.2, 2 November 2000

some cases requires, any state to exercise universal jurisdiction over rape and other crimes of sexual violence committed by agents of the state or combatants in the DRC.⁸¹

Therefore, the Democratic Republic of the Congo should ensure that rape and other crimes of sexual violence are defined consistently with the Rome Statute and other international law, as reflected in the most recent jurisprudence, not only as crimes under international law, such as genocide, crimes against humanity, war crimes and torture, but also as ordinary crimes under national law in other instances.

⁸¹ Amnesty International, *Universal jurisdiction: The duty of states to enact and implement legislation*, AI Index: IOR 53/002-018/2001, September 2001.

APPENDIX 2: SEXUAL VIOLENCE: VIOLATION OF THE RIGHT TO HEALTH AND OF SEXUAL AND REPRODUCTIVE RIGHTS

At various international conferences, governments have condemned rape as a weapon of war:

- The World Conference on Human Rights (1993) expressed “its dismay at massive violations of human rights especially in the form of genocide, ‘ethnic cleansing’ and systematic rape of women in war situations, creating mass exodus of refugees and displaced persons”. Strongly condemning these practices, it reiterates demands “that perpetrators of such crimes be punished and such practices immediately stopped”.⁸²
- At the International Conference on Population and Development (1994), countries were “urged to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation”.⁸³
- The Fourth World Conference on Women (1995) held: “Grave violations of the human rights of women occur, particularly in times of armed conflict, and include murder, torture, systematic rape, forced pregnancy and forced abortion, in particular under policies of ‘ethnic cleansing’”.⁸⁴

Sexual slavery and sexual assault, including rape, constitute **violations of women’s right to health and, in particular, their sexual and reproductive rights**. As this report documents, they may lead to serious reproductive and sexual health consequences: unwanted and early pregnancy and the detrimental health effects of unsafe abortion, physical and psychological trauma, and sexually transmitted diseases, including HIV/AIDS.

In conformity with the right to health, women should have access to health services, including in particular sexual and reproductive health services. Denial of such services to women may constitute gender discrimination in addition to constituting a violation of their right to health.

The **right to the highest attainable standard of health** is codified in a variety of international and regional instrument (ICESCR Article 12, CEDAW Article 12, African Charter on Human and People’s Rights Article 16).

The International Committee on Economic, Social and Cultural Rights has interpreted the right to health as

an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health. A further important aspect is the participation of the population in all health-related decision-making at the community, national and international levels..⁸⁵

⁸² UN World Conference on Human Rights, Vienna Declaration and Programme of Action, Vienna, Austria, UN Doc. A/CONF.157/23, 1993, para. 28.

⁸³ International Conference on Population and Development, Cairo, Egypt, 1994, UN Doc. A/CONF.171/13, para. 4.10.

⁸⁴ Fourth World Conference on Women, Beijing, China, 1995, UN Doc. A/CONF.177/20, para. 11.

⁸⁵ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, *The Right to Health*, UN Doc. E/C.12/2000/4, para 11.

The extent to which governments implement – or fail to implement – the right to health can be assessed by reference to four criteria which the Committee on Economic, Social and Cultural Rights has laid out in its General Comment 14 (The right to the highest attainable standard of health)⁸⁶:

(a) **Availability.** Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity. The precise nature of this obligation will vary depending on numerous factors, including the State party's developmental level. It will include, however, the underlying determinants of health, as discussed above and additionally, hospitals, clinics, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs.

(b) **Accessibility.** Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

- *Non-discrimination:* health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
- *Physical accessibility:* health facilities, goods and services, medical services and the underlying determinants of health must be within safe physical reach, especially for vulnerable or marginalized groups.
- *Economic accessibility (affordability):* health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.
- *Accessibility of Information:* this includes the right to seek, receive and impart information and ideas (cf. Article 19.2 of ICCPR) concerning health issues (cf. Article 24 of CRC on right to education for health). However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) **Acceptability.** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) **Quality.** As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.⁸⁷

Even if available resources are manifestly inadequate to realise the right to health, the DRC must take immediate, concrete and targeted measures to realise at the very least minimum essential levels of the right to health. This will include:

- ensuring the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;

⁸⁶ Ibid.

⁸⁷ Adapted from CESCR General Comment 14, *supra*, para 12.

- ensuring access to the minimum essential food which is nutritionally adequate and safe, to ensuring freedom from hunger to everyone;
- ensuring access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- providing essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- ensuring equitable distribution of all health facilities, goods and services;
- adopting and implementing a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.
- ensuring reproductive, maternal (pre-natal as well as post-natal) and child health care;
- providing immunization against the major infectious diseases occurring in the community;
- taking measures to prevent, treat and control epidemic and endemic diseases;
- providing education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- providing appropriate training for health personnel, including education on health and human rights.

These obligations are considered to be non-derogable, meaning that the state cannot delay their realisation under any circumstances.⁸⁸ The international community too, holds a particular obligation to assist DRC to realise at least these minimum essential levels of the right to the highest attainable standard of health.⁸⁹

Reproductive and sexual rights are composite rights, founded on the various human rights codified under international human rights law.⁹⁰

Building strongly on the elaboration of the rights to health, reproductive rights were first internationally codified at the 1994 International Conference on Population and Development in Cairo. At the ICPD, governments noted that “reproductive health eludes many of the world’s people because of such factors as inadequate levels of knowledge about human sexuality and inappropriate or poor-quality reproductive health information and services; the prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited power many women and girls have over their sexual and reproductive lives”.

They laid down the following definitions of reproductive health and reproductive rights:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. ... [Reproductive health] also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases. (para. 7.2)

⁸⁸ Ibid, para 45.

⁸⁹ Ibid, para 18.

⁹⁰ Rebecca C. Cook, ‘International Human Rights and Women’s Reproductive Health’, in J. Peters and A. Wolper, *Women’s Rights, Human Rights*, Routledge, 1995, p. 259.

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. As part of their commitment, full attention should be given to the promotion of mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality. (para. 7.3)

These definitions were endorsed at the Fourth World Conference on Women (Beijing 1995).⁹¹ The Beijing Platform for Action states that: "The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" (para. 96). At Beijing, governments vowed to "take action to ensure the conditions necessary for women to exercise their reproductive rights and eliminate coercive laws and practices" (Beijing Platform for Action, para. 107).⁹²

Former Special Rapporteur on Violence against Women, Radhika Coomaraswamy, has stated:

Forced abortions, forced contraception, coerced pregnancy and unsafe abortions each constitute violations of a woman's physical integrity and security of person. In cases, where, for instance, government officials utilize physical force and/or detain women in order to force them to undergo these procedures, these practices may amount to torture and cruel, inhuman and degrading treatment.⁹³

In its General Recommendation 19 (Violence against Women), the CEDAW Committee recommends that states "ensure that measures are taken to prevent coercion in regard to fertility and reproduction" (para. 24(m)).

Like reproductive rights, **sexual rights** embrace human rights that are already recognized in national laws, international human rights documents and other consensus documents. These include the right of all persons, free of coercion, discrimination and violence, to the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive health care services; seek, receive and impart information in relation to sexuality; sexuality education; respect for bodily integrity; choice of partner; freedom to decide to be sexually active or not; consensual sexual relations; consensual marriage; freedom to decide whether or not, and when to have children; and freedom to pursue a satisfying, safe and pleasurable sex life.⁹⁴

Considering sexual and reproductive health through the prism of the right to health, UN Special Rapporteur on the Right to Health Paul Hunt has elaborated an analysis of sexual and reproductive rights in terms of freedoms and entitlements⁹⁵:

The right to health, including sexual and reproductive health, encompasses both freedoms, such as freedom from discrimination, and entitlements. In the context of sexual and reproductive health, freedoms include a

⁹¹ See para. 96.

⁹² <http://www.un.org/womenwatch/daw/beijing/platform/health.htm>

⁹³ UN Doc. E/CN.4/1999/68/Add. 4, para. 45, see also paras. 49 and 51.

⁹⁴ www.iwhc.org

⁹⁵ UN Special Rapporteur on the right of everyone to the highest attainable standard of health, *Report to the UN Commission on Human Rights*, UN Doc. E/CN.4/2004/49, 16 February 2004.

right to control one's health and body. Rape and other forms of sexual violence, including forced pregnancy, non-consensual contraceptive methods (e.g. forced sterilization and forced abortion), forced marriage all represent serious breaches of sexual and reproductive freedoms, and are fundamentally and inherently inconsistent with the right to health. Some cultural practices carry a high risk of disability and death. Early marriage, which disproportionately affects girls is linked to health risks including those arising from premature pregnancy. It should be emphasized that although subject to progressive realization and resource constraints, the international right to health imposes various obligations of immediate effect (ibid., para. 27). These immediate obligations include a duty on the State to respect an individual's freedom to control his or her health and body. For example, there is an immediate obligation on a State not to engage in forced sterilization and not to engage in discriminatory practices. In other words, the freedom components of sexual and reproductive health are subject to neither progressive realization nor resource availability.

The right to health includes an entitlement to a system of health protection, including health care and the underlying determinants of health, which provides equality of opportunity for people to enjoy the highest attainable level of health. For example, women should have equal access, in law and fact, to information on sexual and reproductive health issues. Thus, States have an obligation to ensure reproductive health and maternal and child health services, including appropriate services for women in connection with pregnancy, granting free services where necessary. More particularly, States should improve a wide range of sexual and reproductive health services, including access to family planning, pre- and post-natal care, emergency obstetric services and access to information. The Special Rapporteur urges all duty-holders also to ensure access to such vital health services as voluntary testing, counselling and treatment for sexually transmitted infections, including HIV/AIDS, and breast and reproductive system cancers, as well as infertility treatment. ... Women with unwanted pregnancies should be offered reliable information and compassionate counselling, including information on where and when a pregnancy may be terminated legally. Where abortions are legal, they must be safe: public health systems should train and equip health service providers and take other measures to ensure that such abortions are not only safe but accessible. In all cases, women should have access to quality services for the management of complications arising from abortion. Punitive provisions against women who undergo abortions must be removed. Even when resources are scarce, States can achieve major improvements in the sexual and reproductive health of their populations.

The Special Rapporteur offers the following interpretation of the respect/protect/fulfil framework in the context of sexual and reproductive health:

The obligation to *respect* requires States to refrain from denying or limiting equal access for all persons to sexual and reproductive health services, as well as the underlying determinants of sexual and reproductive health. For example, it requires them to refrain from denying the right to decide on the number and spacing of children. The obligation to *protect* means that States should take steps to prevent third parties from jeopardizing the sexual and reproductive health of others, including through sexual violence and harmful cultural practices. The obligation to *fulfil* requires States to give recognition to the right to health, including sexual and reproductive health, in national political and legal systems. Health systems should provide for sexual and reproductive health services for all, including in rural areas, and States should carry out information campaigns to combat, for example, HIV/AIDS, harmful traditional practices and domestic violence.

CEDAW has drawn attention to women's reproductive health in the DRC, noting "with deep concern the high rates of maternal and infant mortality, the low rate of contraceptive use, particularly in rural areas, and the decline in health services". It called on the government to improve the use of contraceptives and to promote the improvement of health services for women throughout their life-cycle.⁹⁶

Deploing the poor health situation of and access to health services for children in the DRC, the **Committee on the Rights of the Child** has expressed its concern with "the very limited access of most children to adequate health care, and the very high rates of maternal and infant mortality, and the lack of an adequate family planning policy". It has drawn attention in particular to "weaknesses in the health infrastructure, including a lack of appropriate equipment within many health centres, the limited quality of services and low immunization rates".⁹⁷ The Committee recommended that the DRC "make every effort to reduce the incidence of HIV/AIDS by preventing its transmission among the population through, *inter alia*, the procurement of suitable medication, a review of legislation, including the repeal of article 178 of the Criminal Code and suitable prevention campaigns. The Committee recommends further that the State party provide assistance to children and their families affected by HIV/AIDS" based on "an assessment of adolescent health problems", including in the area of reproductive health, and "a comprehensive policy in this regard".

On the issues of forced and child marriage, the Committee recommended the implementation of "measures to ensure that traditional marriage practices, including forced marriages, which are harmful to children are prohibited through, *inter alia*, the adoption and implementation of appropriate legislation".

At the regional level, the right to health, including reproductive and sexual health, is codified in the **African Charter on Human and People's Rights**. Article 16(2) obliges states to "take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick". Article 14 of the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003)** [Health and Reproductive Rights] contains the most far-reaching international formulation of women's sexual and reproductive health rights. It holds that

1. States Parties shall ensure that the right to health of women, including sexual and reproductive health is respected and promoted. This includes:
 - a. the right to control their fertility;
 - b. the right to decide whether to have children, the number of children and the spacing of children;
 - c. the right to choose any method of contraception;
 - d. the right to self protection and to be protected against sexually transmitted infections, including HIV/AIDS;
 - e. the right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS, in accordance with internationally recognised standards and best practices;
 - f. the right to have family planning education.
2. States Parties shall take all appropriate measures to:
 - a. provide adequate, affordable and accessible health services, including information, education and communication programmes to women especially those in rural areas;
 - b. establish and strengthen existing pre-natal, delivery and post-natal health and nutritional services for women during pregnancy and while they are breast-feeding;

⁹⁶ UN Doc. A/55/38, paras.194-238, 1 February 2000.

⁹⁷ UN Doc. CRC/C/15/Add.153, 1 July 2001.

- c. protect the reproductive rights of women by authorising medical abortion in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus.

The relevance of the provisions of this article to the current situation of women in DRC is clear. All relevant actors are called upon to give effect to women's health rights, including their sexual and reproductive rights in the comprehensive manner the Protocol calls for.

"Several years of experience in addressing the HIV/AIDS epidemic have confirmed that the promotion and protection of human rights constitute an essential component in preventing transmission of HIV, reducing vulnerability to infection and the impact of HIV/AIDS."⁹⁸

The DRC government has an obligation to respect, protect and fulfil the fundamental human rights of people living with HIV. It must also live up to its obligations under the right to health, including sexual and reproductive health, by establishing and implementing laws and policies that help people to protect themselves against contracting HIV/AIDS. The prevention of sexual violence and the provision of comprehensive health services, including sexual and reproductive rights services, are crucial components of a rights-based approach to combating HIV/AIDS.

In 1997, a wide-ranging consultation by UNAIDS and the Office of the United Nations High Commissioner for Human Rights produced the International Guidelines on HIV/AIDS and Human Rights⁹⁹ as a tool to help states implement an effective, right-based response to HIV/AIDS. The guidelines consist of two parts: 1) the human rights principles underlying the positive response to the epidemic, and 2) action-oriented measures to be employed by governments in the areas of law, administrative policy and practice that will protect human rights and achieve HIV-related public health goals. Each of the Guidelines aims to provide guidance to governments on issues such as those raised in this report, including:

- establishment of an effective national framework for a governmental response to HIV/AIDS which ensures a coordinated, participatory, transparent and accountable approach, integrating HIV/AIDS policy and programme responsibilities across all branches of government (Guideline 1);
- review and reform of public health laws to ensure that they adequately address public health issues raised by HIV/AIDS (Guideline 3);
- review and reform of criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV/AIDS or targeted against vulnerable groups (Guideline 4);
- enactment or strengthening of anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV/AIDS and people with disabilities from discrimination in both the public and private sectors (Guideline 5);
- enactment of legislation to provide for the regulation of HIV-related goods, services and information, so as to ensure widespread availability of quality prevention measures and services, adequate HIV prevention and care information, and safe and effective medication at an affordable price; measures (at both the domestic and international levels) to ensure for all persons, on a sustained and equal basis, the availability and accessibility of quality goods, services and information for HIV/AIDS prevention, treatment, care and support, including antiretroviral and other safe and effective medicines, diagnostics and related

⁹⁸ UNAIDS, *HIV/AIDS, Human Rights & Law*, www.unaids.org/EN/in+focus/hiv_aids_human_rights.asp

⁹⁹ http://www.unaids.org/EN/in+focus/hiv_aids_human_rights.asp

- technologies for preventive, curative and palliative care of HIV/AIDS and related opportunistic infections and conditions; particular attention to vulnerable individuals and populations (Guideline 6¹⁰⁰);
- promotion of a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups (Guideline 8);
 - promotion of the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance (Guideline 9);
 - monitoring and enforcement mechanisms to guarantee the protection of HIV-related human rights, including those of people living with HIV/AIDS, their families and communities (Guideline 11);
 - cooperation through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV-related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV/AIDS at the international level (Guideline 12).

In its Resolution 1308 (2000) "on the Responsibility of the Security Council in the Maintenance of International Peace and Security: HIV/AIDS and International Peace-keeping Operations", adopted on 17 July 2000, the UN Security Council reaffirmed "the importance of a coordinated international response to the HIV/AIDS pandemic, given its possible growing impact on social instability and emergency situation" and recognizes that "the HIV/AIDS pandemic is also exacerbated by conditions of violence and instability, which increase the risk of exposure to the disease through large movements of people, widespread uncertainty over conditions, and reduced access to medical care". It stressed that "the HIV/AIDS pandemic, if unchecked, may pose a risk to stability and security".¹⁰¹

On 27 June 2001, the UN General Assembly adopted its Declaration of Commitment on HIV/AIDS¹⁰², reaffirming that the full realization of human rights and fundamental freedoms for all is an essential element in a global response to the HIV/AIDS pandemic, including in the areas of prevention, care, support and treatment, and that it reduces vulnerability to HIV/AIDS and prevents stigma and related discrimination against people living with or at risk of HIV/AIDS. It also emphasised that "violence against women contributes to the conditions fostering the spread of HIV/AIDS".

At its most recent session – as at previous sessions – the UN Commission on Human Rights passed a resolution on "Access to medications in the context of pandemics such as HIV/AIDS, tuberculosis and malaria".¹⁰³ In this resolution, the Commission acknowledged that "access to medication in the context of pandemics such as HIV/AIDS, tuberculosis and malaria is one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". It called on states "to develop and implement national strategies, in accordance with applicable international law, including international agreements acceded to, in order progressively to realize access for all to prevention-related goods, services and information as well as access to comprehensive treatment, care and support for all individuals infected and affected by pandemics such as HIV/AIDS, tuberculosis, and malaria" and "to establish or strengthen national health and social infrastructures and health-care systems, with the assistance of the international community as necessary, for the effective delivery of prevention, treatment, care and support to respond to pandemics such as HIV/AIDS, tuberculosis, and malaria".

¹⁰⁰ Revised in August 2002, see UNAIDS/02.49E

¹⁰¹ <http://www.reliefweb.int/w/rwb.nsf/s/D1261FD7EA89821C85256B8000774BFB>

¹⁰² UN Doc. A/RES/S-26/2, 2 August 2001.

¹⁰³ UN Doc. E/CN.4/RES/2004/26, 15 April 2004.

The Commission also drew attention to the increase in women's vulnerability to HIV/AIDS due to violence against women and girls, including rape, female genital mutilation, incest, early and forced marriage, violence related to commercial sexual exploitation, including trafficking, as well as economic exploitation and other forms of sexual violence in a resolution on the "Elimination of violence against women".¹⁰⁴

¹⁰⁴ UN Doc. E/CN.4/RES/2004/46, 20 April 2004.

GLOSSARY OF ARMED GROUPS AND FORCES

- APC *Forces armées du peuple congolais*, Congolese People's Armed Forces, a Congolese armed political group based on the town of Aru in north-eastern DRC, bordering Uganda. Reportedly receives Ugandan support.
- FARDC *Forces armées de la République Démocratique du Congo*, DRC Armed Forces. New DRC government army. Units from a number of Congolese armed groups who are signatory to the 2002 All-Inclusive Peace Agreement are designated to be integrated into this force, although little substantial progress has been made on integration.
- FDD *Forces pour la Défense de la Démocratie*, Forces for the Defence of Democracy. A Burundian armed group which has now largely withdrawn from eastern DRC following peace deal with the Burundian government and its entry into a new inclusive Burundi government in November 2003.
- FDLR *Forces démocratiques de libération du Rwanda*, Democratic Liberation Forces of Rwanda. Rwandan insurgent group opposed to the Rwandan government. Present in eastern DRC since 1994 and popularly referred to as the *interahamwe*. Although some elements of the FDLR took part in the 1994 Rwandan genocide, many of its combatants were recruited subsequently.
- FNI/FRPI *Front des nationalistes et intégrationnistes / Forces de résistance patriotique en Ituri*, Nationalist Integrationist Front / Ituri Patriotic Resistance Forces, Congolese armed group in Ituri dominated by the Lendu ethnic group.
- FNL *Forces nationales de libération*, National Liberation Forces. A Burundian insurgent group which has used DRC as a rear area for its military operations in Burundi.
- Mayi-mayi Congolese militia forces, operating under separate local commands, which together formed a major, if incohesive, armed group opposed to Rwandan and Ugandan presence in eastern DRC, as well as to armed groups supported by those two countries. The mayi-mayi is represented in the transitional government.
- MLC *Mouvement de Libération du Congo*, Congo Liberation Movement. A major armed group based on Gbadolite in northern DRC. Signatory to the Peace Agreement and now a major component of the transitional government, in which it holds a Vice-Presidency and a number of ministerial posts.
- RCD-Goma *Rassemblement Congolais pour la Démocratie – Goma*, Congolese Rally for Democracy – Goma. Congolese armed group in eastern DRC and signatory to the Peace Agreement. It holds a Vice-Presidency and a number of ministerial positions in the transitional government. Throughout the conflict the RCD-Goma was backed by Rwanda, which maintains a strong influence over sections of the group. In 2004 the RCD-Goma almost split into pro- and anti-transition factions; these divisions have not been fully resolved.
- RCD-ML *Rassemblement Congolais pour la Démocratie – Mouvement de Libération*, Congolese Rally for Democracy – Liberation Movement. Signatory to the Peace Agreement and now a member of the transitional government. Based around Beni and Butembo in northern North-Kivu.

- RDF Rwandan Defence Force. Rwandan government army. Previously known as Rwandan Patriotic Army (RPA).
- UPC *Union des Patriotes Congolais*, Union of Congolese Patriots. An armed political group in Ituri, dominated by the Hema ethnic group. The UPC has split in two: a wing close to its president Thomas Lubanga (UPC-L) and another wing close to the former UPC Chief of Defence, Floribert Kissembo (UPC-K).
- UPDF Ugandan People's Defence Force. Ugandan government army.