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Profile of providers in the management of gender-based violence in the provinces of Haut-Katanga and Lualaba in the Democratic Republic of Congo

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Abstract

Introduction: In the Democratic Republic of Congo, gender-based violence (GBV) is a persistent health emergency. This study aims to analyze the profile of providers involved in the care of survivors in the provinces of Haut-Katanga and Lualaba, highlighting inequalities in access to training, the distribution of skills and the weaknesses of health facilities.

Methodology: This is a multicenter descriptive study of 100 providers working in public, private, humanitarian and university facilities. Data were collected using a structured questionnaire. Statistical analysis used frequencies, percentages and Chi-square tests to identify significant associations.

Results: Women were in the majority among claimants (53%), particularly in the 25-45 age group. Less than half of respondents have received training in GBV, with a marked deficit in the public sector (26.2% trained). Nurses and doctors are the most represented, while midwives are marginalized. Rural health centers are largely devoid of specialized units (59.1% not equipped). No significant difference was observed between men and women in terms of access to training.

Conclusion: The study reveals a fragmented response to GBV, marked by gaps in training, disparities between structures and under-representation of key players. Structural reform is needed to integrate the management of GBV into health systems in a sustainable way, particularly in rural areas and public services.

Key words : Gender-based violence; Democratic Republic of Congo; Health system; Gender; Midwives; Health structures - Rural health services - Training

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1. Introduction

The natural resources of the Democratic Republic of Congo (DRC) have featured in political debates as the main example of conflict minerals at the root of conflict-related sexual violence. In the world in general, and in Africa in particular, inequalities exist between men and women in many areas of life (Spittaels et al., 2010). Many women and girls are regularly the victims of acts of violence that cause them physical, sexual and psychological suffering, due to the differences established between the sexes in our societies. According to the United Nations, gender-based violence, also known as "sexist violence" or "gender-specific violence", describes harmful acts committed against someone's will, based on the differences established by society between men and women (gender) (Konkobo & Ouedraogo, n. d.).

According to the protocol for the care of victims of gender-based violence used by social services, gender-based violence is any violence perpetrated against a person because of their sex (social sex). Rape, one of the entities that make up gender-based violence, is any act of sexual penetration of any kind, committed on the person of another, by violence, coercion or surprise. Efforts to rape a person that do not result in penetration are considered attempted rape. It is an act of non-consensual sexual intercourse (World Health Organization, 2019).

Detailed survey data from the 2013/2014 Demographic and Health Survey of women aged 15-49 on their exposure to sexual violence committed by intimate partners and others (non-partners) indicates that women living near mining areas are indeed more likely to experience sexual violence of both types, although the effect is stronger for non-partner sexual violence. In the provinces of Kivu and Maniema, the risk of experiencing non-partner sex is particularly high for women living near a mine with the presence of an armed actor (Siri A., & al., 2016). Sexual violence is a medical emergency that requires immediate medical and psychological care to limit the consequences for survivors (MSF, 2021). This MSF report suggests that in order to offer quality care, it is essential that donors and other actors mobilize around the training of health center staff. These staff must be trained in the medical and psychological care of victims in all support programs at primary level (Organization & Women, 2022).

To qualify and care for victims of gender-based violence, structures and trained personnel are needed. Thus, through this study, we aim to determine the profile of providers in the management of gender-based violence in health facilities in the provinces of Haut-Katanga and Lwalaba.

2. Methods

This descriptive, multicenter study was carried out in the provinces of Haut-Katanga and Lualaba, among providers involved in the management of gender-based violence (GBV). Participants were recruited on the basis of convenience sampling, specifically targeting health workers who reported having already managed at least one case of GBV at their facility.

Inclusion criteria included: being a health professional (nurse, doctor, midwife, psychologist, etc.), working in a public or private health facility in the target provinces, and having proven experience in the management of GBV.

Data were collected using a structured questionnaire administered face-to-face. A total of 100 providers were surveyed. Data analysis was carried out using appropriate statistical software to provide results in the form of frequencies, percentages and descriptive interpretations.

3. Results

Table 1 Distribution by gender and age

Age group	Men (n)	Female (n)	Total % of total
< 25 years old	1	6	7 (7,8 %)
25-35 years old	15	24	39 (43,3 %)
36-45 years old	13	21	34 (37,8 %)
46-55 years old	6	2	8 (8,9 %)

Women represent the majority in the 25-35 and 36-45 age brackets, with a high concentration of claimants between the ages of 25 and 45 (81%). There are very few young people under 25. This reflects a young, active professional population. The predominance of women in key age brackets suggests a change in gender dynamics among care providers.

Table 2 Distribution of trained and untrained providers by type of facility

Type of facility	Trained (n)	Untrained (n)	Total	% Trained
Public	11	31	42	26,2 %
Private	9	19	28	32,1 %
Humanitarian / NGO	6	5	11	54,5 %
Academic	5	4	9	55,6 %

Only 26.2% of providers in public facilities are trained, compared with 54.5% in humanitarian facilities and 55.6% in universities. Despite its central role, the public sector suffers from a serious lack of training on GBV. This points to a structural and institutional weakness in the public response.

Table 3 Breakdown of professions by type of health facility

Profession	Public	Private	Humanitarian / NGO	Academic	Total
Attending physician	15	8	5	5	33
Nurse	18	13	4	6	41
Midwife	3	3	1	2	9
Medical biologist	1	2	0	1	4
Public health	4	1	1	2	8
Other appraisals	1	1	0	1	3

The two most represented professions are:

- Nurses (41), who are often the first to detect cases of GBV in primary care facilities;
- Attending physicians (33), who handle medical emergencies and clinical consultations.
- The fact that the majority of these professionals work in public facilities highlights the need to strengthen this sector's GBV capabilities.
- Midwives are relatively few in number in the sample, but their role is crucial in detecting obstetric sexual violence (violence during childbirth, abuse in maternity care, etc.).
- Public health profiles and medical biologists, although in the minority, could play a key role in the epidemiological surveillance of GBV and in supporting prevention campaigns.

Table 4 Breakdown of provider training by gender

Training on GBV / Gender	No	Yes	Chi-square	P(α=0.05)
Female	28	25	53	0.241
Male	26	19	45	0.624
Total	54	44	98	

No significant difference in training by gender (p = 0.624). Training is available to both men and women, but overall coverage remains low (44% trained).

Table 5 Breakdown of results by type of structure and provider training

Training on VBSG	No	Yes	Chi-square	P(α=0.05)
Structures	26	14	40	2,676
Private structures	28	30	58	2,676
Total	54	44	98	

- 30 providers trained in the private sector vs. 14 in the public sector. The Chi-square test suggests a notable difference. Private facilities, which are often better funded or supported by NGOs, offer more training opportunities than public facilities.

Table 6 Ratio of facilities providing treatment for sexual violence

Existence of a sexual violence Management unit	CSR(n=22)	HGR(n=20)
Yes	9 (40.9%)	10 (50%)
No	13 (59.1%)	10 (50%)

59.1% of Centres de Santé Ruraux (CSR) do not have a care unit. In HGRs, 50% have none either. This reflects a glaring lack of institutional arrangements to respond effectively to sexual violence, especially in rural areas.

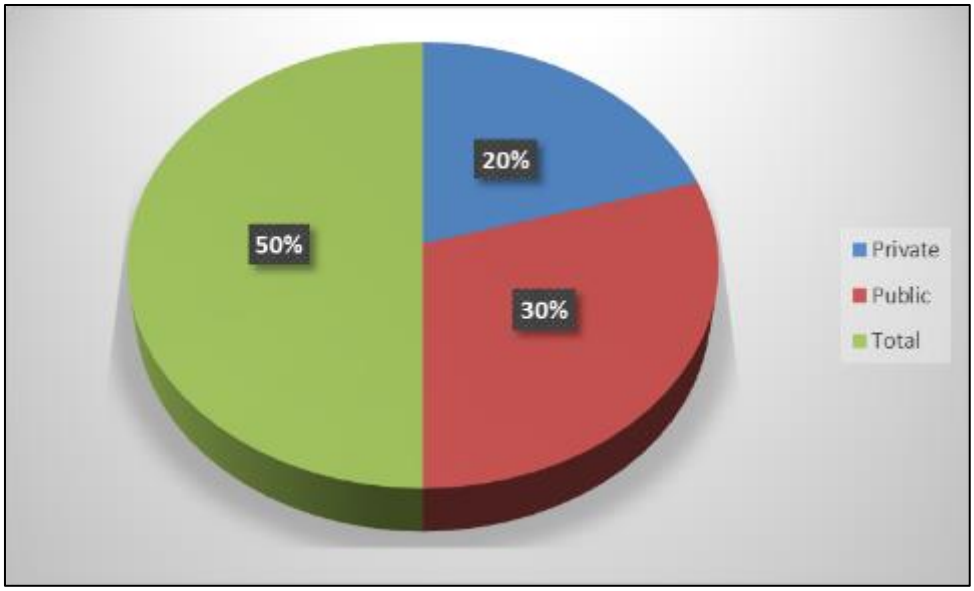

Figure 1 Breakdown of results by private or public health facility Frequency

This distribution suggests a preponderance of public structures in the results (30%) compared with private structures (20%).

4. Discussion

4.1. A fragmented healthcare system in the face of gender-based violence

The results of the study show a lack of systemic structuring in the response to gender-based violence (GBV), particularly in public and rural facilities. This fragmentation reflects a lack of integrated, interdisciplinary health policy.

According to Garcia-Moreno et al. (2015), an effective response to GBV requires organized health systems with clear protocols, ongoing training and intersectoral coordination. Bott et al. (2014) emphasize that untrained providers risk revictimizing survivors by asking inappropriate questions or minimizing the facts. World Health Organization (2013) adds that post-rape care must be available at all levels of the health pyramid, including HIV prophylaxis, emergency contraception and psychosocial support.

In Africa, Mutisya et al (2018) highlight the lack of quality services for survivors in basic structures, compounded by gender stereotypes and patriarchal attitudes. In the DRC, Dougnon et al. (2020) reveal that even in urban areas, providers do not always master holistic care protocols, due to lack of training or supervision. Finally, Human Rights Watch (2021) warns of the lack of accountability and monitoring mechanisms in Congolese mining areas, often linked to sexual violence.

4.2. Inequalities in training by type of facility: a worrying double standard

The disparity observed between public structures (26.2% trained) and humanitarian or university structures (> 50% trained) shows that access to training is conditioned by external partnerships and not by a coherent national policy.

Jewkes et al (2019) observe that NGOs play a compensatory role in the face of structural failings on the part of the state, creating lasting inequalities in access to expertise. In the DRC, O'Callaghan et al. (2013) demonstrated that training funded by donors (UNDP, UNFPA, etc.) is often ad hoc and limited to intervention zones. Freedman (2014) insists that training integrated into national curricula offers a sustainable and egalitarian solution.

Temmerman et al (2015) point out that the absence of post-training follow-up, on-site coaching and evaluation has a negative impact on the quality of the services provided. Similarly, Krantz et al. (2020) point out that providers trained without organizational support can quickly become demobilized or discouraged. Thus, anchoring in public structures requires systemic investment (budget, HR policies, supervision).

4.3. Marginalized role of midwives: loss of strategic leverage

Despite their importance in sexual and reproductive health, midwives are poorly represented in the sample. Yet they are often the first point of contact with victimized women, particularly during prenatal consultations or traumatic deliveries.

Filby et al (2016) show that trained midwives are key players in detecting GBV, particularly obstetric violence (verbal abuse, episiotomies without consent, humiliation). UNFPA (2022) calls for investment in training midwives in psychosocial care, legal documentation and post-trauma management. Homer et al (2014) point out that investment in midwives not only improves maternal health indicators, but also the response to GBV.

In the DRC, Mulumba & Namusobya (2021) observed that rural midwives often receive no specific training on sexual violence, even though they are closest to vulnerable communities. Nganga et al (2020) call for a strategic repositioning of midwives in policies to combat GBV.

4.4. Neglected rural areas: double vulnerability and chronic under-equipment

The results show that 59.1% of rural health centers do not have a sexual violence unit. This constitutes a direct attack on equity of access to care for victims in isolated environments.

Murray et al (2015) explain that the concentration of resources in urban centers creates health deserts for women in rural areas. Semahegn & Mengistie (2015) indicate that rural survivors are less likely to obtain prompt legal or medical assistance, exacerbating the risks of infections and psychological trauma. Sibanda & Machingura (2020) note that rural providers often lack the means to refer victims.

According to UN Women (2021), community care systems need to be strengthened to ensure a rapid first response (PEP kits, counseling). Kiwanuka et al (2020) add that training community relays (RECOs) is essential for early case notification.

4.5. Gender equity in access to training: apparent but insufficient progress

The study shows no significant difference in training between men and women, which seems to indicate a degree of equity in access. However, this numerical equality sometimes masks qualitative differences in perception and commitment.

Morgan et al. (2016) demonstrate that female providers can develop greater sensitivity in dealing with victims, which requires a strengthening of the psychosocial content of training. WHO (2019) points out that female victims are more likely to confide in providers of the same gender, which makes training women particularly strategic.

George et al. (2019) stress the importance of an intersectional approach, taking into account not only the provider's gender but also their cultural environment, experience and clinical posture. Okenwa-Emegwa et al. (2020) remind us that equity in numbers does not always guarantee equivalent competence, especially if pedagogical content is not harmonized.

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that they have no conflict of interest to disclose.

Statement of informed consent

Written informed consent was obtained from all individual participants and / or their legal guardians prior to inclusion in the study.

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