

Integrated Health Project of the DRC (DRC-IHP): A Gender Analysis in the DRC

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Integrated Health Project

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A Gender Analysis in the Democratic Republic of Congo

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List of Acronyms

ANC	Antenatal Care
ARI	Acute Respiratory Infections
BMI	Body Mass Index
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CODESA	<i>Comité de Développement de l'Aire de Santé</i> (Health Area Development Committees)
DHS	Demographic Health Survey
DRC	Democratic Republic of Congo
EC	Emergency Contraceptive
FP	Family Planning
GBV	Gender Based Violence
GDP	Gross Domestic Product
GHI	Global Health Initiative
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HDI	Human Development Index
HN	Head Nurse
IDP	Internally Displaced Persons
IHP	Integrated Health Project
IMF	International Monetary Fund
IRC	International Rescue Committee
KM	Kilometer
MSH	Management Sciences for Health
MSF	<i>Médecins Sans Frontières</i>
MICS	Multiple Indicator Cluster Survey
MONUSCO	<i>Mission de l'Organisation des Nations Unies pour la Stabilisation en République Démocratique du Congo</i>
PEP	Post-exposure Prophylaxis
NGO	Non-governmental Organization
PNDS	National Program for Health Development
STI	Sexually Transmitted Infection
TB	Tuberculosis
TL	Team Leader
TUC	Time Utilization Clock
UN	United Nations
USAID	United States Agency for International Development
VIP	Voluntary Interruption of Pregnancy
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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Executive Summary

The USAID-funded Integrated Health Project (IHP) is a five-year health systems project implemented in the Democratic Republic of Congo (DRC). DRC-IHP aims to improve an enabling environment to increase the availability and use of services, products and high impact practices in the areas of family planning; maternal, newborn and child nutrition; malaria; tuberculosis; neglected tropical diseases; HIV/AIDS; and water, sanitation and hygiene – with gender as a cross-cutting theme. The purpose of this gender analysis was to examine whether and how men and women of various ages differ in their 1) access to resources (information, services, finances); 2) knowledge, beliefs, and perceptions regarding health; 3) health practices and participation; and 4) rights and status. Underpinning all four of these domains is power, and how the men and women within a household and community negotiate and relate to one another. There are two major parts of this gender analysis, a literature review and qualitative formative research.

Research shows that women generally have poorer health outcomes than men, and there is some evidence that this is linked to women's relative power, rights, and access to resources. Culturally and by Congolese law¹, women are expected to defer to men. The DRC has a Gender Inequality Index of 0.71 (0.0 being an equal score, and 1 being unequal), which earns it the rank of 142 of 146 countries.² Despite this low ranking, women's movements have grown in importance and visibility in the last decade, and the DRC signed several international conventions and protocols, notably the Convention on the Elimination of all forms of Discrimination against Women (CEDAW), and the Maputo Protocol.³ However, the DRC did not ratify these protocols, which would have led to real gains in women's rights or given them a platform to plead human rights violations at an international level. The Human Development Index⁴ shows that Congolese women suffer disproportionately from poverty, with a GDP per capita of almost half of that of men's.^{5,6} Furthermore, the DRC has suffered through several regimes characterized by corruption, war, and/or neglect of its general population, which has had disproportionate effects on the status of women in a patriarchal society.

The formative research portion of this gender analysis was meant to apply a gender lens to explore men and women's knowledge, beliefs and practices regarding health, as well as their access to health care and information. Focus group discussions, in-depth interviews, and participatory activities were

¹ The Family Code and labor laws have discriminatory language in them.

² United Nations Development Program. (2011). *Human Development Report, 2011*, New York. Retrieved on website http://hdr.undp.org/en/media/HDR_2011_EN_Table4.pdf

³ African Commission on Human and People's Rights. Retrieved from website: http://www.achpr.org/english/info/women_en.html

⁴ Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁵ United Nations Development Program. (2011). *Human Development Report*. New York. Retrieved on website http://hdr.undp.org/en/media/HDR_2011_EN_Table4.pdf

⁶ Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

conducted in the four provinces where IHP intervenes: Kasai Occidental, Kasai Oriental, Katanga, and Sud Kivu. A total of 864 community members participated in the study, with equal numbers of: men 18-24 years, women 18-24 years, men 25-47 years, women 25-47 years, men 48 years and older, and women 48 years and older. In addition 49 individual interviews of which 26 were with male health service providers and 23 with female health providers were conducted.

In all study sites, it was found that gender roles and norms are well defined and rigid. Women's roles vary slightly with age, in that they enjoy more decision making power as elder women; however, the role of men, as leaders and decision makers, is relatively stable throughout their lifetime. Women are required to be obedient, and the repercussions for disobeying are violence, abandonment, or the husband taking a second wife. Intimate partner violence was cited as problematic in all of the sites, and there is little women can do to change this situation as it is sanctioned by society.

Women have relatively little power in their households, and are required to get permission to do almost anything, either from their parents or from their husband, once married. In most couples, men make any decisions that require using family resources, which includes health care. Even many women who earn their own money are obligated to give it to their husband, who will then decide how the money will be spent. However, the woman is instructed to implement his decisions, as the man is seldom involved in the day-to-day care of the family. There are some types of decisions that women have the final say on or have a strong influence over, but they all concern the care of children. Even decisions that concern women's bodies – number of and spacing of children, contraceptive methods, HIV testing, and frequency of sexual relations – are largely decided by their husbands. Women's lack of autonomy is strongly linked to her health and access to health care.

Although women are much more likely to use health facilities, they still face more barriers to health care and suffer from poorer health than men. As mentioned above, the requirement to ask permission to leave the village to go to a health facility limits their access because men often travel for work, in which case they must seek permission from the person left in charge. Also, a man may decline his wife's request either because family resources are low; he believes she is manipulating him into giving her attention; or out of spite. It was reported that if a man believes that a woman did not do the work expected of her or has not obeyed him, he may punish her by not allowing her to go to a health facility. And, as women do not control family resources – even if they are the greater contributors – they cannot simply go to the health center. In addition, the lack of female health service providers is also a barrier, or at least a concern for many women.

There are many other factors that affect access to health care, for women as well as men. Distances between villages and health centers are sometimes so great that people only travel in cases of extreme illness. And once arriving at the health center, it is not uncommon to have a lack of sufficient commodities and even lack of a health service provider on duty. Because most health service providers are unpaid, they must seek other work to sustain themselves. They charge high fees, even for some

medicines that are supposed to be free, in order to sustain the health center and pay health workers; however, these meager salaries are never enough to support a family. For these reasons among others, the community sometimes seeks alternative care: traditional medicine, sorcery, prayer, or street drugs/self-medication. Sometimes health facilities are used as a last resort, when all else fails.

Several health messages are well known and well understood by the population, but the population lacks self-efficacy or beliefs that practices are necessary. For example, women know that at least four antenatal care (ANC) visits and birthing in a health center are recommended, but they also do not believe that it is always necessary. Knowledge was also very high in terms of exclusive breastfeeding for the first six months, but women do not feel capable of practicing it when they need to work and leave their children behind. Further, women think that their own malnourishment impedes their ability to breastfeed their children. So grandmothers and older children are largely responsible for feeding young children (often a grain porridge), and there is a wide misconception that sugar and oil are important for good nutrition. HIV prevention knowledge varied, but it seemed that those closer to urban centers were better informed. However, accessing condoms is problematic, especially for women and youth.

The quality of care greatly affects the utilization of services as well. Although some community members thought their health center provided good services and were flexible with their financial capabilities, many others had complaints regarding lack of confidentiality, poor reception, discrimination based on perceived wealth, and a lack of respect of patient's rights. It did not seem that gender was a factor in how patients were received, but how wealthy they appeared, as it suggested their ability to pay. There were reports of being asked to pay before treatment, longer waiting times, and in some cases, patients dying because health service providers refused to treat them. In addition, some health workers do not keep information confidential, as some study participants report that health service providers either threatened to disclose or actually revealed their confidential patient information to others, such as their HIV or sexually transmitted infection (STI) status, if they were indebted to a health facility. In addition to exposing their confidential medical conditions, numerous human rights violations were reported, including patient sexual abuse. Some women reported that they were either raped or coerced into having sex with health workers when they could not pay their fees.

Health service providers are not very aware of patients' rights, and they were reported to abuse their position of power. In addition to sexual abuse, some health workers turn women away for health care if they do not have the consent of their husbands. This is particularly illustrated by the fact that health services providers refuse to give women family planning commodities without the explicit consent of her husband. And, when women test positive for STIs, they are denied treatment until the husband is informed and gives his approval – under the pretense that the couple must be treated together to

avoid re-infection. However, men will receive treatment and although it is recommended, it is not required for him to inform his wife or partner.

Sexually transmitted infections (including HIV) surfaced as a major reason for both men and women to seek health care. Men and women alike spoke very often of men's extramarital affairs being the main cause for the spread of STIs. Even if a woman suspects that her husband has been unfaithful and has an STI, she has little power to either refuse sexual relations or ask her husband to use a condom. Using condoms, especially when proposed by a woman, has strong negative connotations, such as he or she has been unfaithful, she is a prostitute, or she is accusing her partner of infidelity. Men are less willing to be tested for HIV and STIs, and sometimes hide their status from their wives for fear that they will discover men's unfaithfulness. Youth were also discussed as being responsible for STI propagation, and it is one of the main reasons for youth's visits to health facilities. Although it varied by site, both young men and women were said to be sexually active at a very young age and with multiple partners. Some said that an unmarried girl in a sexual relationship had the power to decide whether or not to use a condom; which is likely because men may be held responsible for a child born out of wedlock, either by marrying her or by "settling the matter amiably" (giving an agreed-upon sum to her family). However, that power is reversed once she is married.

Women's rights, the relative power of women, and the health and well-being of her family and community are inextricably linked. So improving the quality of health care cannot be done without bolstering the rights of women, empowering women, and holding health service providers accountable for upholding the rights of all patients. It is recommended that human rights and gender become a part of all training. In addition, activities using a positive deviance approach in which recognizing male role models who exhibit positive traits – such as accompanying their wives for ANC visits, discussing family planning, and not tolerating violence against women – are suggested. Further recommendations can be found at the end of the report.

I. Introduction

Overview Integrated Health Project

The Integrated Health Program (IHP) is a five-year project funded by USAID to support the Democratic Republic of Congo's National Program for Health Development (PNDS – *Planification Nationale de Développement de la Santé*). The two components of the project - "Services" and "Other Health Systems" - are designed to create the best conditions for increasing the availability and use of health services, products and practices in the areas of family planning; maternal, newborn and child health; nutrition; malaria; TB; neglected tropical diseases; HIV/AIDS; and water, sanitation and hygiene in 80 health zones in four target provinces (Kasai Occidental, Kasai Oriental, Katanga and Sud Kivu)– with gender as a cross-cutting theme.

Purpose and Approach of Gender Analysis

The first principle of the United States Global Health Initiative (GHI) is to “*focus on women, girls and gender equality,*” and USAID encourages employing a gender analysis in every country for project design. In order to better serve the Congolese population and meet its project goals, IHP conducted a gender analysis to explore how gender and health are related in the DRC. Development professionals have understood for some time the importance of gender equality in development, not only because it is intrinsically just, but because empowering women (who are incontestably on the low end of the power scale) boosts development efforts exponentially. As education of mothers increase, the chances increase that they will have fewer and healthier children. Furthermore, women invest significantly more of their resources back into their family and community. Some recent studies have also shown that community development projects are more sustainable when women are involved in the design and implementation, for example UN-implemented water projects.⁷ Given what is known about gender and development, the potentially transformative role of women in bringing about social, economic and political change should be considered.⁸ Societies can only advance with the full participation of its citizens, both female and male.

The purpose of this gender analysis was to examine whether and how men and women of different ages vary in their 1) access to resources (information, services, and finances); 2) knowledge, beliefs, and perceptions regarding health; 3) health practices and participation; and 4) rights and status. Underpinning all four of these domains is power and how the men and women within a household and community negotiate and relate to one another. There are two major parts of this gender analysis: 1) a literature review analyzing the gender landscape in the DRC – with a focus on health, but covering domains that contribute to the livelihoods of women and men respectively; and 2) qualitative

⁷United Nations Water. (2006). *Gender, Water, and Sanitation: A Policy Brief*.

⁸World Bank. (2012). *World Development Report 2012: Gender Equality and Development Outline*.

formative research - focusing on areas that have not been researched as well as areas that will improve IHP programming and activities. It is important to note that the literature review was not systematic, but the authors utilized all resources found by internet searches and a search for literature in PubMed using the key words “gender and health,” “gender and DRC,” “gender and health and DRC,” “health and DRC,” and “Gender-Based Violence and DRC,” as well as literature the authors were already familiar with.

The formative research was conducted with community members in peer groups, while ensuring the voices of subgroups and vulnerable groups were also heard, as well as with health service providers. It was important to understand the experiences of men and women in general, as they certainly affect health of the two sexes differently, such as decision-making abilities both in the household and the community, as well as women’s and men’s respective roles and tasks within the household and the community. The research objectives were as follows:

1. To explore the specific gender roles, gender norms, and gender relations, according to men and women of different ages in rural settings;
2. To explore the effects of gender (gender roles, gender norms, and gender relations) on health knowledge, health behaviors, and related beliefs and perceptions according to men and women of different ages in rural settings;
3. To explore the effects of gender on access to health care, health information, and quality of care according to men and women of different ages in rural settings;
4. To explore the attitudes and beliefs of health services providers on the differences between the sexes and ages, as well as the differences based on socioeconomic status and geography in connection to the provision of health services.

Because there has been a great deal of research on gender based violence (GBV) in eastern Congo, which is summarized in the literature review, the formative research did not aim to explore this specifically. GBV is possibly the greatest human rights violation and barrier to health and well-being, but the decision not to include it in the research was due to the fact that time constraints would not allow the subject to be explored as it deserves, and the project could not ensure psychological support for those who would be asked to discuss very emotional, and possibly traumatic, events in their personal lives.

It is hoped that the results of this gender analysis will aid IHP and its partners to improve the health of all, particularly women who are disadvantaged on many levels, by designing targeted, gender responsive interventions in the Democratic Republic of Congo.

II. A Review of Gender Literature in the DRC

Brief Context of the DRC

The Democratic Republic of Congo (DRC) has a long and continuing history of political instability and violence, dating back to colonial rule. Belgian colonialism in the DRC was marked by pilfering of natural resources using forced labor and cruel punishments, such as massacres and corporal punishment.⁹ The DRC gained independence in 1960 and, since then, has suffered through several regimes characterized by corruption, war, and/or neglect of the general population. The most recent war of 1998–2002¹⁰ resulted in mass displacement, severe degradation of social services, and food shortages. Although a formal peace accord was signed in December 2002, eastern Congo has since suffered several smaller conflicts that have continued to severely disrupt the lives and livelihoods of Congolese people. In particular, the DRC has become infamous for the staggering rate of rape and gender-based violence, perpetrated by civilians as well as armed militias and the National Army.

Despite its wealth in natural resources, the DRC is one of the poorest countries in the world. It is ranked 168 of 169 on the Human Development Multidimensional Poverty Index,¹¹ and an estimated 71% of the population lives below the poverty line.¹² Recent disruptions, conflicts and subsequent instabilities have decreased formerly self-sustaining families' and communities' ability to secure food and resources.

As of September 2011, there were 71,712,867 people in the DRC. The population is very young, with 50% under 16 years of age, and only 5% older than 60 years.¹³ The average family size has been estimated between 5.4 and 6.3, differing greatly between rural and urban areas.^{14,15} Most people (65%) live in rural areas, a majority of whom engage in agricultural work. Religion plays a very important role in Congolese life. Approximately 50% of the population is Roman Catholic, 20% Protestant, 10% Kimbanguist (a local sect of Christianity), 10% Muslim, and 10% adhering to indigenous beliefs.¹⁶

⁹Electoral Institute for the Sustainability of Democracy in Africa. Retrieved from website in December 2011:

<http://www.eisa.org.za/WEP/drcoverview8.htm>

¹⁰ As rebel groups and small conflicts have continued through the years following, and in light of the 2012 conflict in North Kivu, it is debatable whether the most recent war has ended yet.

¹¹United Nations Development Program. (2011). *Human Development Report*. New York. Retrieved on website http://hdr.undp.org/en/media/HDR_2011_EN_Table4.pdf

¹² CIA Factbook. Retrieved from website: <https://www.cia.gov/library/publications/the-world-factbook/geos/cg.html>

¹³Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

¹⁴ CIA Factbook. Retrieved from website: <https://www.cia.gov/library/publications/the-world-factbook/geos/cg.html>

¹⁵Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

¹⁶ CIA Factbook. Retrieved from website: <https://www.cia.gov/library/publications/the-world-factbook/geos/cg.html>

Gender Landscape in the DRC

The Democratic Republic of Congo can be described as a patriarchal country, with men generally assuming a leadership role in all levels of society: in government, community, and household. Culturally and by Congolese law¹⁷, women are expected to defer to men. Women generally do not have equal legal rights and access to resources as compared to men. The DRC has a Gender Inequality Index of 0.71 (0.0 being an equal score), which confers it the rank of 142 out of 146 countries.¹⁸ Gender roles and norms, the relative status of women, and men and women's relative participation in society are inextricably linked to health and access to resources – including health. The information below is meant to demonstrate the existing body of knowledge surrounding gender and the status of women in the DRC, with an emphasis on health.

i. Political Participation and Legal Status of Women

Historically, women's political participation was not encouraged by either Belgian colonial powers or by subsequent Congolese leaders. Political leaders encouraged women to be good wives and mothers and systematically excluded them from political power.¹⁹ The Constitution currently supports the principle of gender parity in politics and in the public sector; however, this is not often seen in practice. As of 2012, there are 9.8% of women represented in Parliament (only 2% of candidates), 4.6% in the Senate, 15% in the Cabinet, and slightly greater than 1% in provincial government²⁰, which is an overall improvement following the 2006 elections.^{21,22}

The DRC's (then Zaire) longest-ruling president, Mobutu Sese Seko, took certain measures to promote gender equality, such as opening up the Army to women in 1966. After 1975, Mobutu formed a Secretariat to improve the standing of women, and later in 1980 a Ministry for Women and Family Issues was established.²³ However, some believe this was a political maneuver to promote his image to the external world, and these actions did not really alter basic gender inequalities. Although women were appointed as ministers, many were merely considered symbolic and lacked any real power.²⁴

¹⁷ The Family Code, for example.

¹⁸ United Nations Development Program. (2011). *Human Development Report*. New York. Retrieved on website http://hdr.undp.org/en/media/HDR_2011_EN_Table4.pdf

¹⁹ Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

²⁰ Ministry of Gender, Family, and Children. Retrieved from office.

²¹ World Bank. World Development Indicators, 2011. Retrieved from website: <http://data.worldbank.org/country/congo-dem-rep>

²² Ministère du Genre, de la Famille, et de l'Enfant. (2009). *Stratégie Nationale de Genre*. République Démocratique du Congo.

²³ Law N° 080052/35. In 2007, the Ministry of Gender, Family, and Children was created.

²⁴ Ministère du Genre, de la Famille, et de l'Enfant. (2009). *Stratégie Nationale de Genre*. République Démocratique du Congo.

Since Mobutu's era, women's issues have increasingly become a part of the political agenda, albeit slowly. In the 2011 national elections, 49.7% of voters were women, which may indicate that women are exercising their democratic rights.^{25,26} The DRC ratified the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) in 1986. However, the DRC signed, but did not ratify, the Optional Protocol, which stipulates that a State recognize the competence of the Committee on the Elimination of Discrimination against Women -- the body that monitors States parties' compliance with the Convention -- to receive and consider complaints from individuals or groups within its jurisdiction. The Protocol also creates an inquiry procedure enabling the Committee to initiate inquiries into situations of grave or systematic violations of women's rights.²⁷ Not ratifying the Protocol has left Congolese women without a platform to air complaints of discrimination and injustices beyond the Congolese government. Furthermore, the lack of enforcement of laws, such as impunity for perpetrators of sexual violence, further illustrates the weak political will to protect and empower women.

The DRC also signed, but did not ratify, the protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also known as the Maputo Protocol.²⁸ Certain criteria for ratifying this protocol are in direct conflict with the National Family Code, such as the minimum age of marriage for women of 18 years, a woman's right to retain her nationality when marrying a foreigner, and, following divorce, and women and men having equitable sharing of joint property purchased during the marriage.²⁹ The Family Code, still under revision, contains regulations that are clearly discriminatory against women, in addition to being in conflict with international conventions.³⁰

²⁵ Commission Electorale Nationale Indépendante.

²⁶ Some also believe that women are directed to vote for their husband's candidate, and it has been heard anecdotally that illiterate women were instructed which candidate to vote for, but do not actually know if they voted for the candidate they wanted

²⁷ Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW). Retrieved from website:

<http://www.un.org/womenwatch/daw/cedaw/protocol/>

²⁸ Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.

²⁹ African Commission on Human and Peoples' Rights. Retrieved from website:

http://www.achpr.org/english/info/women_en.html

³⁰ Article 352 of the Family Code sets a minimum age of marriage for women that is different to that for men (18 for men, 15 for women). Article 355 states that "Women may not remarry until a period of 300 days has passed from the time of dissolution or annulment of the previous marriage." Article 444 states that the husband is the head of the household, that he owes protection to his wife and that the wife must obey him. Article 445 states that the married couple contributes to the moral and material management of the household under the leadership of the husband. According to article 450, apart from some exceptions, "the wife cannot appear in court on civil matters, acquire, sell or undertake commitments without the authorization of her husband. If the husband refuses to authorize his wife, authorization may be given by a judge. The husband can give general authorization, but he still retains the right to revoke it". According to article 454, only the husband has the right to establish the marital home or residence. Article 467 establishes discrimination in the area of adultery, as it penalizes adultery by the husband only in certain circumstances, while adultery by the wife is punishable in all circumstances. Retrieved from website: http://www.africa4womensrights.org/public/Dossier_of_Claims/DRCENG.pdf

The Ministry of Gender, Family and Children has been active in the promotion of a strengthened legal framework for women's rights, but it has limited resources and capacities.³¹ They recently conducted a gender audit of 10 public and private institutions, as well as other organizations at the national and provincial levels. Although some of the methodology and results were subjective, it generally concluded that there is a need for improvement in gender awareness, gender integration, allotting funds specifically for gender, and women's empowerment among all institutions in order for gains towards gender equality to be realized.³²

Article 15 of the 2006 Constitution confirms the state's responsibility to prevent any form of sexual violence that "destabilizes or delocalizes the family." International parties generally deem the new article on sexual violence as progressive and comprehensive; however, the implementation of the law has been weak at best. Among the criticisms of the law include that the age limit of the sexual assault of minors is 18, but the family code puts the age limit of consensual sexual relations in general at 15; and that the time frame for judicial investigation of sexual assault cases is thought to be unrealistically short.³³ There is no specific law on domestic violence within the Congolese legal system.

The DRC's national gender policy, prepared in 2009, has two key goals: 1) to establish an institutional, socio-cultural, legal and economic environment for achieving gender equity and equal access for men and women, boys and girls to society's resources, and 2) to ensure the effective integration of gender in research, analysis, planning, implementation, and monitoring of evaluation of projects, policies and programs.³⁴ It appears that politicians are beginning to realize that perpetuating gender inequality is detrimental to economic development, if not intrinsically immoral. A World Bank paper summarizes "as long as women in the DRC are insecure, marginalized, and subject to epidemic levels of violence in a climate of impunity and state indifference, DRC itself will remain poor and insecure."³⁵

ii. Gender Norms

The DRC is largely a patrilineal society, with the exception of the Lamba clan in Katanga, which is still matrilineal.³⁶ This situation has limited women's rights to inherit, and thus own, land in the DRC.

³¹ Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

³² Ministère du Genre, de la Famille, et de l'Enfant : Cellule d'Etudes et de Planification de la promotion de la Femme, de la Famille et de la protection de l'Enfant (CEPFE). (2012). *RAPPORT D'AUDIT NATIONAL EN GENRE DES INSTITUTIONS PUBLIQUES ET PRIVEES DE LA RDC*.

³³ Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

³⁴ Ministère du Genre, de la Famille, et de l'Enfant. (2009). *Stratégie Nationale de Genre*. République Démocratique du Congo.

³⁵ World Bank. (2011). *Toward a Gender-Informed Country Strategy, A Background Paper for the FY13 CAS*. Washington, DC: Blackden, C.M.

³⁶ Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

Congolese laws still reserve men's right to own land, which has made it very difficult to change this tradition. Most marriages in the DRC are patrilocal, in that the couple and their offspring are located within the household of or near the husband's family.³⁷ While polygamy is illegal in the DRC, it constitutes 40% of marriages in the province of Kasai Oriental province.³⁸ This means that second and subsequent wives are not legally recognized, thus have no legal rights to children and property.

The Congolese man is generally characterized as the strong, superior head of the household and provider of the family, and the Congolese woman as the submissive and virtuous, caretakers, mothers and wives³⁹ – roles that are legitimized and perpetuated by religious institutions. In interviews held in eastern Congo, leaders spoke of the socialization of children at a very early age regarding the superiority of males and how females need to respect males.⁴⁰ These traditional gender roles make it difficult for women to assert themselves as leaders in the household, in their communities, as well as professionally and politically. As detailed above, legal systems also perpetuate gender inequalities.

There is a clear division of tasks between men and women, and women's tasks are more numerous and sometimes more physically demanding than men's. Women are generally in charge of all cooking, household cleaning and childcare, as well as most farming and selling of agricultural harvests. Men are responsible for earning and managing household revenues, and play some roles in agriculture – usually in preparing the fields (clearing trees and brush, burning fields). Studies in Africa show that, on average, women's workdays may be 50% longer than those of men.⁴¹ Data on gender-disaggregated time utilization in the DRC were not found for this review, but this was one of the topics covered by the formative research to be discussed later in this report.

There is also a clear division in decision-making roles and types of decisions. Decision-making power within the household is determined by two distinct sources of bargaining power: economic and social. According to the DRC Demographic and Health Survey 2007, the only decision that a majority of women (57.4%) make alone is what meal to prepare each day. In most cases, household decisions are made solely by the husband, including large household expenses (51.2%), daily household expenses (38.4%), his wife's visits to relatives (49.7%), and his wife's personal health (55.4%).⁴² Some couples make these decisions jointly, but the overwhelming majority of households report men as either the

³⁷Programme des Nations Unies pour le Développement. (2011). *RAPPORT NATIONAL GENRE (RNG). Draft 3*. République Démocratique de Congo.

³⁸Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

³⁹Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

⁴⁰Trenholm, J.E., Olsson, P., and Ahlberg, B.M. (2011). Battles on Women's Bodies: War, rape and Traumatization in Eastern Democratic Republic of Congo. *Global Public Health*, 6:2, 139-152.

⁴¹ Ibid.

⁴²Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

sole or the final (meaning the wife's opinion is considered) decision makers.⁴³ Even when women earn their own income, in 28% of cases, men alone decide how to utilize their wife's income.⁴⁴

In many regions in the DRC, men control the mobility of women, although data is lacking in terms of the extent of control. Women's autonomy is an important factor in their access to services, such as education, work, and health care,⁴⁵ and was also a topic of this study.

iii. Child Protection

The DRC does not have a good record of child protection. It was estimated that over 3,000 children, mostly boys, were fighting with rebel groups in eastern Congo before the war, and the final count is immeasurable.⁴⁶ Approximately 74 percent of Congolese girls between the ages of 15 and 19 are already married.⁴⁷ Globally, it is known that child marriage makes them especially vulnerable to HIV, obstetric fistulas, and gender-based violence,⁴⁸ in addition to being a human rights violation according to several international conventions and declarations, notably the Universal Declaration of Human Rights, the Convention on Consent to Marriage, and the Convention on the Rights of the Child.⁴⁹

iv. Access to Resources

Education and Information

Congolese women do not have equal access to education and information as men. Overall, there are four times as many women aged 15-49 as men without formal instruction (21 vs. 5% respectively).⁵⁰ The International Monetary Fund's Poverty Reduction Strategy Paper points out that youth literacy has progressed slightly in the 2001-07 period from 71.1% to 72.1%; however, this progress has only benefited males (from 78.3% to 83.1%) but not females, where literacy has declined from 64.3% to 62.3%.⁵¹ Nonetheless, the DRC has achieved a parity rate in primary school enrollment of over 0.90 from 2006 to 2009 and is believed to have a good chance of achieving gender parity in primary school

⁴³ Ibid.

⁴⁴ Ibid.

⁴⁵ World Bank. (2012). *World Development Report 2012: Gender Equality and Development Outline*.

⁴⁶ Ibid.

⁴⁷ Immigration and Refugee Board of Canada. (2006). *Democratic Republic of Congo (DRC): Whether forced marriages exist; if so, the frequency of such marriages, the people who organize them (maternal or paternal family), the regions and ethnic groups involved, the treatment of people who refuse such marriages and the state protection available to them*. (9 January 2006, COD100957.FE).

⁴⁸ International Center for Research on Women. (2007). *How to End Child Marriage: Action Strategies for Prevention and Protection*.

⁴⁹ United States Agency for International Development (2012). *Ending Child Marriage & Meeting the Needs of Married Children: The USAID Vision for Action*.

⁵⁰ Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁵¹ Hyder et. al., cited in: Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

enrollment by 2015,⁵² but the gender gap gets wider when considering primary school completion (0.7) as well as secondary school completion (0.4 - 0.5) for the same years.⁵³

Aside from formal education, women also have unequal access to information. More than half of Congolese women (59.8%) have no access to media (print, radio, or television), compared to 38.5% of men.⁵⁴ This gap becomes more pronounced in rural areas in which 78.2% of women compared to 52.4% of men have no access to media.⁵⁵ According to the 2007 Demographic and Health Survey (DHS), women demonstrated poorer knowledge about health, such as family planning methods and HIV prevention, when compared to men⁵⁶ – an explanation for which may be less access to information, both formally and informally, and this study attempted to explore this possibility.

Economic Resources

In Congo, women suffer disproportionately from poverty. The Human Development Index (HDI) shows that women's GDP per capita is much lower than men's (US\$488 respective to US\$944, in Purchasing Power Parity).^{57,58} Nonetheless, women are increasingly assuming economic burdens; currently 21% of all households are led by a female.⁵⁹ Interestingly, female-headed households are less susceptible to having only one meal per day, in comparison to male-headed households.⁶⁰ Given the overall poorer status of women, this possibly suggests gender differences in survival strategies or money management which deserves to be examined further.

There are gender differences in terms of types of employment, in that although agriculture makes up approximately 50% of the GDP in the DRC, significantly more women (64.8%) are engaged in agriculture than men (48.7%).⁶¹ Women also outnumber men in selling merchandise and the service industry; however, men dominate the higher paying occupations, such as executive positions, as well as skilled and unskilled labor.⁶² Only 28% of eligible women receive a salary, and 17% of women do not

⁵²Proceedings from The African Development Forum (ADF VI).(2008). *Action on Gender Equality, Women's Empowerment and Ending Violence against Women in Africa*. United Nations Conference Centre – Addis Ababa, Ethiopia.

⁵³Institut National de Statistiques.

⁵⁴Programme des Nations Unies pour le Développement. (2010). *Objectives du Millénaire pour le Développement 2015. Rapport Pays 2010*.

⁵⁵ Ibid.

⁵⁶Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁵⁷UNDP. 2008.

⁵⁸Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁵⁹ Ibid.

⁶⁰International Monetary Fund. (2007). *Democratic Republic of the Congo: Poverty Reduction Strategy Paper*.

International Rescue Committee-Burnet Institute. (2008). *Mortality in the Democratic Republic of Congo: An Ongoing Crisis*. Democratic Republic of Congo: Coghlan, B., Ngoy, P., Mulumba, F., Hardy, C., Bemo, V.N., Stewart, T., Lewis, J., Brennan, R.

⁶¹Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁶² Ibid.

receive any compensation for their work.⁶³ In general, unemployment and underemployment affect men more than women (1.3% and 0.7% unemployment, respectively), regardless of their level of education.

Health Care/Health Facilities

In the 1980s, the DRC's health system was considered a leader in the region in their innovative system of using health zones which integrated primary with first-referral services.⁶⁴ Since then, the health system has deteriorated, especially during the years of conflict. During the war, health structures were systematically looted, and were insufficiently stocked to begin with. Due to lack of government funding, many facilities were forced to rely exclusively on patient fees, which were not standardized, in order to pay staff and operating costs.⁶⁵ The government seldom paid their already low salaries, so many doctors and nurses fled during the conflict, sought other employment, or privatized the health center.

Access to health care varies among regions and within health zones. It can be assumed that rural areas have less access to health facilities than urban areas, and vulnerable populations (such as internally displaced persons, or IDPs), women, and children suffer most from poor access. Studies on health care reveal that 40 to 60% of the population self-medicate, with drugs bought at the market, and 20 to 30% seek care at health centers, while even fewer have access to hospitals.^{66,67} However, data disaggregated by sex or other demographics are not available, so it is difficult to estimate how different populations fare.

The lack of roads and public transport in many parts of the country has made it very difficult for people in some regions to access care, especially women who are less mobile in general. This has an impact, in particular, on maternal and neonatal mortality, the prevention of which requires accessible and timely delivery. A study of two hospitals in Nord Kivu found that women living more than 90 minutes walking distance were at an increased risk of obstetric complications and neonatal mortality.⁶⁸ Not surprisingly, women in the poorest households are least likely to have a skilled birth attendant with them during childbirth.⁶⁹

⁶³Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

⁶⁴World Bank. (2005). *Democratic Republic of Congo. Health, Nutrition and Population Country Status Report*.

⁶⁵Ibid.

⁶⁶Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

⁶⁷World Bank. (2005). *Democratic Republic of Congo. Health, Nutrition and Population Country Status Report*.

⁶⁸Ibid.

⁶⁹World Health Organization. (2009). *Women and health: Today's evidence tomorrow's agenda*.

Unless a health facility is funded by an organization, families are generally responsible for financing health services 100% out-of-pocket.^{70,71} Minor health problems are financially problematic for most families, but when surgery or hospital care is required, it could pose insurmountable financial problems for the majority of families.⁷² A study in Nord Kivu found that in order to pay medical bills, 24% of patients sold assets and 18% went into debt.⁷³ Emergency obstetric procedures, like caesarean sections, are very expensive, thus limiting the number of women who can access them and contributing to increase the maternal mortality rate. The high costs of treating obstetric fistulas has led some women to present themselves as rape survivors, as surgeries for fistulas caused by rape are more frequently subsidized by international NGOs.⁷⁴

Despite the work NGOs have done to eliminate costs for health care of sexual assault survivors, it is estimated that fewer than half of Congolese women who experience sexual violence are able to access health centers.⁷⁵ Lack of access to and awareness of available services are the main barriers to women receiving timely care.⁷⁶ And for those who have access to facilities, those health centers are “woefully unequipped to provide even the most basic health services, not to speak of specialized services to rape survivors (appropriate antibiotics to treat STIs, emergency contraception, HIV testing, and PEP).”⁷⁷

While the 2006 *Stratégie de Renforcement du Système de Santé* rightly focuses on revitalizing and giving more autonomy to health zones as well as general quality of care, there is no mention of how to improve access for vulnerable populations, including women. There is also no mention of how to boost the number of women in the health sector (including community health workers, nurses, and doctors), promote women in leadership positions, or include women in decision making process – not even at the community level.

⁷⁰World Health Organization. (2004). *Summary Report of the JOINT ASSESSMENT OF HEALTH STATUS AND HEALTH SYSTEM AMONG CRISIS AFFECTED POPULATIONS IN THE DEMOCRATIC REPUBLIC OF CONGO (DRC) AND THE HUMANITARIAN HEALTH SECTOR STRATEGY FOR DRC.*

⁷¹World Bank. (2005). *Democratic Republic of Congo. Health, Nutrition and Population Country Status Report.*

⁷²Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile.*

⁷³World Bank. (2005). *Democratic Republic of Congo. Health, Nutrition and Population Country Status Report.*

⁷⁴Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile.*

⁷⁵Wakabi, W. (2008). Sexual Violence Increasing in Democratic Republic of Congo. *Lancet*, 371(9606):15-16.

⁷⁶Médecins sans Frontières. (2009). *Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims.* Brussels, Belgium.

⁷⁷Kippenberg J. (2002) The war within the War. Sexual violence against women and girls in Eastern Congo. Human Rights Watch: cited in World Health Organization. (2004). *Summary Report of the JOINT ASSESSMENT OF HEALTH STATUS AND HEALTH SYSTEM AMONG CRISIS AFFECTED POPULATIONS IN THE DEMOCRATIC REPUBLIC OF CONGO (DRC) AND THE HUMANITARIAN HEALTH SECTOR STRATEGY FOR DRC.*

v. Health Differences between Males and Females

Nutrition

Despite the fertile soil and high agricultural productivity, approximately 69% of the population does not get the minimum caloric intake.⁷⁸ Around 24% of Congolese children under five years old are moderately or severely underweight, and 43% have stunted growth.⁷⁹ Some studies have shown male children to be more exposed to the risk of malnutrition, and stunted growth in particular, than female children.^{80,81} It is unclear why male children are more likely to be malnourished, as there is anecdotal evidence that male children are preferred and that boys and men get preferential feeding in the DRC. Furthermore, in other African countries, preference for male children can result in female children getting 'second choice,' less nutritional foods, as well as receiving less medical attention.⁸² In support of this notion, a mortality survey revealed that the rate of deaths from malnutrition for females over five years old was almost twice that of males;⁸³ however, it is unclear whether this is the trend for all ages or whether the rate among adults largely accounts for this rate.

Childhood Illnesses

The mortality rate for children under the age of five is 158 per 1000.⁸⁴ According to a nationwide survey undertaken by the International Rescue Committee (IRC) in 2006-2007, the five principal causes of death for children under the age of five are malaria, diarrhea, respiratory infections, tuberculosis and neonatal conditions, together accounting for over 55% of deaths. Measles is reported to have caused 9.9% of deaths in children under five.⁸⁵ Although the same mortality survey demonstrated some gender differences in illnesses, it is unclear if this may be incidental or due to biological predispositions, or due to gender differences in the treatment of certain illnesses. It is unclear whether

⁷⁸Food and Agriculture Organization. Retrieved from website in December 2011:

<http://www.fao.org/countries/55528/fr/cod/>

⁷⁹Ministère du Plan, Institute National de la Statistique en collaboration avec Le Fonds des Nations Unies pour l'Enfance (UNICEF). (2010). *Enquête par Grappes a Indicateurs Multiples*. République Démocratique du Congo.

⁸⁰Kandala, N., Mandugu, T.P., Emina, J., Kikhela, N., and Cappuccio, F.P. (2011). Malnutrition among Children under the Age of Five in the Democratic Republic of Congo (DRC): Does Geographic Location Matter? *BMC Public Health* 11:261.

Kanegoni, A., and Mukenge, M. (2008). *DRC Issues Report*.

⁸¹Mukalay, A.W.N., Kalenga, P.M.K., Dramaix, M., Hennart, P., Schirvel, C., Kabemba, L.M., Kabyala, B.I., Donnen, P. (2010). Facteurs Predictifs de la Malnutrition chez les Enfants de Moins de Cinq Ans à Lubumbashi (RDC). *Santé Publique*, 2 (5).

⁸²World Health Organization. (2003). *'En-gendering' the Millennium Development Goals (MDGs) on Health*.

⁸³International Rescue Committee-Burnet Institute. (2008). *Mortality in the Democratic Republic of Congo: An Ongoing Crisis*. Democratic Republic of Congo: Coghlan, B., Ngoy, P., Mulumba, F., Hardy, C., Bemo, V.N., Stewart, T., Lewis, J., Brennan, R.

⁸⁴Ministère du Plan, Institute National de la Statistique en collaboration avec Le Fonds des Nations Unies pour l'Enfance (UNICEF). (2010). *Enquête par Grappes a Indicateurs Multiples*. République Démocratique du Congo.

⁸⁵International Rescue Committee-Burnet Institute. (2008). *Mortality in the Democratic Republic of Congo: An Ongoing Crisis*. Democratic Republic of Congo: Coghlan, B., Ngoy, P., Mulumba, F., Hardy, C., Bemo, V.N., Stewart, T., Lewis, J., Brennan, R.

gender differences in childhood illnesses have been investigated thoroughly, or whether gender differences have not been found and thus not reported.

Perhaps more stark than gender differences in childhood illnesses are the effects that gender inequalities in society, or the relative status of mothers, has on the health of children. Children are more likely to have poor health when their mothers are poorly educated; have little decision making power over how to use resources, their mobility, and their own health care; as well as have insufficient access to health information. Research shows that when Congolese women have decision-making power over household economics, the children in the household are healthier.⁸⁶ Women's high decision-making authority was also associated with a greater likelihood of seeking treatment for acute respiratory infections (ARI).⁸⁷ Mothers' education is also linked to childhood nutrition, and according to a study conducted in Lubumbashi, it was a strong predictor of growth stunting.⁸⁸

Malaria

Most of the Congolese population (97%) is exposed to malaria, and only 3% live in malaria-free environments located in the mountainous eastern region.⁸⁹ Malaria seems to affect both men and women equally in the DRC; however, pregnant women and children without mosquito nets are more vulnerable to death due to relatively weak immune systems. In addition, pregnant women who contract malaria are more likely to be anemic, which increases the likelihood of low birth weight or mortality of the newborn. Malaria accounts for 48% of hospitalizations for children under five and 54% for pregnant women.⁹⁰ Other studies indicate that younger adult males have the highest risk of malaria, possibly due to occupational exposures or less frequent use of health facilities.⁹¹

HIV/AIDS

The HIV prevalence rate for the 15–49 age group is almost twice as high for women (1.6%) compared to men (0.9%); however, about 90% of the adult population has never been tested.⁹² Rates are highest in the city of Kinshasa and the eastern provinces. The prevalence rate among female sex workers in Kinshasa is estimated to be as high as 30%.⁹³

⁸⁶Hyder et al.2005. Cited in: Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

⁸⁷Ibid.

⁸⁸ Ibid.

⁸⁹Ministère de la Sante, Secrétariat General. (2006). *Stratégie de renforcement du Système de Santé*. République Démocratique du Congo.

⁹⁰Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁹¹World Health Organization. Retrieved from website:

http://www.who.int/gender/documents/malaria/gender_malaria_leaflet/en/index.html

⁹²Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁹³Ministère de la Sante, Secrétariat General. (2006). *Stratégie de renforcement du Système de Santé*. République Démocratique du Congo.

HIV knowledge is very poor overall, but is slightly poorer for women (15.3% had complete knowledge of HIV, compared to 22% of men).⁹⁴ Interviews in some remote villages in Sud Kivu revealed that some people had heard about the pandemic on the radio, but they did not know exactly what it was or how it was transmitted. Misinformation is rife, and is often associated with superstition. For example, in the Batembo community, the pandemic is associated with incestuous sexual relations and witchcraft. Persons living with HIV/AIDS are thought unable to control themselves sexually, and their illness is viewed as “*God’s punishment for bad sexual behavior.*”⁹⁵ Unfortunately, Congolese women are more vulnerable to perceptions of “bad behavior” than men, and are subsequently stigmatized and sometimes banished from communities because of their HIV status.⁹⁶

Maternal Mortality

The maternal mortality ratio in the DRC is estimated to be 1,289 deaths per 100,000 live births, which is one of the highest in the world.⁹⁷ Only 44% of women attend at least four antenatal visits.⁹⁸ It is assumed that women in rural areas or vulnerable populations are less likely to attend antenatal consultations due to difficult access to health centers and high health care costs, although disaggregated locations were not reported. According to the 2010 MICS, 74% of pregnant women had births assisted by trained medical personnel.⁹⁹ However, other studies place this number at a much lower 23.7%.¹⁰⁰ Emergency caesarians are most likely to save the lives of mothers in cases of difficult births; however, the number of skilled birth attendants who are trained in this practice is unknown.

Reproductive Health and Family Planning

The peak of fertility occurs between 25 and 29 years of age with 271 births per thousand, but differs between rural and urban areas (234 and 180 per thousand, respectively).¹⁰¹ The average family size has been estimated between 5.4 and 6.3 children.^{102, 103} Throughout Africa, fertility is strongly linked to adulthood status and socio-economic security, and the social repercussions for infertility are great,

⁹⁴Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

⁹⁵Bokole, H., Olin, J., Lapika, B.D. (2005). Proceedings from International Conference on AIDS, John Hopkins School of Medicine, Baltimore. *Behavioral research on perceptions of HIV/Aids in Congo(DRC)*.

⁹⁶Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

⁹⁷SRSS, 2008, cited in Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

⁹⁸Ministère du Plan, Institut National de la Statistique en collaboration avec Le Fonds des Nations Unies pour l’Enfance (UNICEF). (2010). *Enquête par Grappes a Indicateurs Multiples*. République Démocratique du Congo.

⁹⁹ Ibid.

¹⁰⁰ International Monetary Fund. (2007). *Democratic Republic of the Congo: Poverty Reduction Strategy Paper*.

¹⁰¹Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

¹⁰²Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

¹⁰³Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

especially for women.¹⁰⁴ There is no country-wide data on the prevalence, but a somewhat outdated study puts the incidence of primary infertility to be between 4.8% and 24% in northeast Congo, and these cases were believed to be caused by iodine deficiency as well as STIs.¹⁰⁵ Adolescent fertility is quite high in the DRC, with a rate of 124 per thousand girls for the 15-19 age group,¹⁰⁶ and a majority of young girls are sexually active by age 14.¹⁰⁷ Unfortunately, comprehensive and accurate sexual education is rare for adolescents, and some religious organizations systematically omit information about condoms as a method of preventing HIV/AIDS and unwanted pregnancies.¹⁰⁸

According to the 2007 DHS, 84.2% of married women and 93.9% of married men have heard of at least one modern method of family planning, but only 19.2% of married women have ever used a modern contraceptive even though 53% approve it.¹⁰⁹ A more recent study similarly showed that 84% of women thought family planning was good, and those who opposed it did so because of fear of health consequences, religious convictions, or their husband's opposition.¹¹⁰ Women do not have decision-making power over family planning, or even their bodies, especially in rural areas. Traditionally, women cannot refuse the sexual advances of their husbands, and do not usually make decisions about their own health care.¹¹¹ More than half of women have never had any discussion with their partner on contraceptive methods or on the number of children desired in the household.¹¹² Despite these cultural barriers, there are laws that support a woman's right to control her reproductive health. The National Reproductive Health policy "is based on the values and principles listed hereafter: The freedom of individual choice, within the couple and within the family; and the equality and mutual respect of the sexes in decision-making and the use of health services."¹¹³

vi. Gender Based Violence (GBV)

Sexual Violence

Several organizations have documented the systematic use of rape in conflict zones as a strategy of war in eastern Congo. NGOs estimate that since 1996, there have been more than 40,000 rapes of

¹⁰⁴Fledderjohann, J.J. (2012). 'Zero is not Good for me': Implications of Infertility in Ghana. *Human Reproduction*, 27(5).

¹⁰⁵Longombe, A.O., Geelhoed, G.W. (1997). Iodine Deficiency Disorders and Infertility in Northeast Zaire. *Nutrition*, 13 (4).

¹⁰⁶Mathe, J.K., Kasonia, K.K., and Maliro, A.K. (2011). Barriers to Adoption of Family Planning among Women in Eastern Democratic Republic of Congo. *African Journal of Reproductive Health*, 15[1]: 69-77.

¹⁰⁷ Ibid.

¹⁰⁸Bosmans, M., Cikuru, M.N., Claeys, P., Temmer, and, M. (2006). Where Have All the Condoms Gone in Adolescent Programmes in the Democratic Republic of Congo? *Reproductive HealthMatters*; 14(28):80-88.

¹⁰⁹Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

¹¹⁰Mathe, J.K., Kasonia, K.K., and Maliro, A.K. (2011). Barriers to Adoption of Family Planning among Women in Eastern Democratic Republic of Congo. *African Journal of Reproductive Health*, 15[1]: 69-77.

¹¹¹ Ibid.

¹¹²Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

¹¹³Programme National de la Santé de la Reproduction. (2008). *Politique Nationale de Santé de la Reproduction en RDC*. République Démocratique du Congo.

women and men.¹¹⁴ Although women make up the majority of survivors of sexual violence, and men the vast majority of the perpetrators of violence, men have been largely overlooked as victims of violence. Men have been witnesses to unspeakable violence against their families, as well as the victims. Fear of stigmatization has made it very difficult to ascertain a reliable estimate of male sexual violence survivors in the DRC. According to records in Masisi, approximately 6% of the survivors treated by *Médecins Sans Frontières* (MSF) were male.¹¹⁵ In addition, countless child soldiers, predominantly boys, were stripped of their innocence and brainwashed to commit violence. However, women and girls make up a vast majority of rape survivors.

Armed militias make up the majority of perpetrators of rape, although the number of civilian perpetrators has been on the rise in recent years.^{116,117} According to records reviewed at Panzi Hospital in Sud Kivu, most attacks occurred in the home (56.5%), with others committed in the fields (18.4%) and the forest (14.3%).¹¹⁸ The same study revealed that 58.9% of all attacks occurred at night, and gang rape accounted for most (59.3%) of the rapes. The mean number of assailants per attack was 2.5.¹¹⁹

The effects of sexual violence on health are immeasurable. An alarming 30% of rape survivors who sought care in eastern Congo are HIV positive.¹²⁰ According to a report compiled at Heal Africa Hospital in Goma, of 4,715 women and girls who suffered sexual violence between April 2003 and June 2006, 702 (14.8%) had genital fistulas.¹²¹ However, it is estimated that only a tiny proportion (0.8%) of fistula cases in the DRC are rape-related, and the remaining are caused obstetrically.¹²² It is assumed that the higher rate of rape-related fistulas treated at Heal Africa Hospital is due to the high number of survivors who seek care there, as is also the case at Panzi Hospital.

¹¹⁴Kanegoni, A., and Mukenge, M. (2008). *DRC Issues Report*.

¹¹⁵Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

¹¹⁶ Various MONUSCO reports put armed perpetrators between 67% and 81% in conflict zones, and 24% in non-conflict zones.

¹¹⁷Bartels, S.A., Scott, J.A., Mukwege, D., Lipton, R.I., VanRooyen, M.J., and Leaning, J. (2010). Patterns of Sexual Violence in Eastern Democratic Republic of Congo: Reports from Survivors Presenting to Panzi Hospital in 2006. *Conflict and Health*, 4:9.

¹¹⁸Ibid.

¹¹⁹Ibid.

¹²⁰Kanegoni, A., and Mukenge, M. (2008). *DRC Issues Report*.

¹²¹Longombe, A.O., Claude, K.M., and Ruminjo, J. (2008). Fistula and Traumatic Genital Injury from Sexual Violence in a Conflict Setting in Eastern Congo: Case Studies. *Reproductive Health Matters* 2008;16(31):132–141.

¹²²Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

Few sexual assault survivors seek care within the recommended 72 hours for administration of post-exposure prophylaxis (PEP), or other needed medical treatment after the assault.^{123,124} It is estimated that fewer than half of survivors of sexual violence are able to access health centers, because of the distance to health centers, lack of awareness, lack of financial resources, fear of perpetrators resurfacing to pursue them, and not wanting to reveal that they had been raped to family or health care providers for fear of rejection.^{125,126,127} In a study of sexual assault survivors in eastern Congo, 55% stated it took them more than a day to travel to a facility that provides relevant care.¹²⁸ Another household survey of 617 women illustrated that the majority (58.6%) sought medical treatment, yet fewer than half (46.1%) of those who sought treatment did so within the 72-hour window, and only 47.4% sought care within the 120-hour window for effective emergency contraception (EC).¹²⁹ Other studies revealed that post-exposure HIV prophylaxis are in low supply and are sometimes unavailable in facilities, which may also have an effect on women's willingness to take the risk to travel to a health facility.¹³⁰

In addition to immediate health concerns, rape often causes psychological distress attributable to the assault itself as well as its aftermath – such as social stigma, reduced income due to decreased ability to work, abandonment by family, and ostracism by their community. If women do not get the care and support they need to recover from the rape, they risk long term health and psychological repercussions. Acute and long-term stress in general is known to lead to digestive problems, pain, sleep problems, depression, and a weakened immune system. The survivors of violence are not the only ones who suffer – the families and communities are often deeply and irreversibly damaged.

Social support is a very important part of a survivor's healing process; however, often women lose social networks or are ostracized as a result of rape. According to interviews conducted in eastern

¹²³Glass, N., Ramazani, P., Tosha, M., Mpanano, M., and Cinyabuguma, M. (2011). A Congolese–US Participatory Action Research Partnership to Rebuild the Lives of Rape Survivors and their Families in Eastern Democratic Republic of Congo. *Global Public Health*, DOI:10.1080/17441692.2011.594449.

¹²⁴Baelani, I., Dünser, M.W. (2011). Facing Medical Care Problems of Victims of Sexual Violence in Goma/Eastern Democratic Republic of the Congo. *Conflict and Health*, 5:2.

¹²⁵Wakabi, W. (2008). Sexual Violence Increasing in Democratic Republic of Congo. *Lancet*, 371(9606):15-16.

¹²⁶Glass, N., Ramazani, P., Tosha, M., Mpanano, M., and Cinyabuguma, M. (2011). A Congolese–US Participatory Action Research Partnership to Rebuild the Lives of Rape Survivors and their Families in Eastern Democratic Republic of Congo. *Global Public Health*, DOI:10.1080/17441692.2011.594449.

¹²⁷Médecins Sans Frontières. (2009). *Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims*. Brussels, Belgium.

¹²⁸Kelly, J.T., Betancourt, T.S., Mukwege, D., Lipton, R.I., VanRooyen, M.J. (2011). Experiences of Female Survivors of Sexual Violence in Eastern Democratic Republic of the Congo: A Mixed-Methods Study. *Conflict and Health*: 5:25 doi:10.1186/1752-1505-5-25.

¹²⁹Casey, S.E., Gallagher, M.C., Makanda, B.R., Meyers, J.L., Vinas, M.C., and Austin, J. (2011). Care-Seeking Behavior by Survivors of Sexual Assault in the Democratic Republic of the Congo. *American Journal of Public Health*: 101, No. 6.

¹³⁰Baelani, I., Dünser, M.W. (2011). Facing Medical Care Problems of Victims of Sexual Violence in Goma/Eastern Democratic Republic of the Congo. *Conflict and Health*, 5:2.

Congo, 29% of women were rejected by their families and 6.2% by their communities.¹³¹ Wives are especially subject to rejection by their husbands. Another study estimates that 20% of women who sought services for sexual assault were rejected.¹³² Men seemed less likely to reject a female relative, such as a sister or daughter, who had been raped compared with a wife.¹³³ There are various reasons why this may be the case, such as fear of disease, “moral contamination,” and the guilt and shame of not living up to one’s traditional role of the protector.¹³⁴ In instances where a man has accepted his wife back, many women reported reduced sexual contact.¹³⁵ Oftentimes children conceived during sexual assault are stigmatized and not fully accepted by the family or village.¹³⁶

It is not uncommon for a woman to be blamed for the rape, or thought of as “spoiled goods.” During focus group discussions held in eastern Congo, some male participants admitted their belief that women might ‘provoke’ rape by wearing revealing clothes, travelling at night, or being far from their community.¹³⁷ Aside from immediate health care, social support may be the single most important factor in a survivor’s recovery. In interviews with sexual assault survivors, women explained that the most valuable thing her husband could do would be to accept her into the household and assist her in seeking medical care.¹³⁸ Many women are not able to resume their former means of earning income, perhaps because of sustained injuries or health problems, or insecurity – such as working in the fields or gathering in the woods where there is a risk of being attacked. For this reason, gaining access to and control over income-generating activities will also have positive benefits for survivor’s health, as well as the well-being of the household.

Prosecuting their assailant may be another important step in the healing process of sexual assault survivors; however, very few cases are seen, and even fewer are prosecuted. Since 2008, the United Nations Human Rights Office has helped bring to court and follow up on 1,221 rape cases, with only

¹³¹Kelly, J.T., Betancourt, T.S., Mukwege, D., Lipton, R.I., VanRooyen, M.J. (2011). Experiences of Female Survivors of Sexual Violence in Eastern Democratic Republic of the Congo: A Mixed-Methods Study. *Conflict and Health: 5:25* doi:10.1186/1752-1505-5-25.

¹³²Kohli, A., Makambo, M.T., Ramazani, P., Zahiga, I., Mbika, B., Safari, O., Bachunguye, R., Mirindi, J. and Glass, N. (2012). A Congolese Community-based Health Program for Survivors of Sexual Violence. *Conflict and Health: 6:6* doi:10.1186/1752-1505-6-6.

¹³³Kelly, J., Kabanga, J., Cragin, W., Alcayna- Stevens, L., Haider, S., and Vanrooyen, M.J. (2011). ‘If your Husband doesn't Humiliate you, other People won't’: Gendered Attitudes towards Sexual Violence in Eastern Democratic Republic of Congo. *Global Public Health, DOI:10.1080/17441692.2011.585344*.

¹³⁴Ibid..

¹³⁵Trenholm, J.E., Olsson, P., and Ahlberg, B.M. (2011). Battles on Women's Bodies: War, rape and Traumatization in Eastern Democratic Republic of Congo. *Global Public Health, 6:2, 139-152*.

¹³⁶Glass, N., Ramazani, P., Tosha, M., Mpanano, M., and Cinyabuguma, M. (2011). A Congolese–US Participatory Action Research Partnership to Rebuild the Lives of Rape Survivors and their Families in Eastern Democratic Republic of Congo. *Global Public Health, DOI:10.1080/17441692.2011.594449*.

¹³⁷Kelly, J., Kabanga, J., Cragin, W., Alcayna- Stevens, L., Haider, S., and Vanrooyen, M.J. (2011). ‘If your Husband doesn't Humiliate you, other People won't’: Gendered Attitudes towards Sexual Violence in Eastern Democratic Republic of Congo. *Global Public Health, DOI:10.1080/17441692.2011.585344*.

¹³⁸Ibid.

374 (30.6%) perpetrators convicted.¹³⁹ Rape crimes are often solved through a transaction between the families (either cash or in-kind).¹⁴⁰ This negotiation often only involves the males in the household and the survivor is seldom involved or consulted in the process. Not surprisingly, many survivors do not feel that justice has been served in these cases.¹⁴¹ On the other hand, many women are unwilling to seek justice because they doubt the efficacy of the justice system or they fear their assailant will retaliate. In a study in eastern Congo, when women were asked whether they would like to see their attacker arrested for the crime of rape, most (58%) women said they would. Significantly, however, fewer women (48.2%) said that they would personally be willing to pursue legal action against their assailant.¹⁴²

Domestic Violence

When discussing gender based violence in the DRC, most people think of sexual assault perpetrated by armed militias. While this phenomenon deserves the media attention focused on it, it has overshadowed the high rate of intimate partner and domestic violence. More than 71% of Congolese women have been subjected to at least one type of violence in the home, most often by husbands.¹⁴³ This number increases to almost 90% among those whose husbands were reported to often drink alone. Little research has been conducted so far, but interviews suggest that the level of domestic violence differs from one region to the other, as well as within regions, and that women's power and status in the respective regions are strongly linked to the prevalence of intimate partner violence.¹⁴⁴

In many areas in the DRC, a certain level of violence is considered a normal part of marital relations, as long as it does not lead to serious injury or death.¹⁴⁵ It is important to recognize that violence is societal norm, perpetuated by both men and women. A shocking 75.6% of women believe men are justified in beating their wives, for reasons such as burning food or leaving the house without first asking her husband. Rape within the marriage is not even considered a crime.¹⁴⁶ According to the 2007 DHS, 77.7% of women believe that refusing their husband sex is only justified in extreme circumstances, such as a known STI or imminent childbirth; and only 17.2% of women believe that it is never justified.¹⁴⁷ Children are also the victims of physical and sexual violence in the home. Of records

¹³⁹United Nations Organization Mission in the Democratic Republic of Congo (MONUC). (2009). Briefing Materials.

¹⁴⁰Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

¹⁴¹ Ibid.

¹⁴²Kelly, J.T., Betancourt, T.S., Mukwege, D., Lipton, R.I., VanRooyen, M.J. (2011). Experiences of Female Survivors of Sexual Violence in Eastern Democratic Republic of the Congo: A Mixed-Methods Study. *Conflict and Health: 5:25* doi:10.1186/1752-1505-5-25.

¹⁴³République Démocratique du Congo. 2008. Enquête Démographique et de la Santé, 2007.

¹⁴⁴Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

¹⁴⁵ Ibid.

¹⁴⁶ Ibid.

¹⁴⁷Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

reviewed in eastern Congo, patients below 18 years of age were more often assaulted by someone known to the family (74%), than by men in military uniform.¹⁴⁸

Conflict and Health

Sustained violence in the eastern provinces has had profound effects on the livelihoods of entire communities, with food insecurity and malnutrition reported to be primary concerns of families.¹⁴⁹ Mortality surveys reveal that an estimated 5.4 million deaths can be attributed to the war since 1997, most of which were not directly caused by violence, but related to the disruption of the economy, and deterioration of household coping mechanisms.¹⁵⁰ Interviews held with sexual assault survivors who sought treatment indicate that they typically eat one meal a day - primarily *fou-fou*¹⁵¹, boiled cassava leaves, sweet potatoes, bananas and some chicken. They reported that large stock animals and goods were stolen by soldiers.¹⁵² Because there are so few opportunities for income in eastern Congo, an increasing number of women and girls (but also some men and boys), are resorting to prostitution in order to survive. This, in addition to sexual violence, is driving up the HIV prevalence among the 15-49 age bracket, which is estimated to be 1.9%, a percentage higher than any other region except for Kinshasa (also 1.9%).¹⁵³

Education is the best chance of breaking the cycle of poverty and improving health, but the education system is among the social services that declined because of the war. Furthermore, Sud Kivu has some of the lowest primary and secondary school completion, for both girls and boys. Many families report that there is no future for their family or village if their children do not attend school, as they are at increased risk of joining armed militias. Families fear for children who join militias, as they fear they will return to the village to rape, loot, and kill members of their household and village.¹⁵⁴

¹⁴⁸Malemo, K.L., Lussy, J.P., Kimona C., Nyavandu K., Mukekulu, E.K. (2011). Sexual Violence toward Children and Youth in War-Torn Eastern Democratic Republic of Congo. *PLoS ONE* 6(1): e15911. doi:10.1371.

¹⁴⁹Glass, N., Ramazani, P., Tosha, M., Mpanano, M., and Cinyabuguma, M. (2011). A Congolese–US Participatory Action Research Partnership to Rebuild the Lives of Rape Survivors and their Families in Eastern Democratic Republic of Congo. *Global Public Health*, DOI:10.1080/17441692.2011.594449.

¹⁵⁰Coghlan, B., Ngoy, P., Mulumba, F., Hardy, C., Bemo, V.N., Stewart, T., Lewis, J., Brennan, and R.2008.Mortality in the Democratic Republic of Congo: An Ongoing Crisis. International Rescue Committee-Burnet Institute, 21.

¹⁵¹ A thick paste of cassava root.

¹⁵²Glass, N., Ramazani, P., Tosha, M., Mpanano, M., and Cinyabuguma, M. (2011). A Congolese–US Participatory Action Research Partnership to Rebuild the Lives of Rape Survivors and their Families in Eastern Democratic Republic of Congo. *Global Public Health*, DOI:10.1080/17441692.2011.594449.

¹⁵³Enquête Démographique et de la Santé – République Démocratique de Congo. (2007).

¹⁵⁴Glass, N., Ramazani, P., Tosha, M., Mpanano, M., and Cinyabuguma, M. (2011). A Congolese–US Participatory Action Research Partnership to Rebuild the Lives of Rape Survivors and their Families in Eastern Democratic Republic of Congo. *Global Public Health*, DOI:10.1080/17441692.2011.594449.

III. Introduction to the Formative Research

The formative research portion of gender analysis explored men and women’s knowledge, beliefs and practices regarding health, as well as their access to health care and information, with the understanding that respective gender roles, gender norms, and gender relations affect the lives, and particularly the health for the purpose of this study, of men and women very differently. A gender analysis focused on the underlying causes of inequity and seeks positive change.

A) Brief Description of Research Sites

Kasaï Occidental

The province of Kasaï Occidental is located in the center of the DRC, and has an estimated population of 6,425,531.¹⁵⁵ Three large ethnic groups constitute the population of Kasaï Occidental, notably the Lubas, the Kubas, and the Lundas. Each of these groups comprises a multitude of ethnic sub-groups.¹⁵⁶ Many more boys (73%) complete primary school than girls (48%), and this trend continues into the first cycle of secondary school to 46.3% and 18.4%, respectively.¹⁵⁷

Kasaï Oriental

The province of Kasaï Oriental has an estimated 8,160,818 inhabitants.¹⁵⁸ The province’s capital, Mbuji Mayi, is inhabited by a population of approximately 1,900,089 individuals. The main ethnic groups are Pygmies and Bantous. More than twice as many boys (68.6%) completed primary school compared than girls (34%), and the gaps doubles with 36% of boys and only eight of girls completing the first cycle of secondary school.¹⁵⁹ In 2005, and the adult literacy rate was of 25%.¹⁶⁰

Katanga

The overall population of Katanga as of 2012 is 9,827,925.¹⁶¹ The dominant ethnic groups are the Luba, the Arunds (subgroups Lunda, Tshokwe, Luena, Ndemba and Minungu), the Sangas, and the Lambas. Forty-seven point five (47.5%) percent of enrolled boys completed primary school compared to 27% of

¹⁵⁵ Institut National de Statistiques

¹⁵⁶ Ministère du Plan. Unité de pilotage du processus DSRP, Kinshasa/Gombe. (2005). *Monographie of Kasaï Occidental, draft 4.*

¹⁵⁷ <http://eduquepsp.cd/province.html>

¹⁵⁸ Institut National de Statistiques

¹⁵⁹ <http://eduquepsp.cd/province.html>

¹⁶⁰ Ministère du Plan. Unité de pilotage du processus DSRP, Kinshasa/Gombe. (2005). *Monographie of Kasaï Oriental, Draft 4.*

¹⁶¹ Institut National de Statistiques

girls, and after the first cycle of secondary school the gap widens to 25% and 8% respectively.¹⁶² The adult literacy rate in adults is estimated at 64.4%¹⁶³.

Sud Kivu

To the east, the province of Sud Kivu has an estimated population is an estimated 4,469,185, as of 2012.¹⁶⁴ The province is delimited in the east by Rwanda (separated by the Ruzizi River and Lake Kivu), Burundi and Tanzania (separated by the Lake Tanganyika). Among the four provinces in this study, the gender gap in primary school completion is lowest in Sud Kivu, with 52% of boys completing and 35.4% of girls, but less than half of girls (12.1%) compared to boys (27%) complete the first cycle of secondary school.¹⁶⁵ The adult literacy rate is 67.1%. The principal ethnic groups are the Bashis, Barega, Bahavu, Bavira, Bafulero, Barundi, Babemba, Banyindou, and Batwa.¹⁶⁶

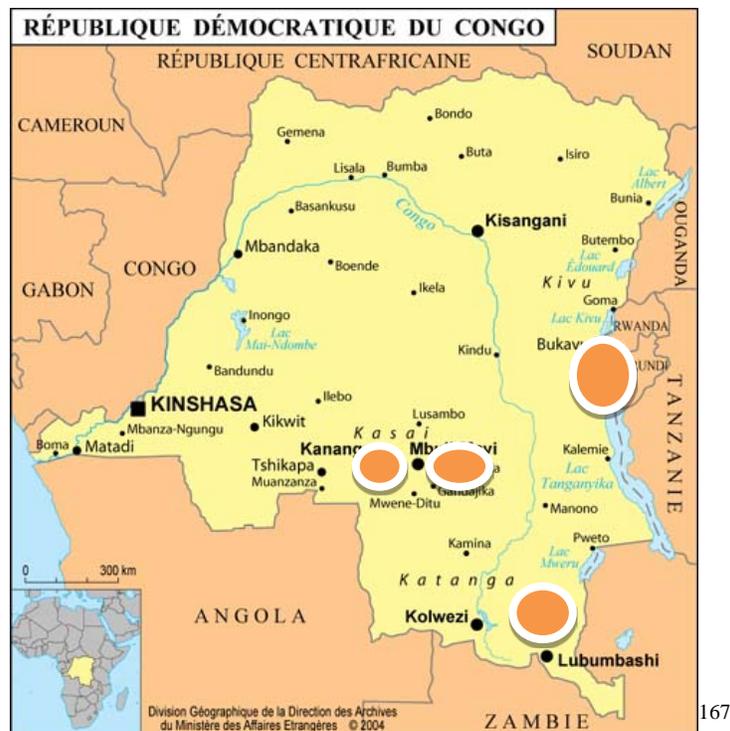


Figure 1: The Democratic Republic of Congo

¹⁶² <http://eduquepsp.cd/province.html>

¹⁶³ Ministère du Plan. Unité de pilotage du processus DSRP, Kinshasa/Gombe. (2005). *Monographie of Katanga, draft 4*.

¹⁶⁴ Institut National de Statistiques

¹⁶⁵ <http://eduquepsp.cd/province.html>

¹⁶⁶ Ministère du Plan. Unité de pilotage du processus DSRP, Kinshasa/Gombe. (2005). *Monographie of Sud Kivu, draft 4*.

¹⁶⁷ http://www.ritimo.org/dossiers_pays/afrique/rdc/rdc_carte.html

B) Study Preparations

The research protocol and data collection tools were reviewed by the Kinshasa School of Public Health Ethical Research Review Board. IHP was given formal consent to conduct the research in May 2012.

The core research team was comprised of a principal investigator and three team leaders (two women and two men). A group of eight facilitators were preselected based on their experience in facilitation or research, and their fluency in French and one of the two local languages to be used in the study: Swahili and Tshiluba. They underwent a three-day training on the principles and qualitative research methodology, and gender. At the end of the training, the core research team selected the four facilitators who would become part of the research team, based on the following criteria: 1) pre-test and post-test results on training material, 2) ability to facilitate focus group discussions, 3) ability to ask open and follow-up questions linked to research objectives, and 4) ability to synthesize discussions. It was also important to respect male/female parity within provincial research teams, so two men and two women were selected. Each of four provincial research teams was composed of a team leader, a facilitator, and two or three transcribers/translators. Transcribers/translators were recruited from the IHP field offices and were selected based on test results of ability in the local language, French language ability, and a writing test.

IV. Methodology

A) Site Selection

Sites were selected using a stratified sampling methodology, by: 1) IHP coordination offices, 2) health areas, and 3) villages. In the provinces of Kasai Occidental, Kasai Oriental, and Katanga, one IHP field office for each province was selected at random.¹⁶⁸ The reason for limiting the geographic coverage in these provinces was due to limited time and funds required to travel to more than one field office, and because the people within these provinces are fairly similar (in terms of ethnicity, culture, and language). Thus, expanding the geographic coverage would not necessarily enrich the information collected. For the province of Sud Kivu, there is more ethnic and cultural diversity, so both field offices were included in the first selection phase. The next selection phase was at the health area level. First, all health areas which are either difficult to access due to transport challenges or distance from the field office, or which pose security risks, were precluded from selection. Health areas were then randomly selected. The third selection phase was at the community level, which was done at random within each health area. All random selection was done by numbering eligible sites and using a random number generator. The table in Annex I indicates the sites selected for the study.

¹⁶⁸ Kasai Occidental only has one field office, so it was selected.

B) Participant Selection

The selection criteria of participants for focus group discussions and community participation activities were developed to ensure discussion groups were mostly homogeneous, but also to ensure that the voices of marginalized groups were heard. The criteria used were that participants in the discussion groups:

- should originate from the same village;
- be of the specified sex of the group;
- be within the specified age segment for the group (either 18-24, 25-47, or older than 47);
- should not be part of the same family;
- should not be health workers or community health workers;
- should not be teachers or public employees (to ensure they were from the site); and
- must be available at the moment of the research and voluntarily accept to participate in the study.

For youth between the ages of 18 and 24, marital status was taken into account, in that both single and married youth were included. The list of the criteria delimiting the inclusion and exclusion of participants was established and sent to the different provincial focal points. With the support of local village leaders, potential participants were identified. Finally, the Team Leaders confirmed their eligibility and made the final selection of eight to ten participants per focus group discussion.

For selection of the health workers for individual interview, the criteria were: they must be doctors, nurses, or midwives and currently be working at the health center selected for the study. All efforts were made to ensure that equal numbers of males and female health workers were interviewed.

C) Description of the Study Sample

In the four provinces, a total of 913 people participated in the study. Focus group discussions were conducted with 432 people, and those same people were administered the socio-demographic survey individually. An additional 432 participated in participatory exercises, either the Decision Matrix or the Time Utilization Clock. The number of participants per focus group or participatory exercise varied between eight and ten people. In order to get representation from youth, adults, and elders, equal numbers of the six target groups participated in group exercises: men 18-24 years, women 18-24 years, men 25-47 years, women 25-47 years, men 48 years and older, and women 48 years and older. Young people below the age of 18 were not included in the study due to research-related ethical considerations which protect minors. In total, 48 focus groups, 24 time utilization clock exercises, 24 decision matrix exercises, as well as 49 individual interviews - of which 26 were with male nurses, 15 with female nurses, and eight with female midwives were performed. The large difference between

male and female nurses interviewed is due to the fact that there were very few female nurses in rural areas, so midwives were sometimes interviewed even though they only provide care for a subsection of the population. Tables on the following pages describe the study sample.

Table 1: Education Level of FGD Participants (%)

	Katanga		Kasaï Occidental		Kasaï Oriental		Sud Kivu	
	Men	Women	Men	Women	Men	Women	Men	Women
None	17.22	20.62	20.34	21.93	1.23	2.34	11.24	17.12
Primary	57.40	46.39	37.89	30.70	35.18	32.03	39.84	36.94
Secondary	18.37	29.90	32.67	41.23	60.31	63.28	47.32	43.24
Tertiary	7.01	3.09	10.10	3.51	3.28	2.34	1.60	2.79
Do not know				2.63				

N= 432

Table 2: Employment of FGD Participants (%)

	Katanga		Kasaï Occidental		Kasaï Oriental		Sud Kivu	
	Males	Females	Males	Females	Males	Females	Males	Females
Agricultural work	28.23	53.17	34.89	27.32	52.34	9.63	30.22	20.09
Contractual work	2.0	1.6	0.9	0.81	1.06	0	3.41	0
Salesman	3.02	0.7	0.52	6.5	4.59	0.88	1.2	2.4
Unemployed	0.21	1.97	8.14	3.87	1	1.08	7.11	5.10
Other	5.92	3.57	10.7	6.35	10.97	18.52	10.61	19.05

N=432

Note: Contractual work includes mining, particularly in Katanga. “Unemployed” in this context means absolutely no income, formal or informal.

Table 3: Distribution of Religious Affiliations among FGD Participants (%)

Religious Affiliation	Kasaï Occidental	Kasaï Oriental	Katanga	Sud Kivu
Christians	94.74	89.84	89.69	86.49
Muslims	1.75	1.56	0	0.9
Animists	0	4.69	0	4.5
No religion	0	3.91	9.28	7.21
Other	3.51	0	1.03	0

N= 432

Table 4: Ownership of Commodities among FGD Participants (%)

	Kasaï Occidental	Kasaï Oriental	Katanga	Sud Kivu
Electricity	1.75	7.03	23.71	18.92
Radio	25.33	28.44	21.56	24.67
Television	1.75	12.5	20.62	13.51
Refrigerator	0	4.69	13.4	1.8
Bike	48.25	58.59	65.8	3.6
Motorcycle	6.14	6.25	19.59	0.9
Car	0	0.78	6.19	1.8
Telephone	26.32	3.13	45.36	15.32
Generator	3.51	0.78	5.15	4.5
Solar panels	2.63	0.78	2.06	1.8
Battery	7.02	7.03	10.31	0.9

N=432

Note: Some participants may have interpreted telephone to mean land line, and not cell phone, as it was not specified.

Table 5: Energy Sources most Utilized among FGD Participants

	Kasaï Occidental	Kasaï Oriental	Katanga	Sud Kivu
Electricity	0	0	7.22	2.7
Charcoal	9.65	41.41	65.98	30.63
Wood	86.84	57.81	26.8	65.77
Manure, fertilizer	0	0.78	0	0.9
Other	3.51	0	0	0

N= 432

D) Data Collection

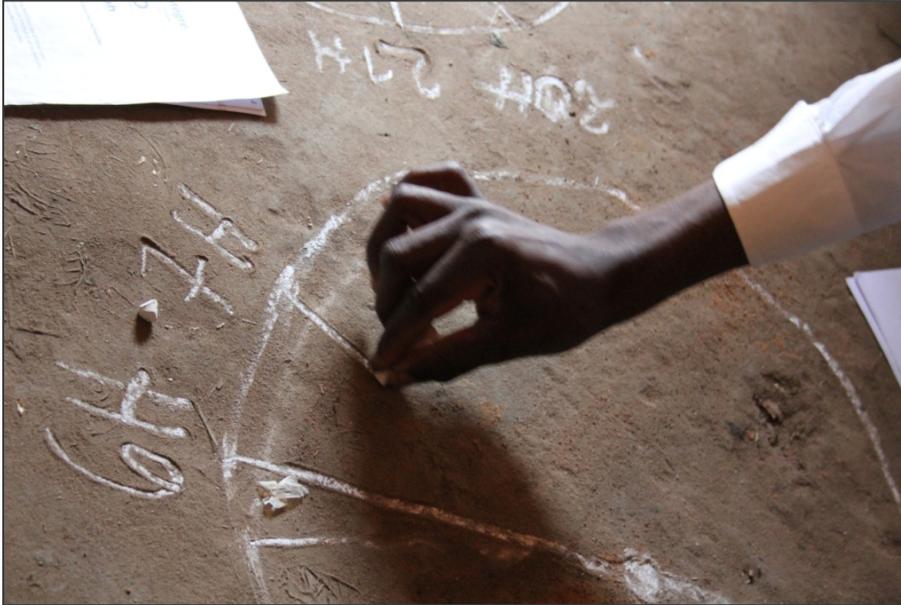


Photo 2: Time Utilization Clock

The following tools were developed to collect data for the study, and can also be found in Annex III:

- Individual interview guides for health service providers;
- Focus group discussion guides for the different targeted categories (young men 18-24 years, young women 18-24 years, men 25-47 years, women 25-47 years, men 48 years+, women 48 years+);
- Time utilization clock (this tool was used so participants could describe their daily activities through visual representations. This information allowed the teams to understand the utilization of time by different family members);
- Decision matrix (this tool was used to identify principal health decision making roles at the household and community levels);
- Socio-demographic questionnaires (this tool allowed for the collection of information on the socio-economic status of participants)

Facilitators were responsible for filling out the socio-demographic questionnaires, leading the focus group discussion and the participatory exercises, and translators were hired to perform live translation of discussions from local language to French for team leaders, who did not understand local languages. With regards to individual interviews with health providers, the majority were conducted by the team leaders in French, except in cases which the health service provider had trouble communicating in French.¹⁶⁹ All discussions and interviews were recorded using two Dictaphones. The transcriptions of

¹⁶⁹ Often, the level of French of interviewees required questions to be translated to local languages in order for them to better understand the questions set forward.

audio files were done immediately after data collection, and the transcriptions were regularly sent to the principal investigator. The quality of the data collected was verified by the principal investigator as documents were progressively transmitted by team leaders.



Photo 3: Decision Matrix

To respect the ethical principles of research, an informed consent was read and participants verbally assented to freely and voluntarily participate in the study. There were no cases of refusal to participate in the study.

E) Data Analysis

The data collected was coded and analyzed independently by two people, the principal investigator and IHP's Gender Advisor, using the MAXQDA.10 software. An initial code book was developed and proceeded to be tested independently by two coders on four focus groups and four individual interviews, for coverage of approximately 10% of collected data. After the analysis of the first test cycle, the rate of consistency in the application of the codes was at 16% which required a revision of the codes and of the coding system in order to ensure a higher rate. The second cycle of testing of the coding system yielded a consistency of 80%, an acceptable rate for the validation of the coding system by both coders. The data was then analyzed using the same software.



Photo 4: Time Utilization Clock Exercise with Men in Kasai Occidental

V. General Results

A) Gender Roles and Gender Norms

While gender roles tend to differ according to age groups, they are virtually identical among the different research sites.

i. Young Women 18 to 24 Years

Young women between the ages of 18 and 24 are assigned the role of domestic tasks by their mothers to prepare them for their future marital life. The chores that young unmarried women are principally responsible for are doing laundry, helping prepare meals, fetching water, selling merchandise, helping with agricultural activities, and supervising younger siblings when parents are absent. This relative power of girls over their younger brothers is more visible when boys are very young and have not yet reached adolescence. From adolescence to adulthood, girls progressively lose their power to make decisions regarding younger brothers, and roles become reversed. Young women seem entirely excluded from decisions made at the community level.

The age of marriage varies between 14 and 19 years of age. Particularly in rural areas where agriculture is the main economic activity, it is not uncommon to meet young women of 19 years that are married with three children. Unmarried girls who attended school explained that school attendance allowed them to express themselves and make certain choices within the household. For example, some girls expressed that they chose whether they would continue their studies or to leave school and get married. It seems that most young women choose to get married, especially in very rural areas where secondary schools are in villages too far for daily commutes. It also seems that young women are not encouraged to continue school, if not explicitly discouraged. Some parents stop paying their school fees or they do not support their daughters if conditions become unfavorable.

“Our intent was to study, but when we arrived at school, we found this difficult and we decided to enter marriage.” FGD, young women, Katanga.

Girls also see marriage as a transformation into adulthood, which gives them a certain status within the community.

“As young girls today, we prefer to marry early instead of study. Even when we have parents that wish to support our studies, we don’t want to. We want development.”¹⁷⁰ FGD, young women, Kasai Oriental.

¹⁷⁰ By development, it is meant “personal development.” This is an example of how young girls do not see the benefit of going to school, and see marriage as liberation from their parents’ house.

When young women become married while they are still in school, it becomes the husband's decision to determine whether or not they will stay in school or drop out. There were also some women who reported that they were not consulted in the decision to be married, but their father decided; however, forced marriage is less common than girls deciding.

The few employment opportunities that are available for youth are reserved for young men. *"The way agricultural business works on most of our land gives priority to young men. It is very rare to see young women have this employment even if we are capable. Our society and our families do not encourage us to pursue this kind of work."*¹⁷¹ **Time Utilization exercise, young women, Katanga.**

Young women are thus limited to engaging in petty commerce or to sell traditional beer known as "munkoyo" in order to meet their needs. It is not uncommon for those who are unable to meet their basic needs to engage in transactional sex, which includes a plethora of risks such as STIs and HIV, in addition to the risks of sexual violence and unwanted pregnancies.

ii. Young Men 18 to 24 Years

Young men see themselves as the successors of the family. It is they who will remain in the family while their sisters will live in another household after marriage. The status of 'future head of household' forms boy's upbringing and provides them with more decision-making power and autonomy within the family relative to girls, even if the latter are older. Boys also model their behavior after their fathers with whom they identify themselves.

"We say like father like son, I must inherit the behaviors of my father. If he is mean then I also must be; even if I try to escape it, it will follow me, it's hereditary." **FGD, young men, Sud Kivu.**

Social pressure as future head of household pushes young men to be more active and entrepreneurial in terms of searching for remunerated work to meet their own needs and those of their parents, if necessary. Young men in regions where agriculture is the main economic activity tend to marry younger, between 25 and 35, than men in mining areas, because the latter believe marriage requires some financial stability.

Young men who work in mines have financial resources that give them a certain independence from their parents, which young women of the same age do not enjoy. In areas without mining resources, young men farm, sell merchandise, or are daily laborers. Young men farmers worry about their economic security as accessing fertile land is becoming rarer, especially in Sud Kivu. And, young men seem to have abandoned agriculture in mining areas, for hopes of earning a regular income. Unemployment, in terms of formally paid employment, is rampant. When they cannot find work with a mining company, young men engage in traditional mining where they risk landslides and pulmonary

¹⁷¹ A village with a very large mining enterprise

illnesses due to improper protection used in the exploitation of minerals. Traditional mining is also unreliable work because mining or agricultural companies often prohibit this “illegal” exploitation work, which pushes young men towards unemployment such as in the health district of Nyamianda, Munanira village:

“We also dig for gold, but recently we do not dig anymore because the BANRO Corporation¹⁷² has already prohibited us from doing so, which is why we have become unemployed.” FGD, young men, Sud Kivu.

iii. Women 25 to 47 Years

Women of this age are the pillars of the household. They wake up around five o’clock in the morning and begin their domestic chores (fetch water, prepare the morning meal) before joining their husbands in the field, and return around four o’clock in the afternoon to continue their household tasks and prepare the evening meal. In the cycle of their daily activities, housewives have almost no personal time.

“We don’t have time for ourselves. Everything that we do is linked in one way or another to the survival of the family. In addition, having time to make oneself pretty is a luxury that we cannot offer ourselves since it will not prevent men from looking elsewhere.” FGD, women, Sud Kivu.



Photo 5: Katangan woman pounding cassava root

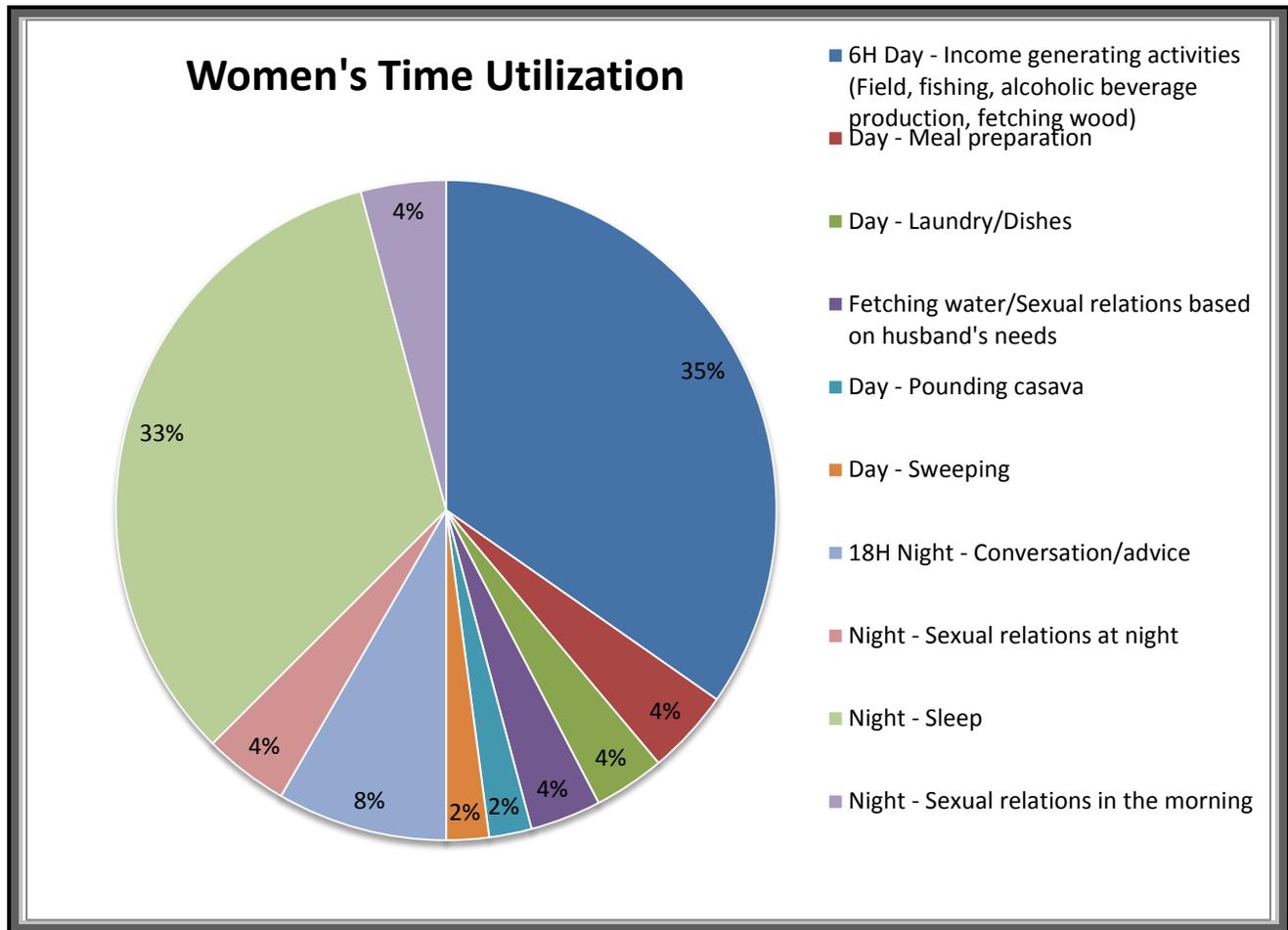
¹⁷²The BANRO Corporation is an agricultural company in the village of Munanira in the province of South Kivu.

The impact of a woman's roles on her state of health is substantial. It is apparent that *"the lack of sufficient rest accumulated by women, in addition to their repeated pregnancies, makes them fragile people, which is why they come to the health center more frequently than men for medical consultations."* **Interview, female health worker, Kasai Occidental.**

In Sud Kivu, women seem to have slightly less physical work relative to those of Katanga and of the Kasais, but only because less farming is done there. The infertility of the soil was mentioned many times in this province, which has obligated women to turn to other income generating activities such as selling merchandise or making traditional beer. These income-generating activities are appreciated by men since they bring additional revenue for the household. Nevertheless, whatever revenue the woman may generate, in most instances she will have to give it to her husband who will decide how to use these resources in the household. To a certain degree, a woman who brings home such resources has more influence in persuading her husband's use of these resources.

The figure below reveals the place that sexual relations, whether consensual or not, hold within the couple. Very generally, these sexual relations occur according to husbands' desires. Time utilization did not vary between research sites. See Annex II for time utilization figures for each age and sex group.

Figure 2: Time Utilization Clock of Women 25-47 Years, Kasai Occidental



iv. Men 25 to 47 Years

Men are generally responsible for the well-being of their households and villages. To this effect, they guarantee access to potable water for the village, build houses and ensure children’s schooling.

“The community expects us to search for money for its development, and to help people who are younger, to encourage young people to study.” FGD, men, Kasai Occidental.

The tasks of men of this age revolve around production and bringing in resources, namely agriculture, charcoal production, and working in the mines. Their role in terms of the health of their families is essentially centered on the payment of fees. Men are less involved in other aspects of family health such as the nutrition of women and children, or breastfeeding of young children as will be discussed further on. The physical work performed by men, such as charcoal production and transportation, has been said to have negative affects their health. Men believe that these jobs are the source of an array of illnesses, such as hernias, sexual weakness, tuberculosis and premature old age.

*"We have our children quickly because our work impacts our sexuality."*¹⁷³ **FGD, men, Katanga.**

v. Women 48 Years and Older

Elderly women generally have a consultative role in the household and community. Up to a certain age, generally 50-60 years old, married women continue to execute the domestic tasks of the household.

In certain cases it is the daughter-in-law that takes over, but increasingly *"... children marry and move away from the paternal household. We therefore are obligated to do all of these tasks ourselves."* **FGD, elder women, Kasai Oriental.**

Elderly married women have relatively greater decision making power than those who are widowed. Nevertheless they remain subordinate to men who are *"the presidents of the household, and the women are the prime ministers and the ministers of health."* **FGD, elder men, Katanga.**

To this effect, elderly women have more than a consulting role in their households and are often authorized to make decisions regarding family health care in the absence of the husband, as well as the use of household resources. Elderly women have in some way "purchased" this decision-making power, since they are often the main provider of these household resources. Even if most men appreciate the financial contribution of women in the household, they are not necessarily ready to give up certain family-related decisions to the women no matter what their financial contribution may be.

Women who are not married or are widowed are excluded from almost all activities in public life. They participate in household decision making only in the case where they are taken care of by their sons who are married. It is not a rare occurrence that elderly woman are declared witches or casters of bad spells in the community. This isolation of widows has been mentioned specifically in Katanga and Sud Kivu.

"I lost my husband more than 15 years ago and now I live alone at home. If I am sick, it is the church that helps to treat me, otherwise my children have all moved far away from me." **Interview with female health worker, Katanga.**

It is very difficult for a widowed woman to remarry, as most men do not want to marry a widow or do not want to be charged with the care of her children.

vi. Men 48 Years and Older

The roles of men do not vary greatly in adulthood. The most significant change occurs when youth leave adolescence and begin adulthood, usually marked by marriage. Elder men are responsible for the education of children and the well-being of the family. In the community, they are involved in the

¹⁷³ By 'sexuality,' it is meant their ability to reproduce.

construction and reparations of houses in the village, as well as the maintenance of roads and of water sources. In addition to public works, elderly men engage in charcoal production, carpentry, agriculture, animal rearing, fishing, and the maintenance of fish ponds. Widowed men can more easily remarry than widowed women, as there is less stigmatization compared to widowed women.

B) Gender Relations and Decision-Making Power

i. Gender Relations in Couples

In general, gender relations greatly disfavor women of the household. The man is seen as the prime decision-maker and the woman as obedient. This arrangement is reinforced by society, so women have little power to change it.

“If you do not do what (the husband) tells you, he can kick you out of the family. If you are lucky, you will stay in the compound but you will be divorced... If your husband is upset and talking, you must stay quiet. If he speaks and you speak as well, then he will become more agitated and raise a hand and hit you.” **FGD, young women, Kasai Oriental.**

In addition to suffering violence, a woman’s refusal to obey her husband’s orders can have consequences on her access to health care. For example, men expect women to execute all agricultural activities, including planting, weeding, and harvesting. If her husband believes her work does not meet his expectations, he will refuse to give her money for health care.

“When the husband tells you to go weed out the corn, if you refuse, at harvest you refuse to carry, once he sells [the harvest] and you are sick he will not accept to pay for your health fees.” **FGD, young women, Kasai Oriental.**

Health workers often reported that men refuse to pay for their wives’ treatment, either for reasons stated above, or because the husband had not authorized his wife to go to the health center for treatment.

“We are in a patriarchal system, so men are number one in the household. It’s the man who decides, so the woman cannot do anything without the approval of her husband. We have the example of the situation which I have mentioned... her husband is absent, and to come here is totally a problem. It is the neighbors who decided to bring her here and up until now we don’t know what the man will decide. Will the man pay the bill or not? The woman is ready to leave, but now she can go there and the husband will arrive and say ‘no, no, I didn’t tell you to go there. Find a solution to this problem with your family and it might be the family of the woman who will come to pay her bill, and the man and his family will decline the responsibility. So the woman is often subordinated.” **Interview with male health worker, Kasai Oriental.**

According to men, earning money and taking charge of the needs of their family are important factors in maintaining the 'balance' and allowing them to maintain their status as decision-makers in the household. Even though men's financial contributions do not cover all of the family's needs, women's contributions are often overshadowed. A husband's authority depends in part on his financial capacity, and sometimes his wife and her family will show him respect only when he provides.

A man that cannot financially contribute will be *"accused of everything and the wife's family may even take back their daughter because she suffers, or the woman will ask for a divorce because of this suffering. Due to a lack of [financial] means, our wives begin to reject us [in bed]."* **FGD, men, Kasai Occidental.**



Photo 6: Women in Kasai Oriental doing a Decision Matrix exercise

Men complain that a wife should not disrespect her husband who contributes little to his family because his lack of means is not a reason to humiliate or minimize them in front of others. Men report that wives' disrespect towards husbands who are unable of providing for their family is a source of dispute among many couples.

"We men notice that we are being penalized because we have given women all the [financial] responsibilities that we once had because of the harshness of life. If for example you are a technician in this or that domain, it so happens that we can spend an entire year without having another opportunity to work... In this case, the man seems irresponsible because he has nothing else to do, which is why I say that women have more responsibilities than men." **FGD, men, Sud Kivu.**

Even though some men do not allow their wives to take certain types of remunerated jobs, the financial contribution of women is usually well received by others. A woman may gain her husband's

respect and increase the likelihood of persuading him to meet some of her needs. Even if a woman earns her own money, she is obligated to present it to her husband and explain the source of the money.

“Even if the husband is absent, she cannot take out a sum of approximately 20 000Fc from the family funds even if it is her money... among everything that the ‘maman’¹⁷⁴ does, even the preparation of alcohol or all her own activities, she presents all revenues to her husband... and the husband decides [what to do with the money] because everything is rightfully his in the first place.” **FGD, elder men, Kasai Oriental.**

The factors that determine a wife’s value are her financial contributions combined with giving birth to many children (preferably boys), especially in monogamous marriages. With the husband’s assent, a wife that contributes to her household will have a say in important family decisions. A woman who is unable to contribute to her household may endure the scorn of her in-laws.

“Even brothers-in-law will think that a woman is trying to exploit their brother.” **FGD, women, Sud Kivu.**

Women nonetheless reported exceptions when the husband was considerate towards his wife even if she has no source of revenue. Exceptions are more typical of elder men who consider their wives as more or less equal partners.

A wife’s financial contribution also has the opposite effect in cases when her contribution is greater than that of her husband. Young women state that they are not motivated to earn more money than their husbands in the household because *“often parents-in-law poison their children (the husband) with bad advice; they will often tell him that the wife is starting to dominate him. This thereby causes a sort of rebellion of the husband against his wife.”* **FGD, young women, Sud Kivu.**

Instead of seeing a woman’s greater contribution in terms of more family income, the husband and his family may interpret it as a threat to his masculinity or a wife’s attempt to dominate her husband.

Strong religious beliefs strongly influence the dynamics in male-female relationships. Religion, as practiced in certain study areas, serves as a justification for certain types of violence against women as well as the refusal to use family planning (FP). The most widely held conception among participants (of both sexes) is that a woman is inferior to a man, and that a man has absolute rights over her once they are married.

“The power that a husband has at home comes from God, not science. It is God who showed that men have the power; it is the Church who demonstrates every day that the husband has the power in the

¹⁷⁴‘Maman,’ a term meaning ‘mother’ in French, is very often used to mean a woman.

household... which is why the Church teaches that everything that a woman finds in her household goes back to the man.” FGD, men, Kasai Oriental.

The same concept is shared among women who think that *“God, in creating men and women, said to the woman that she will submit to her husband and that all her desires will be placed upon her husband.” FGD, women, Kasai Oriental.*

Religion is also used to justify polygamy. *“God created twins so that even if you (a man) take four wives, there will always be a surplus of women to compensate the deficit so that each man can have at least one woman for himself.” FGD, men, Sud Kivu.*

ii. Decision Making

The tables on the following pages display the results of the participatory decision matrix exercises. Participants were asked about the process of different health decisions made within the household or community. These tables cannot illustrate all the variations of the power struggles and decision making in the family or household, and the list of people cited is not exhaustive. The content of these different tables is a synthesis of the decision matrices for each province, meaning that each table includes both the opinions of men and women of different ages in that province, as there was general consensus between them. The data were first analyzed by sex, age, and province, but the only notable differences were between provinces.

The terms ‘woman’ or ‘wife’ will be interchangeably used to describe women of reproductive age, approximately 25-47 years, living in a household. ‘Man’ or ‘husband’ will refer to men of approximately 25-47 years. ‘Maternal aunt/mother/father’ refers to the wife’s family; and ‘paternal aunt/mother/father’ refers to the husband’s family in a given household. ‘Elders’ or ‘grandparents’ will be used to describe people older than 47 years in general – both the paternal and maternal sides, either living within the household or elsewhere.

KASAI OCCIDENTAL

Table 6: Health Decision Matrix, Kasai Occidental

	Man/ Father	Woman/ Mother	Grand parents	Extended family	Children	Other
Nutrition	+	(+)			-	
Hygiene	-	+			-	
Mosquito nets	+	-	-	-	-	
Number of children	+	-	-			
Antenatal care	-	(+)				
Place of delivery/childbirth	-	+				
Care of children	+	(+)				-
Vaccination	-	+				
Contraceptive methods	(+)	+				
HIV testing (couples testing)	(+)	+				
Health fees	(+)	+				-

Tables Key:¹⁷⁵

(+): There are at least two people at this decision level and this person has the final say

+: The person has more influence on the decision than others

- : The person may be consulted but does not hold influence on the decision

In Kasai Occidental, grandparents do not seem very involved in nutrition of the household in general; this responsibility is left to the woman. Elder women will only feed children when they do not go to the field, and if older children are not charged with this responsibility. Sick children are often the woman’s responsibility, and the father will intervene only to pay medical fees or to transport the child to the hospital if the illness worsens. Women frequently bring home mosquito nets distributed by organizations and also ensure that children sleep under them, and men are responsible for purchasing mosquito nets as needed. The decisions to use contraceptive methods and test for HIV are the sole responsibility of the husband. With regards to antenatal care, it is the woman who decides at what moment she wishes to obtain ANC, but it is the husband who gives her the money and authorizes her to make the trip to the health center. In the table above, the (+) refers to the decision to get ANC, and not the authorization to attend the center.

¹⁷⁵These tables are a compilation of all the decision matrices of the province. Although there were some variations, there was general consensus, and the majority opinion was reported.

KASAI ORIENTAL

Table 7: Health Decision Matrix, Kasai Oriental

	Man/ Father	Woman/ Mother	Adult children	Paternal parents	Maternal parents	Others
Nutrition	-	+	-			
Hygiene	+	(+)	-	+	+	
Mosquito nets	(+)	+	-	-	-	
Number of children	+	-		-	-	
Antenatal care	(+)	+				
Place of delivery/childbirth	+	(+)				
Care of children	(+)	+	-	-	-	
Vaccination	+	(+)		-	-	
Contraceptive methods	+	-				
HIV testing (couples testing)	(+)	+				
Health fees	(+)	+				

The majority of decision-making power in Kasai Oriental is concentrated on the head of household. Women make decisions concerning the location of childbirth, the vaccination of children, and family hygiene. Grandparents are implicated in ensuring the adoption of behaviors linked to family hygiene, as it was reported that young people are uninformed about good hygiene. Men are responsible for purchasing mosquito nets for the family; however, their daily use is the responsibility of women, often helped by the eldest daughters. Men are not responsible for attaching or detaching mosquito nets for children who do not sleep in the same room as them.

KATANGA

Table 8: Health Decision Matrix, Katanga

	Man/ Father	Woman/ Mother	Maternal Aunt	Paternal Father	Paternal Mother	Others
Nutrition	(+)	+				
Hygiene	+	(+)				
Mosquito nets	+	(+)				
Number of children	(+)	+			-	
Antenatal care	+	(+)	-			
Place of delivery/childbirth	(+)	+			-	
Care of children	(+)	-				
Vaccination	(+)	+			-	
Contraceptive methods	(+)	+		-		
HIV testing (couples testing)	+	(+)				
Health fees	(+)	-				

In Katanga, more than anywhere else, men have a monopoly on health decisions. Some decisions are left to women, such as antenatal care, hygiene, the use of mosquito nets, and HIV testing. Paternal grandparents often help with health fees when their son is unable to cover all the costs. Women state that they can convince their husbands to undergo HIV testing following the recommendation of health workers, something that was not evident in other provinces. Young women affirm that they have the power to request that their partners use condoms to avoid unwanted pregnancies prior to marriage. Once married, however, women lose this decision making power to men.

SUD KIVU

Sud Kivu seems to be the province where women are most involved in decision making related to the family health. For decisions linked to the health of women or children, women have the latitude to make certain decisions without power struggles with the husband or his family. Despite this, men always decide on the number of children they will have. Even if women are unable to use contraceptives without the approval of their husbands, it appears that they are often the ones who initiate the discussion on family planning and are often able to persuade them.

Table 9: Health Decision Matrix, Sud Kivu

	Man/ Father	Woman/ Mother	Children	Paternal parents	Extended family	Health providers
Nutrition	(+)	+			-	
Hygiene	+	(+)	-			
Mosquito nets	+	(+)				
Number of children	(+)	+		-		
Antenatal care	+	(+)			-	
Place of delivery/childbirth	+	(+)				
Care of children	+	(+)				
Vaccination	+	(+)				-
Contraceptive methods	+	(+)		-		
HIV testing (couples testing)	(+)	+				
Health fees	(+)	+				

During the course of the decision matrix exercises, men often viewed themselves as having the final say in most household decisions. In their absence, or in the case of an emergency, some women can make decisions such as bringing a child to the health center. Young unmarried people admit that they do not have the final say in virtually any household decision. With age, women begin to have more decision-making power in the household, presumably due to fact that their financial contribution to the household increases with age, and men are more inclined to give their wives more decision-making

power over time. Men usually make the final decisions, but they prefer to direct their wives or children to execute those decisions.

C) Gender-Based Violence

As there is already a large body of research on gender-based violence in the DRC, some of which is summarized in the literature review, this was not one of the subjects included in the formative research. Nevertheless, study participants spoke of violence in all four of the provinces. Below, intimate partner violence and violence against patients are highlighted; however, other types of domestic violence were also mentioned, notably corporal punishment of children either by parents or siblings.

i. Intimate Partner Violence

“To beat one’s wife when she does not obey her husband is normal because it is the man who pays the bride price and he is the head of the family.” FGD, women, Katanga.

Women’s tolerance of intimate partner violence brings to light its complexity and how it is woven into societal norms. It is not uncommon for marital disputes to involve physical violence, and most people seem to find it within a man’s rights to ‘control’ his wife. Very few women report abuses to health centers; however when they do, health service providers feel helpless, or are either unwilling or ill-equipped to address the problem beyond the treatment of physical wounds.

“We do not have the ability to investigate the cases of physical violence that reach us. If they are unmarried youth and they admit to having been assaulted, we request a police report prior to treating the patient. But in many cases, even if we suspect a case of violence, we can’t do anything if the victim brings up another cause to justify her wounds... In the case of violence within the couple, no one files a complaint, thereby in the eyes of the law, it is not a crime or infraction and we are authorized to proceed with the treatment.” Interview with male health worker, Katanga.

Participants discussed that they believe there are justifiable reasons for a husband beating his wife, which were:

1. The mismanagement of family resources. Some women are accused of having wasted resources that her husband authorized her to manage.
2. When the woman travels without previously informing the husband or the person responsible in the husband’s absence. On the contrary, men can travel as they please without needing to even inform their wives.
3. When a woman is suspected of infidelity.
4. A woman’s refusal to follow her husband’s orders.
5. A woman’s refusal to engage in sexual activity with her husband regardless of the reason.

“Most disputes among our husbands and us are due to the frequency of sex. Once you refuse to give yourself to your husband at night, you are giving him an excuse to go find a prostitute elsewhere the very same night and he can bring back illnesses of all kinds. To add to that, no one will take a woman’s side when her husband complains about her in that regard. It is always the woman who is wrong.” FGD, women, Katanga.

This demonstrates the passive complicity of the whole community in the face of the violence and pressures women face in their homes on a daily basis.

Sexual violence within the couple was also discussed frequently, although many women seemed to express it in terms of an undesirable necessity in marriage. Even if women believe forced sex is not normal, they are often helpless to do something unless they want to risk being divorced, abandoned, or their husbands take a second wife who is more “docile” and “polite.” A woman’s refusal to engage in sex is considered a sign of disobedience and grounds for divorce. When questioned whether they believe that they have the right to refuse sexual intercourse when they do not desire it, women stated that they have the right but they fear the consequences, especially since no one will help them if they have problems with their husband. A woman’s lack of autonomy limits her from exercising her rights despite knowing what they are.

ii. Sexual Violence against Female Patients

Another form of violence against women discussed in all four provinces, but less frequently than domestic violence, is health service providers’ sexual coercion or rape of patients. *“You can tell him that your problem is a headache and he will tell you that he will look here below (the genitals)” and “there are even doctors that will force you to have sexual intercourse in their office. If you scream people will think that you are undergoing treatment and that is why you are screaming, or what is happening is childbirth.” FGD, young women, Sud Kivu.*

Women admit to never denouncing such cases due to the fear of being accused of lying, or being denied care in future visits to the health center. Many husbands reported that they either prefer female health workers treat their wives or to accompany their wives to the health center to avoid this situation.

Women reported that some health workers ask them for sex if they are unable to pay all of their health fees. They say that there are health workers who will often try to benefit from a desperate situation by offering free medication for her child in exchange for sexual favors.

“When you arrive for treatment, some health workers will start to tell you love stories and will place the condition that you sleep with him in order to treat you... You will tell him that if a person came to the center it was to receive health care and not to get married.” FGD, young women, Kasaï Occidental.

As participants were never asked directly whether they experienced violence in health centers, it is difficult to estimate how widespread of a problem this is. Assuredly, this behavior cannot be generalized to all health centers or all male health workers. On the other hand, the fact that this information surfaced as frequently as it did without explicitly being asked indicates that it is an issue. Health workers did not admit having personally witnessed this of their colleagues, but they affirm that such situations could occur and that they have heard anecdotes on this subject.

D) Health Service Utilization

i. Men's Utilization of Health Services

In terms of accessing health services, adult men are those who least often attend health centers. Men typically go to health centers only when their illness worsens and they have used up all other available options (traditional treatments, itinerant pharmacies). The waiting time at the health centers, either because of the number of patients present or due to the absence of the nurse, are deterrents for men. In addition, young people (especially men) believe that their bodies are resistant to disease.

"We observe that men do not arrive often at the health center because even if you ask them to come to a consultation, they will say 'no, my body functions normally, you should not deceive me, that is your opinion but my opinion is that I am healthy, so my health is good'." **Interview with female health worker, Katanga.**

Men are more likely than women to self-medicate. In case of *"small illnesses, we have roots and leaves which we can find on our way to the fields; we prefer to save money for the care of women and children. A man can always cope."* **FGD, men, Katanga.**

Youth in general rarely use health centers, but young men do less so. The reasons that young men go to medical consultations are for malaria, hernias, respiratory illnesses (usually due to the production of charcoal), wounds (such as those due to landslides in mines), and STIs. Even with STIs, *"young men come to the health center when they can no longer hide their illness and those odors begin to be released due to the infections."* **Interview, female health worker, Kasai Occidental.**

Men often transport charcoal or other merchandise on their bicycles to sell in distant villages or markets, and it is on these long trips that men reported to have had sexual relations that lead to the contraction of STIs.

ii. Women's Utilization of Health Services

Women represent the group that uses health centers the most, which was ubiquitous in all of the research sites. Antenatal care (ANC) and STIs are the principal reasons for the consultations of adult married women in this study, in addition to children's illnesses. Malaria, obstetric complications, and

miscarriages¹⁷⁶ were also mentioned as being common. New mothers rely on elder women to help them with the first few childbirths (whether at a health facility or at home) and to care for them during the first months of the newborn's life. After the first six months after childbirth, the mothers-in-law continue to play a predominant role the mother's and newborn's health.

Young unmarried women also clearly have health needs, but do not make decisions about their own health, and must always request permission from parents or the person in charge of the family to receive health care. They explain *"because you cannot allow yourself to go out of your parents' home in order to seek treatment without their permission . . . You are obligated to wait. Even if you feel that you will die, if your parents do not allow it, you will stay there."* **FGD, young women, Sud Kivu.** In instances which young women do seek care, it was mainly for cases of malaria or STIs. Less common but still among the main reasons for seeking health care, according to health service providers, were post-abortion complications (especially in Katanga, Sud Kivu, and Kasai Occidental).

iii. The Effect of Quality of Care on Service Utilization

a) Attitudes of Health Service Providers

The attitude of providers towards the patient can either deter or encourage patients in coming to health facilities. *"There are providers that greet you well, and starting with this welcome you are half healed."* **Decision Matrix exercise, women, Katanga.**

Participants recognize that in some health centers, particularly in rural areas, health workers take good care of the sick and welcome them with empathy. For example, some health workers treat patients and allow them to pay at a later time if they do not have the means to do so immediately. However, complaints of discrimination based on how patients dressed (believed to be an indication of their capacity to pay fees) were common, more so at hospitals.

"[Health workers] will welcome you very well only if you have money. There is a man in another village whose wife was gravely ill and he had to accompany her to the hospital. Since he had left that hospital with a debt some time ago, she was not treated . . . until she died the health workers did not want to treat her prior to the husband paying his first debt." **FGD, young women, Katanga.**

Poor quality of reception was cited most often in the provinces of Katanga, Kasai Occidental, and Sud Kivu, and in certain urban centers of Kasai Oriental, where health providers were said to place the patient's capacity to pay consultation fees as a prerequisite to his or her treatment. Another common complaint was that some health workers give priority to members of their family and acquaintances.

¹⁷⁶ Many health workers reported that women had miscarriages because of their heavy workloads.

“Reception is very negligent in this way: If the brothers of the provider are sick, and I too arrive at the center with my illness, they will first treat the brothers of the provider. In order to treat me, it will be after them.” **FGD, young men, Kasai Oriental.**

Overall, perceived wealth plays a greater role than gender in how patients are received. Health workers defended that they do not discriminate between patients. At the same time, health workers also mentioned that the health centers’ lack of resources is a reason why they are obligated to place an emphasis on fees before care. In cases which patients are not capable of paying fees, someone (usually the husband) stays at the center to work off the fees, or valuables (such as cloth) can be exchanged for treatment received. Some patients accumulate debts to the health center, which makes it very difficult to return to the facility, even if medical attention is needed.

“When you have a lot of debt, you will be embarrassed and humiliated in front of everyone.” **FGD, elder women, Kasai Oriental.**

As men are the decision makers in all financial matters, women are sometimes powerless to settle their debts and seek health care, or they disproportionately bear the shame of poverty as primary users of health services.

Another way in which health service provider attitudes may affect utilization is negative gender stereotypes. Some providers prejudge women whom they consider to be weak and less intelligent in comparison to men.

“The woman has a lot of, there is a lot of... how could I say this, um... There are many reactions that pass through the organisms of women. I can maybe speak of the menstrual cycle, there are women who have dysmenorrhea... but women as I said have an immune system that is a little inferior to the immunity of men.” **Interview with male health worker, Sud Kivu.**

Furthermore, some health workers doubt women’s capacity to understand the importance of advice, and thus will only give instructions to their husbands. *“There are these careless women, even when you give them drugs at the ANC, she will go, and she will leave them on the table.”* **Interview with male health worker, Kasai Oriental.**

b) Confidentiality

Confidentiality is also an important factor influencing participants’ utilization of services. In all research sites, the majority of participants affirmed that health workers keep their HIV status confidential. However, other types of information are not kept confidential, such as the contraction of STIs and requests for condoms, which deters patients from coming to health centers. Men will even travel to other health centers for anonymity. Some health workers, specifically in Sud Kivu and Kasai Occidental, were said to bully patients into paying debts by threatening or actually releasing a patient’s

confidential information in their village. The discretion of health workers was said to be very important in their provider utilization choice. *“I do not want to be treated by a nurse who will reveal all of my secrets in his [consultation room].”* **FGD, women, Katanga.**

Treating all of a patient’s sexual partners for STIs is a standard protocol. Health workers stated that they call upon both husband and wife to be treated, however, the procedure in which this is done differs between sexes. If a woman’s husband was not informed of his wife’s STI status, the health worker will often refuse treatment of the wife.

“In the case of an infection in a woman, I call upon¹⁷⁷ the husband so that he may also be treated. If he does not come, I turn away the wife.” **Interview with female health worker, Katanga.**

Men are also encouraged to bring their wives in the case of STIs or HIV, yet no health worker mentioned refusing a man treatment in the absence of his wife.

“It is not even frequent for men to come get screened. But when they come we test them without asking for the presence of their wives.” **Interview with female health worker, Katanga.**

In order to avoid being asked to bring in their wives for treatment, as it would then reveal their infidelity, some men prefer to go to health centers far away from their place of residence. Since women have less liberty and must get permission from their husbands to travel outside the village and use family resources, they do not have the opportunity to be treated elsewhere. Therefore, the husband is almost always informed of their wife’s illness.

Lack of confidentiality was also cited as a problem in maternity wards, where midwives are accused of revealing how women behave in childbirth, or women’s defects, marks or signs in intimate places of her body.

“Midwives do not keep secrets either. They can help a woman deliver, and then begin to tell other people; the information will arrive to her husband. On the way [home] he will begin to insult her. And when her husband hears the nonsense that happened along the way, he will believe that ‘my wife is a prostitute that is why we discovered the parts of her body...’ Even when you deliver (a child), the providers will speak of all your defects [to others].” **FGD, elder women, Kasai Occidental.**

According to some participants, the only information that service providers will keep confidential are the ones that incriminate them, such as clandestine abortions. *“They hide only one [type of] information: that of the girls on which they perform an abortion, because they know that if such information got out, they will be sent to prison.”* **FGD, elder women, Katanga.**

¹⁷⁷ To ‘call upon’ the husband means either to ask the woman to call her husband, or for the health center to call the husband

c) Competence of Health Service Providers

The perceived competence of health service providers also affects service utilization.

“Some health workers do not even know what to give to patients. They will fill the prescription with drugs and say that at least one of the prescribed drugs will heal the patient.” FGD, men, Kasai Occidental.

While some health workers received their training in nursing school, others learned on the job. There are some head nurses who began their career as community health workers or as vaccination volunteers and have, through practice, become nurses without formal training. Researchers noted that there were numerous misconceptions among health service providers. For example, it was mentioned by numerous health workers that tuberculosis is caused by excessive physical activity, or that tuberculosis is transmitted when one eats or drinks from the same cup as a person with tuberculosis. It was also common for health workers to cite poorsanitation as a source of malaria.

“In order to avoid malaria we have been told [by health workers] that we must sleep undermosquito nets and place a purifying tablet in drinking water.” FGD, women, Kasai Oriental.

Health workers also did not understand the differences between the sexes in health care (such as different symptoms of the same disease, prevalence of diseases, or different side effects of drugs) nor any notion of gender and its implications on health and health care. All health workers affirmed, however, that they care for all patients equally, without discrimination. Except for discrimination based on payment capacity and blatant cases of sexual violence, this was corroborated by the population.

d) Remuneration of Health Workers

Health workers repeatedly complained, and community members concurred, that they do not receive payment from the state. This not only puts pressure on their livelihoods, but also the livelihoods and health of the community. In order to earn enough money to survive, many health workers look for other work, so this limits the time that they spend in health centers. Women often reported the absence of nurses at health centers when they come in for ANC or vaccinations.

In addition, head nurses do whatever is necessary to ensure the operations of the center to have enough resources to pay the personnel, which puts financial pressure on the population.

“You see, I am alone here, I work alone. In order to be paid, when I hold 50,000Fc (approximately \$55), I pay my own percentage--20,000Fc--or 40,000Fc for the central bureau. If we are two, how will we live each with 10,000Fc (approximately \$11 a month)? Even 20,000Fc in my home is not enough. That is why I must also farm.” Interview with male health worker, Katanga.

A consequence of this is the virtual absence of women as health providers in rural areas. Given that most health workers are not paid by the State, monthly health center revenues are not guaranteed, and women say they cannot work in rural areas and work without the guarantee that they will be paid at the end of the month.



Photo 7: Health Center in Kasai Occidental

e) Availability of Basic Provisions

According to the community members and health service providers, stock outs of drugs and basic health commodities are a recurrent problem. Some centers are supported by NGO partners who provide them with drugs more or less regularly, in addition to provisions from the central bureau. Participants accuse health workers of selling drugs meant to be free for certain populations. Furthermore, some health centers only receive drugs from the health zone central office, which only covers a portion of the needs for the month. The head nurse needs to find ways of obtaining additional drugs, either from private pharmacies or other providers in order for the center to function.

“At times there are many months that will go by during which we have all the products, and then we will be out of stock for as many months.” **Interview with female health worker, Sud Kivu.**

Once the stock out is known, the number of women coming to ANC starts to diminish and many will self-medicate using ambulant pharmacies and traditional medicines.

The absence of beds in delivery rooms was also signaled in all health centers, preventing women from seeking services that require hospitalization. Separate male and female hospitalization rooms are rare, and under no circumstances will men sleep in the same room as women and newborns.

“If the nurse tells me that my illness requires hospitalization, I prefer going to Fungurume (approximately 45km) or Kolwezi (more than 100km) because I cannot stay in the same room with women who have recently delivered a child.” FGD, young men, Katanga.

In addition, some delivery rooms are too exposed to the public which makes women uncomfortable during childbirth. In order to avoid being seen or exposed, some women wait until it is night time to go to the health center for childbirth, risking delivering the child at home.¹⁷⁸

iv. Sex of Health Provider

The sex of the provider seems to be more important for men than for women. While some women state having no sex preference when choosing providers, the majority of women affirm that they prefer being consulted by female health workers, especially for gynecological consultations. Women rarely request to be treated by a female provider. But, some men insist upon a male health provider for them, and a female health provider to treat their wives.

“It is uncomfortable to have your sex touched by a woman... you risk having an erection and it’s really embarrassing in front of a woman.” FGD, men, Sud Kivu.

According to some participants, a health worker of the same sex is more inclined to maintain the confidentiality of his or her patient.

While most women said that they do not have a preference for health service providers for most treatments, some are more comfortable in health centers where they may be assisted by female nurses. Indeed, for antenatal consultation as well as for problems of STIs, women say they are more at ease speaking with female rather than male nurses.

“Let women have female nurses, and let men also be assigned a male nurse. Because other husbands also desire many women... we have often noticed that providers envy the wives of others at the health center, you find a provider with someone else’s wife doing foolish things. These are the behaviors that push us to make choices among providers.” FGD, men, Kasai Occidental.

Women say that going to antenatal consultation in a center where there are only men is not at all comfortable, and some prefer to stay at home rather than going to antenatal consultation with a man.

v. Alternative Medication

Some people, at least for specific illnesses, prefer to use alternative medicine. There are illnesses that are believed to originate from mystical sources, such as curses, thus can only be treated by sorcery or

¹⁷⁸It is important to note that delivering children at home is against the law and is subject to sanctions, from the payment of a fee to the woman’s imprisonment.

by the church. Symptoms or illnesses believed to not be curable by modern medicine are convulsions, typhoid fever, anemia, gastritis, and epilepsy.

“In the case where a woman or her family insists in helping pay the fees, or if they suggest to see a traditional healer, the husband will say that the illness has its origin in the woman’s family; a reason for which they insist on paying the fees or seeing a traditional healer.” FGD, men, Katanga.

The cost of treatment in a health center also pushes those without means to choose alternative medication, such as traditional medicines (roots and plants), sorcery, church, or street drugs. Traditional medicines are very appealing to many as they are inexpensive and highly accessible, and the reception by traditional healers is also very different from the reception of health centers.

“It is not what you have in your pockets that will determine how the healer will behave towards you... sometimes it is free and quick, we do not have to wait for hours.” Decision matrix exercise, elder women, Kasai Oriental.

Sometimes people use traditional medicine as a first recourse for illnesses, and only turn to modern medicine when illnesses worsen.

“We receive children that are gravely sick because parents prefer to try traditional medicine and come here when this fails and the child is in a critical state.” Interview with male health worker, Katanga.

E) Access to Health Care

i. Principal Barriers to Women’s Access to Health Care

a) Need for Husband’s Authorization

Though men state that they make their wife and children’s health a priority, married women cannot travel to the health center without the prior agreement of her husband or person in charge of the family in his absence. This poses a problem when the husband is away and emergencies occur, when a woman must rely on others before she can seek care for herself or her children. If a woman takes the initiative to go to the health center without her husband’s approval, the husband may refuse to pay for fees and medicine.

According to young men, women are ‘capricious’ and often invent their illnesses to get their husband’s attention. Men say that they decide to bring their wives to health centers when they notice serious signs of illness, such as vomiting, convulsions or strong fevers. Men also punish their wives, for disobedience or whatever else, by refusing to accompany her to the health center.

“When you are insubordinate, your husband will not take care of you. But when you obey and respect his will, he will respect your rights.” FGD, young women, Kasai Occidental.

In cases in which women test positive for a sexually transmitted infection, all health workers interviewed affirmed that they would require the presence of the husband prior to proceeding with the woman's treatment. While some health providers stated that they would proceed with the woman's treatment and schedule an appointment for the couple to do a full treatment, other health workers categorically refused to treat a woman in the absence of her husband. However, informing the female sexual partner or wife is not a requirement for men's treatment.

Prescribing family planning contraceptives is another practice for which health workers require the husband's presence or prior approval. A woman who is alone (whether single or married) cannot obtain contraceptives through health centers.

"When a health worker gives contraceptive methods to a married woman, it may be because she is his girlfriend and he does not want her to get pregnant." **FGD, elder men, Katanga.**

Although health workers make efforts to convince married couples to use family planning products, they categorically refuse to give or prescribe contraceptive methods to couples who do not yet have children or young people who are unmarried. Condoms are the only exception, but possibly because there is a preconception that condoms are used as prevention against STIs. Similarly, health workers will inform parents if adolescents come with STIs or unwanted pregnancies.

There is no specific law on withholding contraceptives from women without her husband or parents' approval. However, there is some confusion on the National Policy for Family Planning, or some health workers refuse contraceptives to a woman by herself for cultural reasons. Health workers said that they want to avoid confrontations or potential problems with the husband or parents, so they want to be sure that the person responsible for the girl or woman is well informed.

b) Access to and Management of Family Resources

On the whole, women do not have access to the family's economic resources, even if they contribute the greater part of household funds. To what degree a woman can manage household finances depends completely on what level of responsibility her husband gives her. Certain men will not involve their wives in any aspect of financial management, or only day-to-day purchases commonly refer to 'small spending.' On the other hand, some men concede that women are better money managers and thus entrust them with this task, while others give their wives money management responsibilities due to their relative contribution or because of their 'love for their wives.'

"If a woman contributes something to her family, it is normal for her to have a say in the use of these resources. In reality, contributing financially to the household attracts the respect of a man for his wife." **Decision Matrix exercise, men, Katanga.**

There are things, however, that women are never authorized to do in the family no matter what her financial contribution may be, notably the sale of household property even if it may belong to the woman.

Whatever difficulty the family is in, the husband will accept with great difficulty the help from the woman's family.

"If your parents-in-law give you money it is a humiliation for a man. That is why we prefer to take credit from a friend or a neighbor than to ask or accept help from any member of the woman's family."

Decision Matrix exercise, young men, Kasaï Occidental.

c) Insufficient Financial Means

The family's financial means is a barrier for men, women, and children, but it will be discussed in this section as it seemed more prevalent among women. Prior to considering attending ANC or being vaccinated, the woman must first think of the money required.

"If you do not have money, what will you tell the health provider? Even in this case you could be scared to approach him... For him to treat you, it is absolutely necessary to give him money." **FGD, women, Sud Kivu.**

"Even if you have farmed, a single sick child can cause you to spend everything on his care. The fees to treat children vary between 25,000 CDF and 30,000 CDF (\$27 and \$33); here we are sick of children's illnesses." **FGD, women, Katanga.**

In Sud Kivu, it was mentioned multiple times that when a person is unable to pay fees in certain health centers, he or she will be held prisoner in the health center until the debt is paid, or someone else (even a stranger) pays for his or her liberation. Women reported that some women only attend ANC during the eighth month of pregnancy to avoid consultation costs. For the same reason, some children are vaccinated only during vaccination campaigns. The existence of mutual health organizations¹⁷⁹ in Sud Kivu somewhat facilitates the accessibility of health care for women.

d) Physical Distance

The distance between health centers and villages are often very long and do not permit pregnant women to travel for routine consultations. Researchers' quick review of consultation records in a few health centers demonstrated that the majority of patients in these records are within 10 km where the health center is. Many pregnant women and some children go without ever going to the health center to be vaccinated.

¹⁷⁹Women frequently mentioned mutual health insurance in Sud Kivu, however, only 6 - 10% of the population is actually involved in a mutual. It was mentioned infrequently or not at all in the other three provinces. Members of mutual health schemes do not pay 100% of treatment costs because the mutual will pay a portion.

“My child is now three years old and I have never vaccinated him because I do not go to Kalonga (principal city in the health zone) except in cases of emergency.” **Decision Matrix exercise, women, Katanga.** This sentiment was very common in rural areas.

ii. Barriers to Men’s Health

Attending a health center is often considered a sign of weakness among adult men, who often spoke of their bodies being stronger than that of women. Men also spoke of long waiting times which deter them from going to health centers for their own care, but also accompanying their wives. Indeed, women also testified to very long waiting periods (hours) prior to being consulted by health workers.

If family resources are scarce, men prefer that their wives and children be taken care of first. Also, when a woman is sick and cannot accomplish her domestic tasks (cooking, fetching water), very few men are ready to take over these tasks from the woman. They prefer to look for another woman within the household to accomplish these tasks. For this reason, men prefer that women get better quickly and take up their place in the household, and sometimes even prioritize their wife’s health above that of their children’s.

“If my wife and child are both sick, I would first treat my wife... Even if the child dies, I will be able to have another with my wife; but if it is my wife who dies, I will have problems in marrying another woman.” **FGD, men, Kasai Occidental.**

F) Gender and Health

i. Sexual and Reproductive Health

a) STI/HIV

Sexually transmitted infections (STI) are very frequent in the areas studied, and affect the married and unmarried, and men and women. It is believed that the number of STI cases is on the rise due to increases in prostitution and debauchery.

“Young girls prostitute themselves, some married women engage in adultery.... even married men engage in adultery with young girls, people don’t respect themselves anymore... even young girls of 12 years of age do it.” **FGD, young women, Sud Kivu.**

Voluntary counseling and testing services (VCT) are not yet part of the minimum package of activities in certain health centers, particularly in Sud Kivu. Health workers have expressed the need for training in order to include HIV in their routine informational activities for women during the course of their ANC.

“In terms of HIV, we first need to receive support so that this activity may be there... for the moment we are too limited, we cannot just say anything, because we do not have this activity here, we do not know

what is done with regards to this activity. And with case management, we don't know either."

Interview with female health worker, Sud Kivu.

b) STIs/HIV and Unwanted Pregnancies in Youth

In all research sites, youth were said to begin sexual activities very early--between the ages of 12 and 15. As stated previously, STIs and unwanted pregnancies are among the principal reasons for youth seeking health care, but it is commonly believed that these phenomena occur at a younger age and are more prevalent than in years past.¹⁸⁰ In the Wikong health zone in Kasai Oriental, health providers reported especially numerous cases of STIs, unwanted pregnancies, and requests for abortion among young unmarried women.

"The practice of [sexual promiscuity]¹⁸¹ in young people is a very common practice in this zone, and people do not even hide it anymore." **Interview with male health worker, Kasai Oriental.**

Some youth, especially in rural sites, do not know how to prevent STIs or unwanted pregnancies. Posters in health centers provided by NGOs are the principal sources of information on the protection against STIs/HIV among youth; however, not all youth use health centers.

"One day I picked up a used condom and I emptied out the whitish liquid that was inside and I started to blow it up like a balloon. It was a friend who later explained to me what it was." **Decision Matrix exercise, young women, Katanga.**

Parents and churches typically do not discuss condoms as a prevention method (especially of pregnancies), and often do not discuss sexuality at all. If prevention methods are discussed, it is abstinence, even though it is admitted that youth will not follow this advice.

Most youth know the different methods of avoiding STIs/HIV very well, particularly those in or around larger towns, due to greater access to school and media, but still engage in risky sexual behavior. One reason that youth practice unprotected sex is that condoms are not available in all health centers and where they do exist, young people say they are embarrassed to buy them. Social conventions make it difficult for youth to access condoms, but exponentially more so for young women who suffer severe social sanctions for having condoms.

"If we see an unmarried girl who comes to ask for condoms, she will literally be considered a prostitute... Since you are not engaged why would you come ask for condoms, what are you planning on doing with them?" **Interview with female health worker, Kasai Oriental.**

¹⁸⁰ As this was not a quantitative study, we did not ask people to state over which period of time the increase has occurred, so we were not able to compare with actual data (nor was it the purpose of the study). People stated the 'prevalence' of STIs and unwanted pregnancies has increased and the age of population is lower, but we don't actually know if that is true.

¹⁸¹ The word 'prostitution' was actually used, but upon probing it was understood that they meant sexual promiscuity as they defined prostitution as 'having many sexual partners, but not necessarily with a monetary compensation.'

Although sexual violence was not explicitly asked of participants, some young women did admit that they contracted STIs due to sexual violence. Women rarely report cases of violence to health workers or law enforcement officers for fear that their parents will be informed. Should a rape be known, the survivor is stigmatized or will find herself without marriage proposals, so parents actively discourage reporting of cases.

“A girl who has been raped is already defiled and no one will marry her when they know her story.”
FGD, women, Sud Kivu. So, many STI cases are reported to health worker for causes other than rape.

It was reported in all of the research sites that many youth have multiple sexual partners, which in addition to increasing the spread of STIs and HIV, poses other problems. First, some young women become pregnant and are not certain of the father.¹⁸² In cases where the man accepts responsible for the pregnancy, the girl’s family usually insists they be married, especially in Kasai Oriental. In Sud Kivu, however, parents seem less likely to push marriage in cases of pregnancy, though it is unclear as to why. A man is usually required to compensate the girl’s family if he does not marry her. Another problem associated with youth having multiple sex partners without using condoms is it is difficult for health workers to treat all those potentially infected. Generally, girls are better at designating their sexual partners and bringing them in for testing. Young men, on the other hand, admit with great difficulty that they have STIs, let alone inform all of their sexual partners.

“Some youth tell me that they have contracted the illness by walking on something in the village, or that they were infected in the restrooms.” **Interview with male health worker, Katanga.**

In many cases the young man will be treated alone and risks being re-infected by one of his partners. As discussed earlier, the prerequisites for treatment, namely informing sexual partners, is different for males and females. As most health service providers require parent notification when unmarried youth come for STI treatment, some youth will avoid coming at all. In order to convince youth of bringing their parents, some health workers deceive their patients into believing their illness is something other than a sexually transmitted disease.

c) STI/HIV and Infidelity among Married Couples

Health service providers report that they treat more STIs in married couples than in unmarried youth. However, this may be explained by youth’s reticence to be come to health centers for STIs, as well as the fact that STI testing is done systematically when women attend ANC sessions (generally, more married women attend ANC than unmarried women). Married men rarely propose using condoms with their wives, and women generally do not have the power to ask their husbands to use condoms. When health service providers detect STIs in married couples, health workers do not feel comfortable

¹⁸² It is common for young people to have multiple sexual partners, and in the case where young women become pregnant while she has more than one sexual partner, she would be unable to identify who the father is.

suggesting condoms as a prevention method and have to be tactful and careful in bringing up the subject of infidelity with the couple. Despite their strong suspicions, women rarely accuse men of being unfaithful, at least not openly. But, in most cases a man will openly accuse his wife of infidelity. There is a widely-held belief that the first person to be tested positive for STIs (including HIV) is the person who brought the infection to the family, and if women are the first to have the virus detected (which is likely given routine testing during ANC), this may partly explain why they are accused.

In addition to women's relative status in a relationship, attitudes and beliefs regarding condom use, especially in a marriage, is also an impediment. Some men, notably those of Katanga, believe they are only at risk of STIs and HIV when they are traveling and sleeping with women who are from elsewhere, such as Zambian women.¹⁸³ They believe that the women in their village are healthy and do not have STIs. Some men report they are willing to wear condoms upon a woman's request once they return from their travels. But when women do not make this request, men will not use them--even if they have had unprotected sex during their trip.

"Wearing a condom by my own will is a way of admitting to my wife that I have slept with another woman and that I may be sick." **Decision Matrix exercise, men, Katanga.**

Women's beliefs and attitudes towards condom use are also an impediment to couples using condoms. Some women believe that only prostitutes use condoms, so if a man suggests using a condom, she will refuse because it means he doubts her fidelity. Also, according to women, asking a man to wear a condom is inappropriate for a woman who knows she is faithful to her husband.

When asked why men engage in extramarital affairs, it is often said that men have greater sexual appetites than women, or that they 'need' sex more often, as well as with multiple partners, than women do. It is widely believed that men will develop a hernia if he spends a long time without sleeping with a woman. Although it is generally believed that men commit adultery much more than women, there are also women who are unfaithful. However, women who engage in extramarital affairs generally do so for economic gain.

"Due to famine... to poverty, in order to have something to eat, to wear, they prostitute themselves with someone else's husband. Prostitution in Sud Kivu concerns people of all types...from youth that are 15 years of age up to old men... In the case of free women, they prostitute themselves in order to procure food for their children." **FGD, young women, Sud Kivu.**

As women who feel it necessary to engage in transactional sex are not in a position of power to ask their client to use condoms, STIs and HIV are huge risk factors. Young men affirm that they prefer running after married women because they are more easily manipulated and do not insist on using

¹⁸³ Men in Katanga often cross the border to Zambia to do business.

condoms. Young women who still live in their parents' home are worried of becoming pregnant and have relatively more power over their sexual health (as they do not 'belong' to anyone yet).

When a woman tests positive for an STI, health workers will convoke the husband for couples' treatment, to which husbands usually respond. However, there are cases where men categorically refuse to come in for treatment under the pretext that they do not feel ill.

"You go to the hospital and the health provider will discover infections... many women suffer from infections. You will be asked to take drugs for the treatment of couples; the man will refuse to take them. You will finish [the treatment] and when you will sleep with your husband, after sexual relations you are infected once again." **FGD, women, Kasai Occidental.**

The situation becomes more complex in the cases of polygamous marriages.

Similarly with STI testing, women who have tested positive for HIV are more open to informing their husband and co-wives of their status to avoid the spread of the virus. On the contrary, men prefer to keep their status secret despite the risk of transmitting to the whole family. In addition, men sometimes do not respond to health workers' requests that they be tested when their wives test positive. This story was shared by a male nurse in Katanga:

"... men are more complicated. Two years ago we had a positive case. It was a woman with two children and we called upon her husband who is polygamous. He did not come. His wife even left for Zambia over there to be tested again and they found that the two children were also positive. The husband was also in Zambia; when he heard that he was being convened at the hospital he took his motorcycle and quickly returned here... you see. In order to address men, it's really a challenge... the second wife is here and recently she's pregnant so when she will come to ANC, it is at that time that we will ask her with regards to the HIV test. She does not know the situation of her co-wife and her husband." **Interview with female health worker, Katanga.**

Health workers assert that they let HIV-positive patients choose whether or not to reveal their status.

d) Abortions

The mention of abortions was surprisingly frequent in all of the provinces, given the DRC's strict laws and punishments. Indigenous plants and pharmaceutical products, such as antibiotics, were said to be most frequently used to induce abortion, although clandestine abortions performed by health workers was also mentioned. According to health service providers, abortions are almost always done by young unmarried girls,¹⁸⁴ since having a child out of wedlock severely limits a girl's marriage propositions.

¹⁸⁴ Health workers said that they very seldom heard of married women getting abortions.

“Few boys will marry a girl they have impregnated, let alone a girl who has aborted or who already has a child.” **FGD, young women, Sud Kivu.**

Young women seek services far from home to avoid the community finding out, and are reassured that health workers who help them abort will not divulge their secret because they risk imprisonment if authorities find out. There are also some health service providers who believe it is their role to discourage young women from getting abortions for religious convictions.

“We receive cases of unwanted pregnancies and our work is to bring the woman to accept, with teachings, conversations that we have with each woman. In fact we will ask this mother to accept this child, to accept her pregnancy. Because we often tell them that God wanted this pregnancy and God knows that this child can become a president, become a minister, and well, the woman will calm down little by little, little by little until the pregnancy comes to an end.” **Interview with female health worker, Sud Kivu.**

The majority of abortion-related visits to the health center are for severe complications. Health service providers, especially in rural areas, do not have the appropriate tools or knowledge for post-abortion case management, let alone urgent care.

“We sometimes receive such cases and these cases are often treated from home, and when it becomes complicated they are brought here as emergencies.” **Interview with male health worker, Sud Kivu.**

e) Family Planning (FP)

Men and women both reported a desire for a large family, for slightly different reasons. Women explain that having many children guarantees her place and status in the household, even in cases of difficulties with the husband. If there are only a couple of children, the husband can easily drive her away for whatever reason and marry another woman. For men, on the other hand, children (especially boys) constitute the wealth of the family. Despite the economic toll of numerous children on already impoverished households, men and women alike believe that having many children is a gift of God. And although there is widespread recognition that multiple close-spacing pregnancies are a health risk for both the mother and newborn, there are still numerous barriers to accepting family planning. There are also many societal pressures to have a large family. Some women are accused of being sterile if the couple is childless after two or three years of co-habitation,¹⁸⁵ and her in-laws may pressure the husband to take a second wife.

As shown previously in the Decision Matrix tables, both the decision of how many children to have and whether or not to use contraceptives lie principally with men (with the exception of women in Sud Kivu

¹⁸⁵ Specifically discussed in South Kivu.

who seem to have the final decision-making power regarding which contraceptive method to use, once the husband decides whether to practice FP).

“It is the husband who gives the order, if he wants 20 children it is he who decides.” **FGD, young women, Sud Kivu.**

Couples’ discussions of FP will usually ensue following a health worker’s advice or a woman’s request. But women report that men often refuse to practice family planning.

“We don’t plan pregnancies because it is impossible. Men request sexual relations erratically and we are obligated to meet their requests in order to avoid problems. That is why we ‘become a madam’¹⁸⁶ each year.” **Interview with female health worker, Katanga.**

Men who have children of both sexes more easily accept using contraceptive methods. In households where the children are exclusively girls, however, the husband will refuse to use FP because he hopes to have a boy who will one day be the heir of the family.

For couples that have accepted and adopted methods of FP, the husband places the responsibility of avoiding getting pregnant on the woman. When unexpected pregnancies occur, men blame their wives for failing to avoid it.

“In my case, I had tried to limit births after we had had our sixth child. We managed during four years, but after, my wife knowingly became pregnant and another child arrived. So the space between the sixth and seventh child is of five years instead of two or three years as we had been accustomed to doing. The sixth child is now in the fifth year of primary school while the one who follows him does not even attend primary school yet. Women are those who cause these problems because they are neither educated nor intelligent.” **FGD, men, Sud Kivu.**

When men accept family planning, they tend to prefer natural methods such as the calendar method, but this is usually very difficult for couples to adopt. Women often complain that these methods fail due to men’s impatience during the fertile period in their cycle. Women have no choice but to satisfy her husband’s desires despite the risk of becoming pregnant.

There are numerous misconceptions regarding practicing family planning, such as couples have to limit the number of sexual encounters or limit the number of births.¹⁸⁷ Some believe that if a woman stops having children early, she will often become ill; or after repeatedly taking birth control, the woman will be unable to have more children.¹⁸⁸ Despite these misconceptions, participants were aware of

¹⁸⁶ A way of saying one pregnancy a year

¹⁸⁷ “Four births” was often mentioned. It’s not clear where this specific number came from, but it may be that health workers advised some patients to limit the number of births to four.

¹⁸⁸ Specifically discussed in Kasai Oriental.

available family planning methods in their areas. The most frequently cited contraceptive methods were condoms, injections, the calendar method, cycle beads, and withdrawal. Participants were also cognizant that the last three methods are the least effective contraceptive methods.

Health service providers' attitudes towards women's rights and autonomy as well as their misunderstanding of national policies are also major obstacles to women's access to modern contraceptive methods. A married woman cannot obtain methods of family planning, such as Depo-Provera, implants, or birth control pills through health facilities without the presence and agreement of her husband. Similarly, most health providers will not provide contraceptives to unmarried girls, even if they are adults. But there are some health service providers that will give pills and Depo-Provera to young girls.

"Starting at the age of 14 until they are married, girls can access FP methods without problems, because if we do not give them, they will become pregnant." **FGD, young women, Kasai Oriental.**

Condoms are an exception since they are distributed during NGOS-supported sensitization campaigns for STIs and HIV in health centers. Strangely, many health workers did not even mention condoms as a method for family planning, but really associated them with STI prevention. And while health workers assert that they do not provide FP without the presence of husbands, *"other women manage to obtain injections in secret and it creates disorder within the household; this is why women are beaten by their husbands."* **Interview with female health provider, Sud Kivu.**

f) Antenatal Consultations (ANC)

Antenatal consultations represent the main reason for women's health center visits, apart from their children's health visits. For this reason, health providers often take this opportunity to transmit all types of health messages, as well as those specific to ANC. In fact, women reported that they received most of their health information during ANC visits, including messages about hygiene, nutrition, the importance of vaccination, breastfeeding, and STIs/HIV (except Sud Kivu, where HIV messaging rarely occurred).¹⁸⁹ It is interesting to note that older women reported that they had no means to receive new health information since they no longer attended ANC, and thus are not the target audience of health messaging. Despite the fact that ANCs are the primary reason for women's health center visits, many women never attend ANC, attend only once during a pregnancy, or they only respect the visits for certain childbirths. Women recognize the importance of ANC, but very few adhere to regular visits for reasons similar to women's barriers to health care mentioned earlier, including:

- Women who have had multiple pregnancies do not feel the urgency to attend early ANC because they say their bodies are already accustomed to pregnancies and only one antenatal visit will suffice, around the seventh or eighth month of pregnancy. *"Some say that starting ANC at the third*

¹⁸⁹HIV was rarely reported as one of the messages during ANC visits in South Kivu

*month is very early. So we must only educate. But there are those who respect and others who neglect... those who come late are the multipara.*¹⁹⁰ **Interview with female health worker, Katanga.**

- Some first-time mothers do not know that they are pregnant and come late for consultation (around the fourth or fifth month).
- Women lack financial means to pay for consultation or transport fees.
- Women with unwanted pregnancies and wish to hide pregnancies will not attend.
- The waiting time at health centers is too long, which interferes with women's domestic duties.
- The distance between the village and health center is too long. *"I cannot walk 10km to go to the health center and 10km to return home with my belly. Even if I wanted to, I could not."* **FGD, women, Kasai Oriental.**

Another barrier may be men's lack of involvement in antenatal care, as they are the primary decision-makers where finances are concerned. Men seem to have a lack of interest in the process of women's and children's health, and they will usually only accompany them in cases of emergency or serious illnesses. In a few rare cases, husbands will accompany their wives to the health center for routine ANC if the travel distance is too long and the wife cannot walk the round trip in the same day.

Antenatal care is generally considered a feminine activity, and some men reported feeling excluded from the woman's treatment process and have even been prevented from entering the consultation room. Health workers affirm that they do not allow men in the consultation room because they are not comfortable examining a woman's genitals in front of her husband, and thus cannot properly conduct a pelvic exam. Even when men question why they are not authorized to participate in their wives' consultation, health workers do not provide explanations.

"When I bring my wife to the hospital, why do nurses ask me to step out and stay outside when she is my wife, why is that?" **FGD, men, Kasai Oriental.**

Instances are rare that the husband insists and succeeds. Men who insist on being present have said that they do so because of known inappropriate behavior of health workers.

¹⁹⁰ Multiple births.

ii. Water, Sanitation and Hygiene



Photo 8: Defecation Area, Katanga

Health service providers and community members alike cited diarrhea and malaria as two of the most common diseases of children under five years old – both of which stem from unhygienic water and poor sanitation. Decision making regarding water, sanitation, and hygiene is very clearly divided between men and women. Water management and sanitation at the community level, such as cleaning public spaces and managing point-of-use water systems, are generally the responsibilities of adult men. However, women do participate in the execution of cleaning public spaces, directed by men. Women are responsible for food sanitation, water, and personal hygiene of the family. Men take the responsibility of yard sanitation, deciding when and how to clean the space around the household.

Information on hygiene is obtained from parents (hygiene is taught to young daughters), health centers through awareness campaigns, or through ANC sessions at the health center.

“The problem of bilharzia has considerably diminished because health workers have prohibited us from bathing in the river. Currently we have showers and latrines in each house.” FGD, men, Sud Kivu.

Indeed, access to water, especially potable water, appeared to be one of the crucial problems in all of the villages visited.

“We transport 20-liter water cans on our heads and walk a distance of four or five kilometers in the mountains. This works takes us the best part of half of the day.” Time Utilization Clock exercise, young women, Katanga.

Many women complain that their work makes them more susceptible to water-borne diseases, and often mention dermatitis. Due to water shortages in some villages, women wash themselves in the same water they use to clean cassava.

“Pregnant women obtain this illness when they retrieve cassava from the ponds where they leave the cassava for so many days. When they wash themselves in this same water, they are contaminated by germs, and it is these germs that cause this pathology.” **Interview with female health worker, Kasai Occidental.**

Table 10: Most Frequently Used Water Sources

	Katanga	Kasai Occidental	Kasai Oriental	Sud Kivu
Water from a tap within the home	4.12	0	1.56	4.5
Water from a tap on the property	3.09	2.63	0	9.01
Water from a public tap	20.62	4.39	50.78	34.23
Open well within the home	0	0	5.47	0.9
Open well on the property	0	0	0.78	2.7
Public open well	18.56	0	9.38	0.9
Covered well on the property	4.12	0	1.56	0
Public covered well	0	2.63	0.78	1.8
River	19.59	31.58	10.94	28.83
Lake	9.28	0	10.16	0
Canal	0	0	0.78	0
Spring water (Covered pump)	20.62	58.77	4.69	16.22
Other (stream, rain water ...)	0	0	1.56	0

N= 432 (Insignificant differences between sexes)

Health workers report that there are infections whose symptoms are similar to STIs caused by women’s poor hygiene, notably in Katanga.

“Not all infections we observe in women are due to unprotected sexual relations. There are women who have no notion of bodily hygiene especially at the time of their menstruations. They use pieces of ‘pagne’ (a textile) to sponge menstrual flows, and this piece of ‘pagne’ is not always clean. Even worse, some will use the same piece of ‘pagne’ for their entire menstrual cycle.” **Interview with male health worker, Katanga.**

When asking women what information they have received regarding hygiene, they mentioned hand-washing, the sanitation of compounds, the protection of food, regular washing, etc., but nothing regarding women’s hygiene.

iii. Nutrition

Men are responsible for purchasing food for the family, and the cooking and daily rationing are women's roles. Many participants initially attributed men with the responsibility of household nutrition; however, deeper discussions revealed that it is more multifaceted. The responsibility for nutrition changes according to the age of the family member.

a) Breastfeeding and Young Child Feeding

Generally, women know very well that it is best to exclusively breastfeed newborns until six months of age. Despite this knowledge, the application of the practice poses great difficulties for women given her productive role in the household. On average children begin eating porridge from one, two or three months of age (Sud Kivu, Kasai Occidental, Katanga). To carry out daily tasks, such as going to the fields or fetching water, women leave their newborns at home with older children or other family members. If the child cries, the person in charge – usually the mother-in-law -- will give the infant either water or porridge.

“Staying at home for the first six months to breastfeed is very difficult because they must work, which is why as early as three months it is possible to introduce porridge.” FGD, young women, Sud Kivu.

Time utilization exercises illustrated that there is no time dedicated to childcare. It seems that the care of children is not considered a task which women must devote specific time, and this task is shared by numerous women and older children.

Some mothers believe that their milk is insufficient to nourish her baby – despite hearing numerous messages explaining otherwise.

“It is also the malnutrition of mothers that push them to feed their children prematurely. If the mother does not eat well how do you expect her to have good milk to give to the child? Instead of making the child suffer I must give him porridge because the baby will cry every time.” Focus group, elder women, Sud Kivu.

Women seem to be receiving and understanding the information regarding exclusive breastfeeding, but some women do not believe it.

“We have been shown this way, but we do not practice it. We can give birth to a child today but she will start drinking water the same day; why is this? It is because of poverty.” FGD, women, Kasai Oriental.

Young childhood nutrition is primarily the mother's responsibility, and the father is uninvolved beyond providing funds. As children become older than one year, young children's diet preoccupies parents less because children will eat whatever adults do. The quality of children's diet depends upon financial capacity, mother's knowledge of nutrition, elder children's and/or mother's-in-law knowledge of

nutrition, and food taboos.¹⁹¹ It seems that children’s malnutrition is due more to insufficient knowledge of available local products than a lack of availability them. When listing the foods required for the healthy development of young children, fruits and vegetables are absolutely absent. Foods with a large quantity of sugar and oil are believed to be the best for a child’s health.

“For a child to grow up properly, he or she must eat foods with lots of sugar, but we do not always have the means of purchasing sugar to put it in the porridge.” FGD, elder men, Katanga.

Table 11: Decision making in Nutrition of Young Children and Newborns

	Father	Mother	Grandmother	Others
Katanga	-	(+)	+	
Kasaï Occidental	-	+	-	-
Kasaï Oriental	+	(+)	-	
Sud Kivu		+	-	

Note: The nutrition of newborns includes breastfeeding

Table 12: Contribution of Food to the Household

	Father	Mother	Adult children	Others
Katanga	(+)	-	+	
Kasaï Occidental	(+)	+		
Kasaï Oriental	(+)	+		
Sud Kivu	(+)	+		

Note: Participants interpreted this as purchasing food with money, and not products grown or collected by women.

*The above tables represent combined data provided by different target groups included in the study.

Some men claim they understand children’s nutrition better than women, but avoid revealing their knowledge for fear that women will request that they bring home nutritious and expensive foods.

“If I begin to tell my wife how to feed the children, she will begin to ask me to either pay for meat or fish for the children even though she will be the one to eat the majority of these foods. So I stay quiet and let her do it, but otherwise I do know how to nourish children.” Decision Matrix exercise, men, Katanga.

This demonstrates not only the low priority men place on childhood nutrition, but also their misconception that nutritious foods must be expensive.

¹⁹¹ Food taboos for children were noted especially in Kasai Oriental, Katanga, and South Kivu, and include certain types of birds, meats, fish, and wild fruits.

b) Nutrition of Pregnant Women

While participants of the study affirm that pregnant women must eat foods rich in vitamins, they are unable to cite specific foods that they should eat. Similar to young children, there is a multitude of taboos surrounding pregnant women's nutrition which vary according to the province, but they all include very nutrient-rich foods. Violating taboo foods are said to either have a negative impact on the way in which a mother will deliver her child, or on the child.¹⁹² Men do not seem to have any food taboos in the research sites. Aside from taboos, women believe that nutrient-rich foods make the baby grow excessively, causing women to endure difficult deliveries or possibly a caesarian.



Photo 9: Pregnant woman carrying child and a basket, Kasai Oriental

iv. Social Support

Social support is strongly linked to mental and physical health. It seems that men and women seek social support differently, which may affect their health. Women rely on extended family in cases of economic, health, or emotional difficulties. For married women, husbands are the first person with whom they discuss problems and prefer discussing late at night when everything is calm and they feel they have a position of power in the bed “at the time of the sorcerers.” This does not always yield the support expected, and women then turn to extended family, friends and lastly the church. Participants in all four provinces have a strong attachment to religion, and many women turn to the church and

¹⁹²Among these prohibited foods were eggs: the child will be bald; certain birds: the child will have regular convulsions; dogs, boas, turtles, domestic animals, jackals; electric fish: the child will make the same movements as the fish does in water; pigs: the woman will spend many painful days without being able to deliver the child; beans, animal intestines, gorillas, and bats. Many of these prohibitions correspond to beliefs that continue to be present but tend to have a diminishing influence on pregnant women. Women admitted that they eat certain taboo foods in hiding, such as beans.

prayer when confronted with difficulties that they are unable to overcome in their family or community.

Men do not seek support from others like women do. *“As a man, I always try to fix my problems without resorting to anyone else.”* **Decision Matrix exercise, elder men, Katanga.**

Men admit the pressures they endure as head of the household accelerates aging. *“A man cannot tell his friends his problems which seem difficult... when the wisdom of men finishes, it is then that the wisdom of God begins.”* **FGD, elder men, Kasai Occidental.**

Men prefer keeping their worries to themselves or to pray. Men will involve their wives in situations which the problem is very visible, such as an illness. Youth tend to seek social support from their friends and their same-sex parent. Widows who live alone have the least social support, and increasingly rely on the church when faced with difficulties. *“When I feel badly, I pray to God so that he may help me.”* **FGD, elder women, Katanga.**

There was a virtual absence of formal institutions (state or private) aimed at providing psychological or emotional care, even for survivors of sexual violence. The health centers are not equipped to provide mental health support and subsequently violence survivors do not get the care they need. Furthermore, while STI and HIV testing is supposed to be systematic for women attending ANC, there is a dearth of facilities to provide counseling or psychosocial support for HIV survivors in the areas of study.

G) Health Communication

i. Health information

It seems that the study population received the vast majority of its health information through formal messaging, as opposed to informal interpersonal communication. For rural women of reproductive age, the primary health messages are received through ANC, community health workers, the church, and lastly the radio. Women also get information during routine vaccinations, or the distribution of treated mosquito nets. Information transmitted during ANC revolves around hygiene, STIs, the illnesses of children, vaccination, malaria, nutrition, HIV, and spacing births. In cities, however, the radio and television were cited among the most accessible methods to obtain health information for both men and women. Despite seemingly being exposed to multiple health messages, women do not seem better informed than men.

Men have greater access to mass media, such as radio, than women do, and primarily learn new health information in this way. Men also obtain some essential information through health workers during their brief time at the health center, or during informal discussions with friends in the village. Youth are the least exposed to health information.

Community health workers were said to be one of the most accessible and appreciated sources of information for the community because they are usually known, can easily engage in interpersonal communication, and discussions often take place in their homes.

“When the community health workers passes by the home and finds it empty, he will write something on the door or walls to indicate having stopped by, and to invite the person to visit the health center for more information.” **FGD, men, Sud Kivu.**

However, the efficacy of community health workers poses two challenges: 1) there are very few female community health workers in the village, and 2) almost two-thirds of community health workers are inactive, according to health providers. Each community health worker is supposed to cover 15 households, and the desertion of only one community health worker can overload others. In addition, similar to health service providers, community health workers seemed to have certain misconceptions regarding illnesses such as tuberculosis or malaria. The fact that there are fewer female community health workers than men is largely due to the voluntary nature of the work, which conflicts with their domestic duties, and the requirement to be literate, which is very low among women in rural areas.

Churches have also been cited as resource points for health information in certain villages. *“There are also certain churches that help us. Some churches in their preaching give messages to the community explaining that if you see your child or your sick person suffering from this or that, you must bring them to the health center.”* **Interview with male health worker, Katanga.**

Some health centers collaborate with churches and deliver health messages. Also, some nuns work at health centers, which make the link between health facilities and church easier. *“If there is a meeting at the health center, we pass the messages to the churches, or we tell the (village) chief and he will inform people.”* **FGD, men, Sud Kivu.** However, sometimes the church and health providers do not agree on health advice, which poses a contradiction for the community. For example, health service providers recommend the use of condoms to protect against STIs/HIV while churches prohibit the use of condoms.

ii) Health communication within the couple

Women and men affirm that they discuss certain health information they receive, but it is generally concerning test results after medical consultation, or the woman expressing her health need to the husband in order to obtain his authorization to travel to the health center. Women systematically report back to their husbands upon returning from the health center, yet the opposite occurs only very rarely, such as in the case where the illness is worsening, or when the husband runs the risk of being bedridden. If men discuss family health with their wives, it is usually to give directives or accuse them of something they are doing wrong. For example, when children fall ill with diarrhea, mothers are

always accused of being at fault. *“It is because of your negligence that the child has become sick.”* **FGD, men, Sud Kivu.**

Perhaps part of the reason why health communication is rare in a couple is because of sheer lack of time. When they occur, health-related exchanges between men and women are brief and only occur when there is a tangible need. The ideal moment for women to discuss the health of the family with her husband is late at night. But men say that nighttime should not be for communication, since at this time they need two things: *“have sex and sleep.”* **Time Utilization Clock exercise, women, Katanga.**

“Men are not receptive. They blame us when we attempt to begin a conversation with them saying: ‘what type of conversation are you bringing up at this hour of the night?’ Sometimes he will leave you and go towards the one who gives him peace: ‘stay! I will go where there is tranquility’...and he will go either with the co-wife, or with another woman... In order to avoid this we do not insist on the subject.” **FGD, women, Kasai Occidental.**



Photo 10: One of the few female nurses, Kasai Occidental

H) Women’s Perceptions on their Rights

Women affirm that they have certain rights in their families and in society, but many of these rights are not respected. Participants understand that they have the right to access to health services, to water, to appropriate nutrition, to a proper place of rest, to obtain drugs at the health center, to reduce births, and to be free of violence. Women explain that only their rights to eat and have a place to sleep are respected because these fall under the cultural obligations of men when they take a wife. As for their other rights *“they are not respected due to poverty, life is so difficult that no one thinks of their rights anymore.”* **FGD, women, Sud Kivu.**

Women consider themselves powerless and do not know what to do in order for their rights to be respected, and they turn towards God as a last option. *"I always ask questions to my God, why do others have a better life than mine? What have they done towards God? I often complain."* **FGD, elder women, Katanga.**

I) Barriers to the Recruitment of Women as Health Workers

There was a conspicuous absence of female health service providers, especially nurses and doctors, in all of the research sites. While there were midwives in all the health centers visited, health centers with female head nurses were rare, and only existed in one peri-urban health center visited during this study. Health service providers and community members alike agreed on the benefits, if not the necessity, of having female health providers. According to health service providers, both male and female, barriers to women becoming nurses and doctors are as follows:

- Girls abandon their studies early to get married and do not have the opportunity to complete the training to become a nurse which takes at least twelve years.
- Female nurses cannot work in rural areas if their husband is not present in the same zone. *"If I have to work in a village far from my husband, how will I fulfill my domestic duties? My husband will have many reasons to marry another woman."* **Interview with female health worker, Katanga.**
- Women have competing domestic duties. *"Women are not always available in order to meet the demands of the profession of nursing."* **Interview with female health worker, Sud Kivu.**
- Frequent pregnancies make women less desirable as candidates. *"We are not often recruited because we as women have a lot of antenatal and postnatal leaves, which is why women are not really preferred."* **Interview with female health worker, Katanga.**
- Rural posts are less desirable than urban posts due to challenging living conditions. *"Women from our domain, women who have finished the ITM (Technical Medical Institute) prefer to work in the city, or to be hired in the city. They refuse to live in the village, because in the village, there are family members in the village, and the payment of a salary is not assured, and the lifestyle is very difficult."* **Interview with male health worker, Kasai Occidental.**

It is important to note that no one mentioned women's technical capacity to occupy these posts as a reason for low recruitment. On the contrary, everyone interviewed affirmed that women provide the same quality of care as men.

According to women, the greatest barrier limiting their access to remunerated employment in general is their husbands. It was said that women sometimes have to choose between a saving a marriage and pursuing a career, especially if the husband does not have the same or better earning opportunities.

The husband has latitude to ask the employer to *“not recruit his wife... he has seen that his wife is more intelligent than he is, which is why he refuses for her to work. When you work it means you are above his orders, and his friends will mock him saying that it is your wife that feeds you and dresses you.”*
FGD, women, Kasai Occidental.

Educated women are prejudged to not have respect for their husbands, which is why men avoid marrying women more educated than themselves. *“Other husbands say that we cannot marry a woman who has a level of education, because they are educated and do not respect their husbands.”*
FGD, women, Kasai Occidental. The exception to this is men who are educated and have more egalitarian attitudes.



Photo 11: A village road in Kasai Occidental

VI. Discussion

Women hold very little power in Congolese society -- in politics, in the community, in the household, and even over their own body. Men are the decision makers of Congolese households, and women must obey their husbands, or risk violence, social stigma, and/or abandonment. Obedience for one's husband is not only a social norm, but it is also reinforced by religion and the law, notably the Family Code. In a typical household, men control all decisions regarding family resources, including who may and when to access health care; and how to use finances, including those earned by women; make decisions regarding family planning, including how many children to have, when to have them, and whether or not to use family planning methods; and even decisions about what a woman can and cannot do, such as when a woman can travel, when to have sex, and whether or not she can seek health care. So women are constantly navigating a power landmine where they must obsequiously keep their husbands pleased if they want access to health care, to avoid violence, to avoid them taking a second wife, or to stay in their husband's house with their children.

Women's lack of autonomy affects their health and well-being, and also that of their children, on many levels. First of all, a woman cannot leave the boundaries of her village, and sometimes her household, without prior consent of her husband. For most rural women who live very far from health centers, this becomes a real barrier to health. Women state that their husbands travel for work often or they simply refuse, either because it is not a priority given the family's meager resources or sometimes out of malice. At times, men accuse their wives of being "capricious" for demanding health care or they punish their wives for not obeying them, thus not giving authorization to go. In any case, too many women are not accessing the health care they need, especially for childbirth, as is evident by the maternal mortality rate in DRC being among the highest in the world (1,289 deaths per 100,000 births).¹⁹³

Oftentimes not seen as the public health issue it is, intimate partner violence was discussed openly among participants in this study, despite the fact that it was not a research objective. Women are beaten by their husbands for any array of reasons, and the community either condones or ignores it. More than 70% of women have experienced violence—physical, emotional, or sexual--by an intimate partner in the DRC.¹⁹⁴ The stress that a woman experiences, as well as the stress of her children who often witness domestic violence, surely has an effect on her health as there are numerous studies linking stress to illnesses. Not only is violence affecting her mental and physical health, but it is a human rights violation and specifically a child's rights violation because no child should live with violence. A woman who lives in fear, humiliation, and pain can hardly be expected to guarantee her

¹⁹³SRSS, 2008, cited in Swedish International Development Cooperation Agency. (2009). *The Democratic Republic of Congo (DRC) Country Gender Profile*.

¹⁹⁴République Démocratique du Congo. 2008. *Enquête Démographique et de la Santé*, 2007.

children's health, and spiritual and mental development. She does not even have sovereignty over her own identity and body.

Family planning is also a decision concerning their own bodies that escapes women. Not only does a typical woman not have very much weight in the decision of how many children she will bear, but she must negotiate very carefully in order to have her children healthily-spaced apart. Perhaps because men are scarcely involved in the details of bearing a child – including antenatal consultations, nutrition of pregnant women, childbirth, breastfeeding, and even early childhood care and feeding – they rarely initiate discussions with their wives about family planning. Women can bring up the topic and some men agree to family planning, but only if they already have children, and at least one son.

But some women are afraid to even bring up the topic, and others are afraid to stop having children as it may compromise their place in the household. According to the 2007 DHS, more than half of women have never had any discussion with their partner on contraceptive methods.¹⁹⁵ Furthermore, very few health service providers will consult with women or give her family planning methods without the consent of her husband. So, even if women want to clandestinely use family planning, they often cannot. Reproductive health programs must look beyond women of reproductive age, who have little decision making power, and target husbands (or couples) and health service providers if there is to be a public health change.

Sexually transmitted illnesses (including HIV) surfaced as a major reason for both men and women to seek health care; however, once again, a woman's lack of power over her own body causes her to suffer more than just physical symptoms. Although many women are unfaithful to their husbands, it was generally agreed that men are largely responsible for bringing infections into the household, and perpetuate the transmission. There does not seem to be any data on the percentage of men and women who are unfaithful to their spouses, but men's extramarital affairs were a common discussion during this study among women and men alike. There is a dangerous misconception that only women from "other villages" have infections, so condoms are not always used. Furthermore, men often put off being tested until their infection is unbearable and then sometimes conceal the infection from their wives (so that she won't discover he's been unfaithful). And there is complicity with the health service providers on this matter, who assuredly ask men to inform their wives, but they do not press it. When women test positive for STIs, however, they are denied treatment until the husband is informed and gives his approval – under the pretense that the couple must be treated together to avoid re-infection. Couple treatment is an excellent protocol, but there is a double standard in the practice, and under no circumstance should someone be denied health care. Even if a woman suspects that her husband has been unfaithful and has an STI, she is in little position to either refuse sexual relations or ask him to use a condom. Using condoms, especially when proposed by a woman, has strong negative connotations,

¹⁹⁵République Démocratique du Congo. 2008. Enquête Démographique et de la Santé, 2007.

such as he or she has been unfaithful, she is a prostitute, or she is accusing her partner of being unfaithful.

Married women and youth also engage in risky sexual behavior, but it differs from that of married men. Some married women and young unmarried girls engage in transactional sex, but they do not always have the power to negotiate condom use. As this study did not target women who engage in transactional sex, it is difficult to understand how common it is and what the terms are. However, some young men did say that married women did not require them to use condoms. Transactional sex stems from a power imbalance, thus it would seem that women would find it difficult to insist on protection. But, some sources suggest that the HIV rate for sex workers is quite high in the DRC, as much as 30%.¹⁹⁶ Although it varied by site, both young men and women were said to be sexually active at a very young age and with multiple partners. Some did discuss that an unmarried girl in a sexual relationship had the power to decide whether or not to use a condom; however, that power is reversed once she is married.

But women's lack of autonomy is not the only barrier to health care, and there are male-specific barriers to health care as well. The barriers that seem to affect men and women more or less equally are well known to anyone who works in the DRC: poverty, distance to health facilities, bad roads, lack of essential medicines, high costs (for travel, consultation, and medicines), poor quality of care, lack of patient awareness, health service providers' poor knowledge or skills, cultural beliefs, opportunity costs, and absence of health service providers because they are seeking a way to earn money elsewhere. Health facilities that have either a church or an organization supporting them seem to fare a bit better, providing training, medical supplies, and essential medicines, although frequent stock outs were cited as a problem. But, when being a health worker in a rural post is not a lucrative or even self-sustaining job, it is not surprising that quality health care is compromised. Most health service providers are doing the best they can with the little they have. But in order to run a health center, health service providers require high fees for their services and medicines, which drain the poor or becomes a barrier for them. The population will use alternative medicine (traditional, sorcery, prayer, self-medication, or use street pharmacies) if they cannot access health facilities. If these other methods fail, they use modern health facilities as a last resort, which requires health workers with the skills to deal with severe and urgent cases.

Quality of care issues came up often, such as confidentiality, reception, and health workers' skills, compassion, knowledge, and respect for patient's rights. The study's participants discussed these in terms of it being a deciding factor in which health facility to use (when more than one choice was feasible), which health worker to see, and also whether or not to go to a modern health facility at all. Some felt that they were well cared for and respected, so they felt that the health center was a place that was there to serve them. Many reported that if they did not have enough money to pay for

¹⁹⁶République Démocratique du Congo. 2008. Enquête Démographique et de la Santé, 2007.

services or medicine, that the health workers would negotiate a payment system or a trade. But for others, the payment issue was a serious complaint. There were reports that health workers or receptionists discriminate, not on the gender of the patient, but on how likely they were to pay, based on their appearance. It seems that modestly-dressed patients, especially in hospitals, were either made to wait longer than better-dressed patients or were asked to pay up front before any treatment was done. The community is well aware that this is discrimination and a violation of their rights. However, the community is not empowered to address it. Some even reported that health workers either threatened to disclose or actually revealed their confidential patient information to others, such as their HIV or STI status, if they were indebted to a health facility. Those who are indebted to a health facility are in precarious position, as this very situation may occur, or they are too embarrassed to seek care again if they cannot pay their former debt.

Health service providers sometimes extend the limits of their responsibilities if not directly violate the rights of patients. Most health service providers will refuse certain treatment to women if their husband or a parent (for unmarried women) is not present or has given approval, as has already been discussed with STI treatment and family planning. Some health workers were reported to refuse couples family planning commodities if they do not yet have a child. Congolese authorities have been aware of a lack of legal protection for women's reproductive health in the DRC since 2001 and have discussed this topic in the report for national reproductive health policy. However, little has been done in the past decade to improve this. There is confusion even among health professionals in the interpretation of terminology in the national reproductive health policy, but a specific law that requires a husband's approval for a woman to use family planning methods does not exist. Many health service providers are unclear on what they are obligated to do, but others refuse family planning to women simply because they do not want women's husbands (or parents) to harass them if they find out.

A blatant and disturbingly frequent violation of human rights is sexual abuse of patients – either in terms of rape or sexual coercion for medical treatment. This apparently happens frequently enough that men will either insist on being with their wives at the health center or they will not allow their wives to be treated by male health workers. Women are afraid to denounce these cases because then they may not have a place to go when they are sick. Much more work needs to be done in terms of informing people of human rights as well as forming a governing body to hear complaints of human rights violations, especially those of violence.

Men also experience some barriers to health in a culture which expects men to be fertile and strong. Going to a health facility for a “small” problem is seen as a sign of weakness, so oftentimes men wait until their condition is serious for fear of appearing un-masculine. Many men said that they give priority to the health of their family, usually because resources are scarce and men feel that their bodies are stronger than women's bodies, so they will recover more easily. It was also said that if a

woman is too sick to attend to her duties, this upsets the balance of the whole household, so some men make sure that their wives get treated.

Men also said that they felt that health centers are a place for women and children, so in addition to being a barrier to their own health care, it is a barrier to men accompanying women and children on their health visits. Most men are not interested in the details of their family's health, and others do not feel that it is acceptable to be by a woman's side during a health visit, as it is not the norm. But those who want to accompany their wives, such as during antenatal visits, report that health workers often refuse. Therefore, more work needs to be done in terms of making health facilities more welcoming for the entire population.

In terms of antenatal consultations, the message that they are important is well-known by women, but women either doubt the credibility of these messages or believe that they are asked to go earlier than necessary, to go more often than necessary, and that going after being a "veteran" is not necessary. Behavior change needs to be done beyond messaging, and husbands need to be involved. Knowledge was also very high in terms of exclusive breastfeeding, but women do not feel capable of practicing it when they need to work and leave their children behind. Women also think that their own malnourishment impedes their ability to feed their children. Grandmothers and older children are largely responsible for feeding young children, and there is a wide misconception that sugar and oil are important for good nutrition. HIV prevention knowledge varied, but it appears that those closer to urban centers were better informed. Myths and stigma still abound, and putting knowledge into practice is still a challenge, as discussed above. What was surprising, though, was the fact that there were misconceptions among health service providers, particularly regarding malaria and tuberculosis; however, the fact that many never received formal medical education may explain this finding.

Another surprising finding was the reported frequency of post-abortion care, especially among young girls, given the law and repercussions for breaking it (prison). For some young girls, the consequence for not having an abortion seems worse – which is stigma, abandonment of parents, and being unmarried. And society does not have a place for unmarried women, as widowed women will attest to. This also partly explains the regularity of early marriage. Some young girls are taken out of school and compelled by their fathers to marry someone, usually much older. However, young girls more frequently "choose" to get married, as this offers them instant status in their community. In reality, a young rural girl's options are few: the gender parity rate for primary school completion ranges from 0.4 to 0.8 in the four provinces, but drops to 0.2 or 0.3 for the first cycle of secondary school.¹⁹⁷ Therefore, a girl sees fewer female classmates with each progressive year and may not be aware of what possibilities exist with further education, such as job opportunities, which in her immediate surroundings are rare and she sees few female professionals. She is perceived as being the equivalent of a housemaid at her parents' house, where sometimes even her younger adolescent brothers have

¹⁹⁷Institut National de Statistiques.

the right to order her around. Getting married, even as young as 14 or 15, may seem like the best choice.

Female professionals are rare in rural areas, and female health services providers are no exception. Most midwives are women, but there are areas where a female nurse cannot be found. Women are completely responsible for all informal health, but only represent a small percentage of health service providers in the formal health sector, and very few exist in provincial or national posts. Several things make it difficult for women to work in the formal health sector, especially in rural posts, among which are their competitive productive and reproductive roles.¹⁹⁸ Also, a woman often needs to get approval from her husband to work, and up until about six years ago his written approval was required for all employment. This poses a problem in terms of working in rural posts, as she will likely not be allowed to leave her household duties to work elsewhere. The lack of women in rural health posts affects the health of rural women who prefer to have a woman treat them (and *need* women to treat them, as there are reportedly many men who abuse women in their consultation rooms). If women are largely absent from health facilities, who will ensure that women are receiving the quality of care they need and that their rights are respected? Without doubt, there are a few men who are champions for women's empowerment and rights, but given what this study revealed, they are few and they need help.

Women's rights, the relative power of women, and the health and well-being of her family and community are inextricably linked. Therefore, improving the quality of health care cannot be done without bolstering the rights of women, empowering women, and holding health service providers accountable for upholding the rights of all patients.

¹⁹⁸ Gender Specialists refer to women as having a "triple role": reproductive, which consists of bearing children, productive, which refers to all work whether paid or unpaid, and community, which involves all community work or representation, such as groups.



Photo 12: Female nurse in Kasai Oriental, among the few women to graduate from the Medical Technical Institute (*Institut Technique Médicale* - ITM)

VII. Recommendations and Lessons Learned

Programmatic recommendations vary little between provinces and the recommendations below apply to all four provinces. The target audiences for these recommendations are the Integrated Health Project (IHP) and organizations working in the health domain in the DRC. It is important to note that some of these recommendations may already have been implemented by either IHP or other organizations, but perhaps not in the study sites.

Human Resources (specific to IHP)

- Apply and respect the fundamental principles of gender equity at local IHP offices promoting the recruitment and retention of women as members of the project staff.
- Orient IHP personnel on the content of national laws, human rights, and gender.

Activities/Awareness/Communication

- Capitalize on male role models who support and accompany their wives in their access to timely health care, do not tolerate violence, and support women's empowerment; and initiate interventions of positive deviance in the community.
- Organize a competition between villages of the health areas on the support of men towards women. Select pilot villages (a village by health zone or health area) and award a symbolic prize to deserving villages.
- Work with health service providers to encourage men to accompany wives and to involve the men in the health discussion. Work with health service providers to treat families or couples, instead of individuals.
- Work with communities to make exclusive breastfeeding a norm and to support women in doing so.
- Initiate activities for the best practices in maternal breastfeeding for women (it was not rare to see women breastfeeding while they are walking or fetching water, and few women take the time to clean their breasts prior to feeding the child – which can lead to diseases).
- Periodically organize women's health days during which free consultations and essential drugs are offered to women. These days will also serve to advocate the respect of women's rights to access health, and many other useful communications intended for community and decision makers.
- Conduct culinary demonstrations based on local products proper to each zone intended for mothers and older women (and possibly also older children). As IHP is already implementing culinary demonstrations, it is recommended that this be scaled up, as there did not seem to be evidence of this activity in the study areas.
- Initiate hand washing activities for school-aged children, especially once they exit bathrooms.
- Conduct demonstrations on how to purify water sourced from rivers and canals.
- Health messages must take into account elderly women and men. For radio messages, the best time to reach everyone would be between six and nine o'clock in the evening.
- Conduct activities with youth on STI/HIV prevention information and distribute condoms - especially at mining sites.
- In order to increase attendance at health centers, a model activity was run by a nun and nurse in Katanga. She organized and encouraged women attending ANC to create songs which spoke of the advantages of

ANC. According to her, women were eager to come to the center on the days of ANC sessions due to this activity, and she noticed an increase in attendance during this period.

- Support local NGOs and CBOs in providing and expanding socio-psychological care for survivors of violence (at least one establishment per health zone).
- Place greater emphasis on the concept of spacing births rather than stopping or limiting births. In fact, men are more open to spacing births and agree that spacing births allows a family to better develop. Limiting or stopping births, however, go against precepts of Christian religion.

Improving Health Systems and Services

- Develop a sustainable system for supporting health institutions. Health facilities lack commodities, skilled health service providers, and funds to properly maintain a health center. NGOs are improving systems, but some aspects are not sustainable – notably the payment of health service providers and providing medicine.
- Ensure that project support, such as medicines, indeed arrive at the level of health centers and that they do not stop at the level of the central bureaus.
- Dedicate a portion of *all* health trainings to gender, human rights, and patients' rights (health service providers, health management teams, CODESAs, community health workers, etc.).
- Find strategies to build skills of *all* health personnel and strengthen knowledge management. In general, head nurses participate in meetings and trainings, and often get transferred, leaving a knowledge void at the health center.
- Select, train and motivate community health workers for experimental activities that mobilize men to accompany their wives to health centers, and that recognize the specific health needs of women.
- Bolster HIV activities (information and counseling), especially in Sud Kivu which have not yet integrated HIV in their routine activities.
- Provide health centers with equipment to furnish delivery rooms including beds and delivery kits.
- Ensure that delivery rooms provide privacy to women in labor, at least to the outside world.
- Actively encourage the participation of female community health workers in the communication activities of health centers.
- Aid health centers and community health workers to improve detection and care of moderate malnutrition in children and pregnant women.
- Retrain health providers and community health workers on tuberculosis and its modes of transmission.
- Improve the conservation of vaccines and the maintenance of the cold chain. In some of the health centers visited, the cold chain did not work either due to a technical breakdown, or due to the lack of fuel.

Partner Collaboration

- Develop a map of health actors working in the same zones as the IHP in order to better coordinate efforts, and to avoid duplicating interventions. The mapping of actors will identify each individual, group, or partner that plays a role in the framework of improving the health of the population.
- Better link collaboration between health centers, school and churches - which are also places where women and girls obtain health information.

Advocacy

- Distribute key results of this report to health authorities and partner organizations.
- Advocate to the Ministry of Health and its decentralized services for the regular salaries of all service providers.
- Advocate to the Ministry of Health to recruit more female health workers using affirmative action, and also make working conditions more favorable to women.
- Encourage the use of mutual health organizations in all sites, and especially women's membership.
- Encourage health centers to accept men in the consultation room to accompany their wives when they wish to do so and with the agreement of the women.
- Advocate for improving mental health care, such as ensuring that it is truly integrated in the complementary package of activities and that health center staff are trained to refer cases to hospitals. People suffer from various mental health problems or traumas that should be treated, such as post rape, post abortion, domestic violence, among others.
- Advocate to clarify the content of the national reproductive health policy, especially the chapter linked to the women's rights to access to contraceptives, and to guide and inform health workers.
- Advocate making more widely available certain services to be offered in villages such as ANC, vaccination, de-worming of children, the distribution of condoms (male and female) to youth who express the need, the testing of cases of malnutrition, the distribution of nutritional products for extreme cases, and nutritional demonstrations as an advanced strategy. Some of these activities can be led by community health workers who will need to be trained to this effect.

The improvement of a population's access to quality health services is an issue that goes beyond the capacity of an actor, an organization, a project or a program, let alone the component of a project/program. It calls upon the synergy and harmonization of actions of many stakeholders and actors, in health and social development.

It is recommended that IHP prioritize the fifteen following recommendations during the following project year:

1. Orient IHP personnel on the content of national laws, human rights, and gender. This has been done to some degree, but should be scaled up.
2. Capitalize on male role models who support and accompany their wives in their access to timely health care, do not tolerate violence, and support women's empowerment; and initiate interventions of positive deviance in the community.
3. Work with health service providers to encourage men to accompany wives and to involve the men in the health discussion. Work with health service providers to treat families or couples, instead of individuals.
4. Conduct demonstrations on how to purify water sourced from rivers and canals.
5. Health messages must take into account elderly women and men. For radio messages, the best time to reach everyone would be between six and nine o'clock in the evening.
6. Conduct activities with youth on STI/HIV prevention information and distribute condoms - especially at mining sites.
7. Place greater emphasis on the concept of spacing births rather than stopping or limiting births. In fact, men are more open to spacing births and agree that spacing births allows a family to better develop. Limiting or stopping births, however, go against precepts of Christian religion.

8. Dedicate a portion of **all** health trainings to gender, human rights, and patients' rights (health service providers, health management teams, CODESAs, community health workers, etc.).
9. Support local NGOs and CBOs in providing and expanding socio-psychological care for survivors of violence (at least one establishment per health zone).
10. Provide health centers with equipment to furnish delivery rooms including beds and delivery kits.
11. Ensure that delivery rooms provide privacy to women in labor, at least to the outside world.
12. Actively encourage the participation of female community health workers in the communication activities of health centers.
13. Distribute key results of this report to health authorities and partner organizations.
14. Encourage health centers to accept men in the consultation room to accompany their wives when they wish to do so and with the agreement of the women.
15. Advocate to clarify the content of the national reproductive health policy, especially the chapter linked to the women's rights to access to contraceptives, and to guide and inform health workers.

Study Limitations

It was not possible to for all ethnic groups and representatives from all geographic locations covered by IHP to be included in this study. However, the degree of agreement among the four sites targeted in this study attests that the results should be useful for other sites.

The topic of child health was also not sufficiently explored, as it was not the main objective of this study. Child health was treated as one of several health domains, like nutrition, hygiene, and HIV. There are certainly many nuances to how children versus adults are prioritized and cared for, but this study could not dedicate sufficient time to this topic.

It was not also possible during the course of this study to properly investigate sexual violence, nor was it possible or ethical to probe into cases that were mentioned during the study. Sexual violence was not among the study's objectives and the research team was not equipped to provide the psycho-social needs that inquiry into such a sensitive subject might have induced. Due to the unavailability of appropriate support structures for the care of the post traumatic effects of sexual violence in the areas of study, research teams were instructed to avoid probing into this topic with community members. Nonetheless, gender based violence was voluntarily discussed by women and health workers.

Challenges Encountered

The study took place with relative ease, and the research teams worked without major difficulties that could obstruct the quality of data collected. Nonetheless, the following difficulties can be reported:

- Unavailability of logistical elements (vehicles) for certain research teams during the first few days of research, which delayed the commencement of the research in certain sites. The teams adjusted and made up time. In general, delays were anticipated, so it did not affect the overall length of field visits.
- The inaccessibility of certain villages by road. The teams adjusted by changing research sites when the scheduled one was inaccessible.

- Slow pace of certain transcribers. This was not anticipated, but an extra transcriber was hired in three of the sites, and this did not affect the overall timeline of the activity.
- Difficulty for certain team leaders to access the internet in order to use the established system of exchange and data reporting, which produced delays in the transmission of data. This was anticipated, and wireless internet cards were budgeted; however, sometimes the internet was too slow to send large files. In this case, files were sent when passing through larger urban areas.
- Unavailability of certain communities at the moment of data collection. This rarely occurred, and the teams reselected villages that were available.
- Dialects spoken in certain communities were different from those in which the collection tools had been translated and tools have to be adapted for local dialects.
- Female health workers (nurses) were scarce in rural health centers; however, this was not a surprise. The research teams did their best to interview as many women as possible.
- Some health centers were managed by a single health worker, which made it impossible to interview two health providers per the research protocol.
- In Sud Kivu, the local IRC coordination office judged it necessary to suspend data collection due to security concerns for the research team. The work in Sud Kivu resumed with other research teams at a later point.

Annexes

Annex I: Research Sites

Research Sites Selected

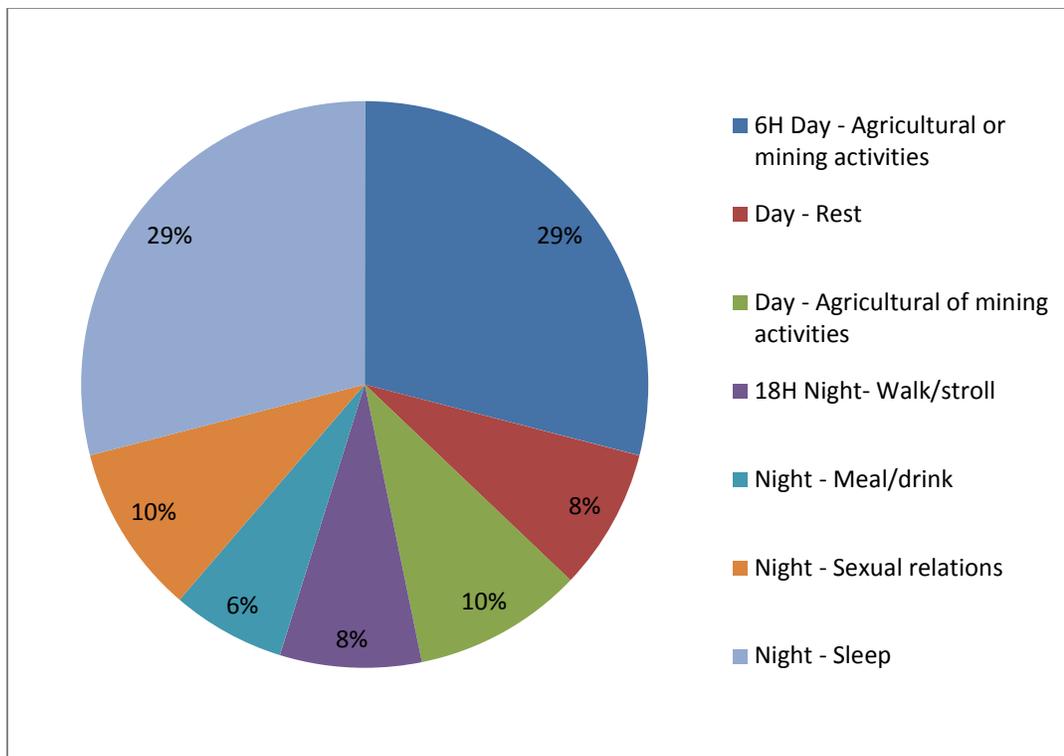
	Kasaï Oriental	Kasaï Occidental	Katanga	Sud Kivu
Health Area	Mwene Ditu (Urban)	Luiza (Urban)	Nord Katanga (Urban)	Bagira (Peri-urban)
Village	Macici	Tutante	Kampula	Kahero
Health Area	Lupita	Lubonbdaie	Pwibwe	Katana
Village	Mwambo Zolo	Tshinkuku	Kima	Mugeri
Health Area	Kalenda	Mututela	Manga Manga	Mumbambano
Village	Mbaya Museng	Kalomba	Dilila	Ntabunge
Health Area	Wikong	Tshikaji (Peri-urban)	Lualaba	Ciburhi
Village	Kanda Makond	Nganza 1	Tshikopo	Kabalole
Health Area	Kanda Kanda	Isasa	Fungurume	Kibungu
Village	Zenga	Nguy Amvula	Pwibwe	Mbogwe
Health Area	Bibanga	Ndekesha	Libudi	Nyamianda
Village	Bibanga	Batayi	Kando	Munanira

Note: All sites were rural except for those indicated as urban or peri-urban.

Annex II: Time Utilization by Sex

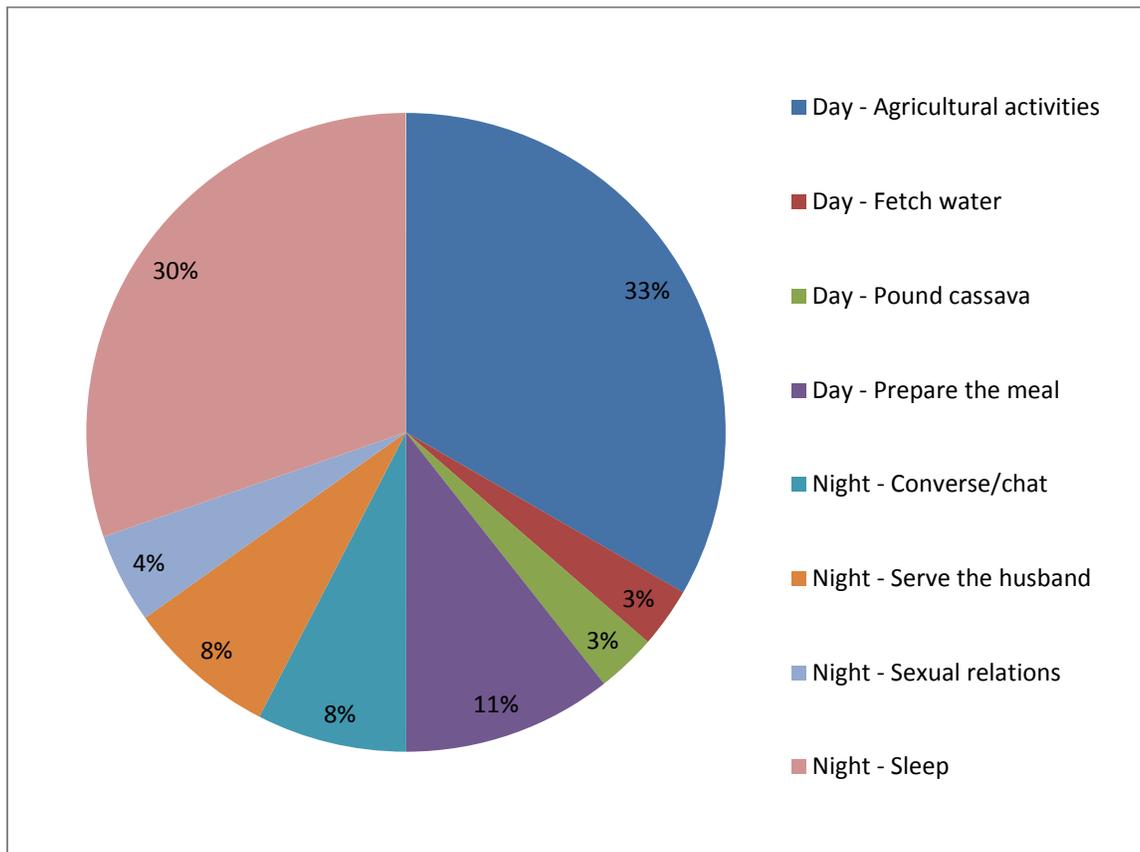
Different categories of people included in the study have been asked to describe their daily activities and the time typically allocated for each activity. The exercise has revealed that according to age and sex, the division of daily tasks varies considerably. Each of the clocks below is a compilation of different clocks from the same age category in all four provinces. The activities described in these clocks are not rigid, but represent the way in which target groups interpret their daily activities. In addition, these clocks were produced on the basis of consensus among the participants of a group. In fact, even in groups of ten people, daily occupations slightly differed, and a discussion was necessary to reach a consensus. Details of the clocks are mentioned in the comments below each diagram.

Figure 3: Time Utilization Clock of Young Men 18-24 Years of Age



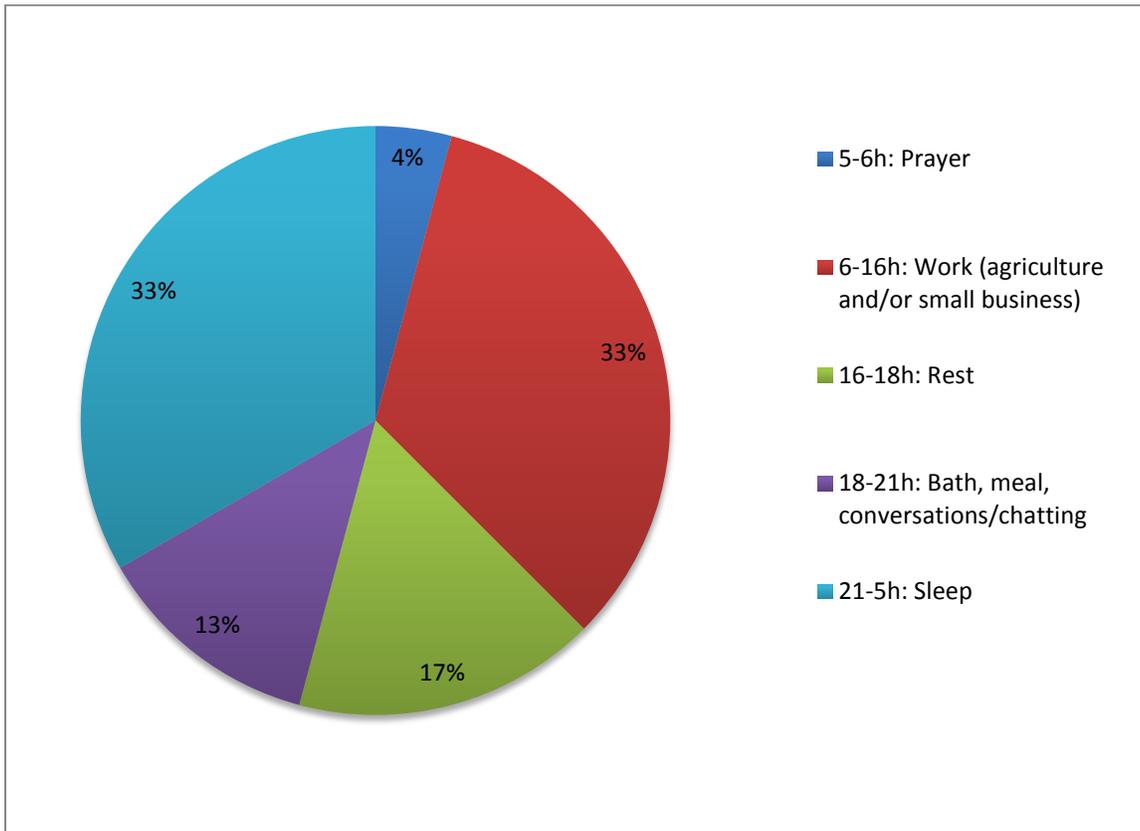
Comments: For young men, agricultural activities and mining constitute their central occupation approximately 39% of the time. In the time utilization clock of young men (one must recall that some were and others were not married), there is no occupation that places them in contact with women or children. This confirms FGD analyses demonstrating that young men are not involved with childcare (nutrition for example), and also the lack of communication in young couples. According to these analyses, the only time young couples communicate is at night, when going to bed.

Figure 4: Time Utilization Clock of Young Women 18-24 Years of Age



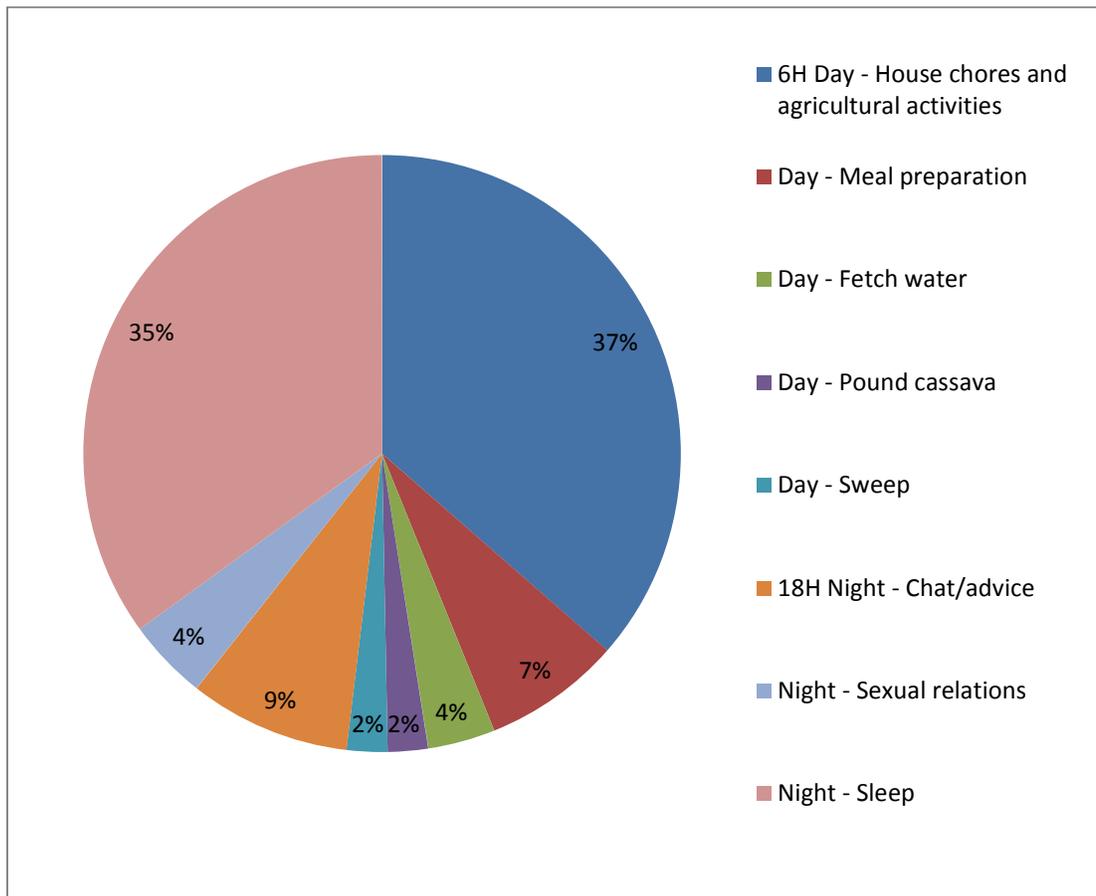
Comments: Contrary to young men, young women allocate approximately 50% of their time to agricultural activities and domestic work. After routine activities, those who are married continue to take care of their husband by giving him water to bathe, preparing him dinner, and executing tasks according to the husband's will. For those who are not yet married, they either attend school or engage in small business (generally the sale of traditional beer) in the village. Young women (married or not) frequently mentioned that they engage in conversation with children, friends or their husbands, if they are present, at night. This also confirms FGD data which demonstrates that the majority of communication (whether it be health or other subjects) are initiated by young women, and husbands are not always available or open to this communication.

Figure 5: Time Utilization Clock Men 25-47 Years of Age



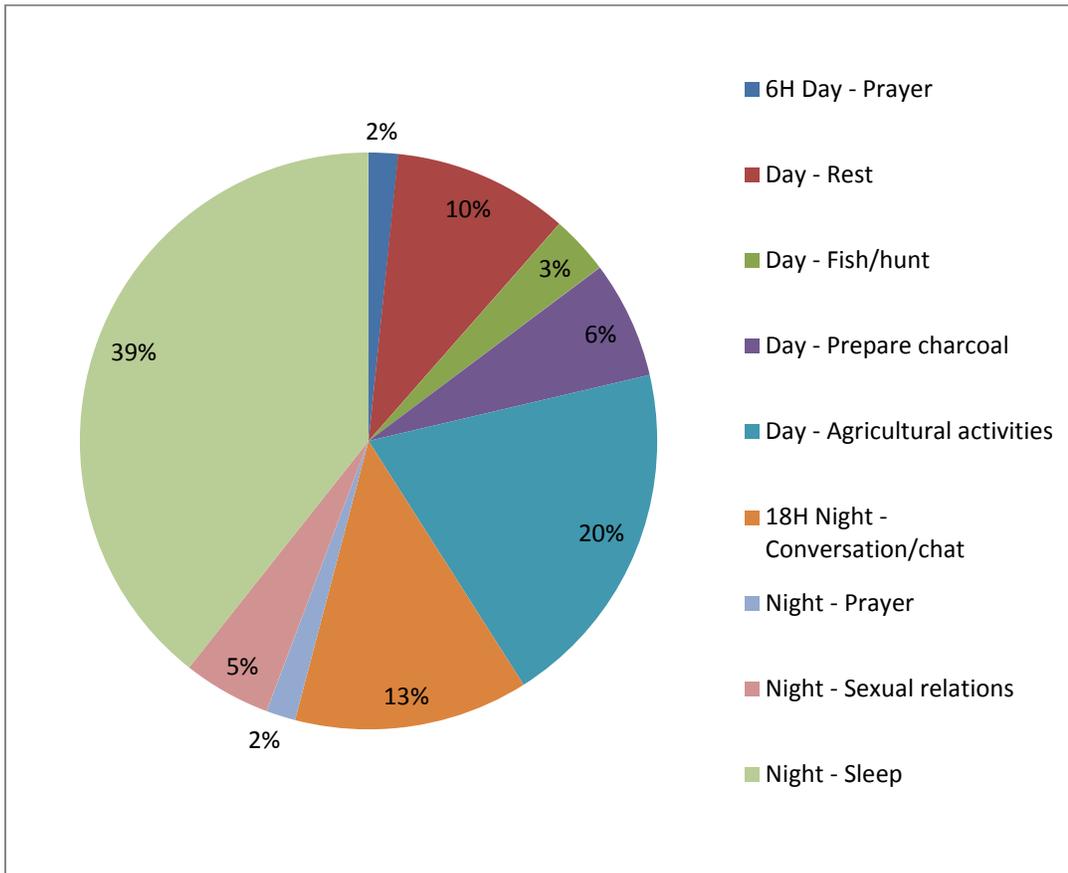
Comments: Adult men have mentioned less work in their time utilization clocks than young men, but the time allocated to each activity is greater. Mining work, agricultural activities, and commerce (especially in cities) constitute a large part of adult men’s activities. Contrary to young men, adult men seem to spend more time with the family, women and children. They dedicate approximately 13% of their time to family conversations. This confirms FGD data which shows that men are more present and communicate progressively more with the family as their age advances.

Figure 6: Time Utilization Clock Women 25-47 Years of Age



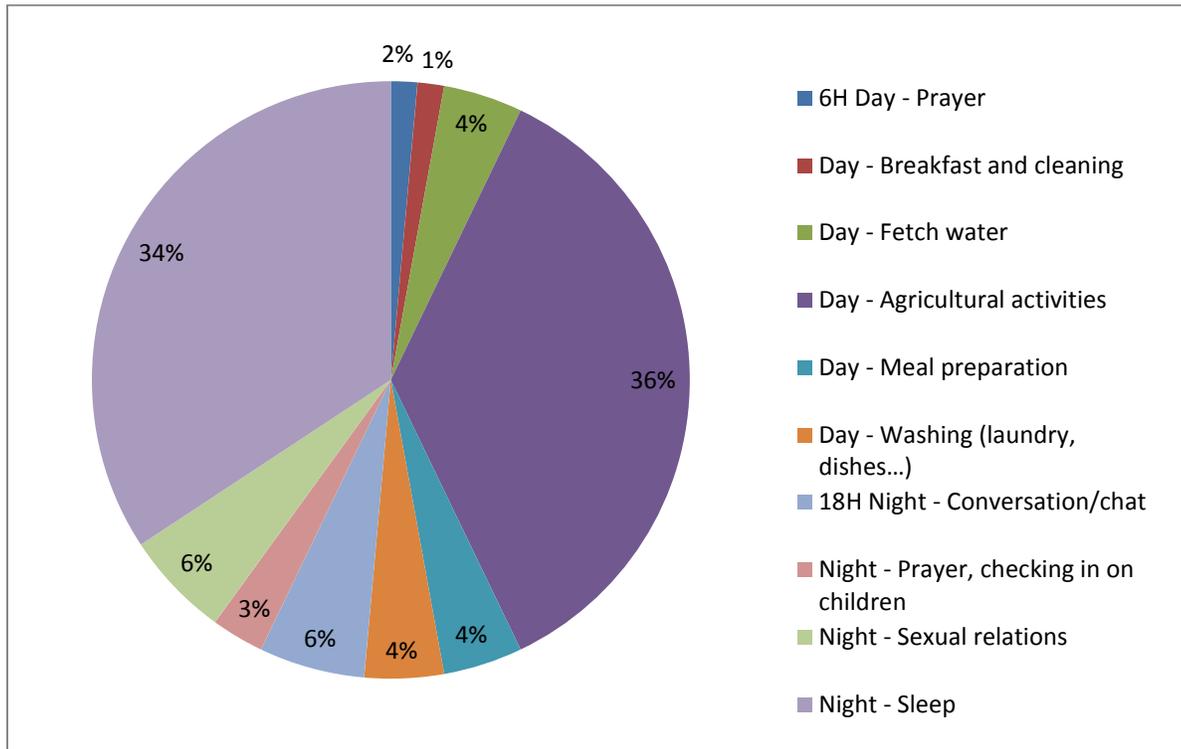
Comments: Similarly with young women, adult women mentioned conversation and communication with family members for 9% of their time. Their day is filled with agricultural work (37% of the time) that they execute either with men or on their own. Their sleep time is relatively equal to that of men of the same age segment, or approximately 35% of the time. Adult women have not reported any activity directly linked to the care of children during the day. This is due to the fact that they do not dedicate a specific time for the nutrition of children. This situation reinforces the idea that women do not have the time to correctly put into practice the advice given by health workers for the care of children (breastfeeding for example). Other household work seems to have greater importance than the maintenance and care of children, because a woman is appreciated by her husband and parents-in-law in terms of her capacity to fulfill the needs of the household and husband.

Figure 7: Time Utilization Clock Men 48 Years and Older



Comments: Men of 48 years and older begin their work day slightly later than adult men between 25 and 47 years of age. Agricultural activities and the production of charcoal take up approximately 32% of their time. They dedicate about 13% of their time to conversation with children and women and are more present in the household during the day. The presence of elder men in the home during the day is due to the reduction of the intensity of their physical work. They return earlier from the field relative to young people and women.

Figure 8: Time Utilization Clock Women 48 Years and Older



Comments: Agricultural work (weeding, planting, harvesting) constitute the great majority of daily activities of women 48 years and above. Fetching water and engaging in conversation with children are also activities that take up more time for women. Contrary to men of the same age group, women continue to be more active than men despite their advanced age. We have seen in the analysis that women above the age of 48 become the principal provider of family resources. Elderly women frequently mentioned caring and monitoring children or grandchildren as one of their tasks. As highlighted in the analysis, elderly women confirm their involvement in the care of children (nutrition and hygiene).

Annex III. Data Collection Tools

Informed Consent (To be read prior to each activity)

Activity code:.....

Hello and thank you for receiving us today. My name is and my colleagues are and We work for the Integrated Health Project financed by USAID which aims to improve the access to adequate health services for all. We are currently conducting a study on gender and access to health in your locality. This study consists in discussing with men and women such as yourselves in order to collect information that would help us develop targeted and effective interventions for everyone to enjoy improved access to health care in your locality. The activity we would like to carry out consists in asking questions concerning your practices, behaviors, ideas and knowledge with regards to the access and utilization of health services, in addition to the potential barriers which may limit men and women from having equal access to health care. Your participation in this study is important for us because you are members of the community in which the project works. Your participation is free and voluntary. You have the right to refuse to answer certain questions if you wish, and you also have the right to stop this [interview/group discussion] or to retire when you wish to do so without sanction, judgment or other consequence. Your participation until the end of this activity, however, is important to its success.

With your permission, we would like to use these Dictaphones to record our conversations, and both listen to them and transcribe them at a later time in order to avoid having important information evade us. The information you will provide us will remain confidential and will not be revealed to anyone else. They will only be used in the context of this research, and eventually in the context of the implementation of the Integrated Health Project.

Today's activity will last between two and three hours' time.

Do you have any questions you would like to ask?

Should you wish more information on this research, on the project in question, or on the use of collected data, please contact:

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Do you accept to participate in our activity today?

Yes: Continue the activity

No: End of the interview/discussion

Focus Group Guide

Introduction:

Today's work consists in conducting a group discussion on health and social relations among the different social groups that compose your community. The discussion will unfold as follows: we will ask you questions and each participant is free to speak. It is not necessary that everyone be in agreement with one point of view. We would rather have a discussion among you on these different points of view. Everyone must speak and stay within an acceptable timeframe so as to allow others to give their opinions. There is no right or wrong answer. Each answer you will put forth is very important. Let us try to make an effort to avoid criticizing the opinion of others, and to stay put as much as possible to avoid disturbing the group. Let us stay until the end of the activity and make visible the numbers when we speak. It is important to maintain order in the debates so that the Dictaphones may properly record the conversations.

Domain of Exploration I : Gender relations and power/decisions

- 1.1. What does the community expect from you as a young woman?
 - In which spheres of decision making do you participate within your community?
 - What is your participation in these spaces?
- 1.2. According to you, as young women what are your roles within your household?
 - How are these roles different from those of your husband's?
 - Do these roles differ if you are married or not?
 - Do you feel capable of accomplishing what is expected of you?
- 1.3. How do your responsibilities as young women influence your health?
- 1.4. When you feel that problems become too difficult (overwhelming), what do you do?
 - With whom do you speak of your difficulties?
- 1.5. What do you think of your decision making power in your household?
- 1.6. What are your financial and material contributions in the household?
 - How are these contributions different from those of your husband?
- 1.7. Does your financial contribution bring changes in your relation with your family?
 - If you are incapable of contributing, what would be the consequence?

- What is your decision making power with regards to household spending?

Domain of Exploration II: The effects of gender relations on knowledge, behavior and access to health

- 2.1. In your opinion, what characterizes a person in good health?
- 2.2. In your opinion, what characterizes a person in bad health?
- 2.3. In your opinion, do women and men have the same opportunity of being in good health?
 - What are the factors that expose the former and latter?
- 2.4. Primarily in which context do you obtain health information? (from where, from whom, how)
 - The health of children and mothers?
 - Reproductive health and family planning?
 - Water, sanitation and hygiene?
 - Infectious diseases (malaria, tuberculosis, HIV)?
 - Nutrition?
- 2.5. What important messages have you retained?
 - How has this changed your attitudes and habits?
- 2.6. How is this information shared and discussed within your household?

Domain of Exploration III: Effects of gender relations on access to resources and healthcare

- 3.1. When someone in your household is sick, what do you do?
 - Who are the people involved in this process?
 - To what degree can you influence the discussion and final decision?
- 3.2. How do your actions vary depending on the person affected?
- 3.3. What are the barriers that render impossible the access to health care when you/your children need it?
 - How do you overcome these barriers?

Domain of Exploration IV: Perception of rights and quality of services

- 4.1. As young women, do you believe you have rights related to health?
 - What are these rights?
 - Are they respected?
 - Does your information remain confidential?
- 4.2. When you present yourself at a health center, how are you greeted by the health providers?
 - How does the reception differ for men and for women?
 - Do you feel respected?
- 4.3. What motivates your choice of health provider?
- 4.4. How could the behavior of health providers towards you/your family be improved?

Time utilization clock

Today's activity consists in leading a discussion regarding the activities you carry out in your household from sunrise to sunset. We would like to work collectively to draw a circle, and this circle can be considered your regular work day. Following the completion of this drawing, we will divide the circle based on your activities and according to the time you allocate to each of these activities. It is both important and desirable for everyone to participate. As we progress with this task, you will increasingly understand what it entails.

First step :

Discussion questions:

- Edify the list of daily activities
- Place these activities within the clock

Once the clock has been drawn, describe the clock...

This time division depends upon whom?

For each activity, what do you think of:

- The duration?
- The weight (Ability/ease to execute task)?
- The impact on your health?
- What other person(s) is involved in this activity (for each activity)?
- How does this division differ based on the season?
- If you compare your time utilization with that of men, what are the main differences? (If possible, draw the equivalent clock for men)
- What other activities would you like for men to add to their clock?

Second step :

Draw the desired clock: If it were up to you to decide upon the division of your time and of your activities, how would you proceed?

- What other person(s) would be involved in this activity? (for each activity)
- What are the reasons for which you have divided you day in this way?
- What prevents you from dividing your day in such a manner?

Decision Matrix

Introduction: Today's activity consists in conducting a discussion on the different health decisions you are brought to make in your households and communities. It is a group task that requires the participation of everyone. We would like for everyone to feel at ease in this activity which is why we would like to move forward using drawings and representative objects available here. I will explain to you how we will proceed.

How to proceed?

- Begin by listing the people that compose a family
- Symbolically represent each person by a drawing or object
- Then ask participants to list different health-related decisions made in the household.
- Draw three concentric circles (small, medium, large)
- Take the decision categories one at a time and place them in the center of the circle.
- Ask participants to place the persons that participates in the decision making process according to their weight in making that decision.
- The person who has more decision making power will be closer to the decision (small circle) and the person with less decision making power will be at the third level of the circle (outer sphere).
- Repeat the same exercise for the different decision making categories identified.

At the end, the team will find itself with a completed matrix.

Must cover:

- Family planning
 - o Who decides upon the number of children?
 - o Who decides upon the spacing between births?
 - o Who decides whether to used contraceptive methods (modern and traditional)?
- Use of mosquito nets
- Place of childbirth
- The treatment of children
- Vaccination of children and mothers
- Who pays for health fees (of women and children)
- Nutrition (Who decides? Who pays?)
- Access to antenatal health services
- Practices for hygiene (adoption of new practices, purchase of materials)
- HIV testing
- Treatment of sexually transmitted diseases

Who are the people who participate in the decision making process?

Who are the people who have the most influence in the decision making process?

Who is the person who has the final say in the decision? What other elements may influence the decision?

Individual Interview Guide for Health Workers

Introduction:

Today's activity consists in asking you questions concerning your work, and to obtain your point of view concerning gender and access to health. We are interested exclusively in your points of view on the matter. We would like for this interview to be an exchange between us. All your answers are interesting for us without any exception. We would therefore like for you to speak openly. Once again thank you for receiving us, and thank you for your availability.

1. What are the categories of persons that consult you frequently?
2. What explains that these persons are here more frequently than others?
3. In terms of access to health information, what may be the differences between these persons?
4. What may be the differences between people with regards to their health beliefs?
5. In terms of health problems, what may be the differences between men and women?
6. What may be the differences between adults and children with regards to health problems?
7. In terms of health problems, what may be the differences between boys and girls?
8. When a patient enters if your health center, how do you proceed?
 - What are the different steps?
9. How do you feel when faced with a patient who is a man/woman (opposite sex)?
10. Can you describe the situations in which a woman presents herself to your services and you believe it is necessary to contact her husband?
 - What would you do if you are incapable of contacting her husband?
 - What would you do if you are unable to proceed with her case management?
11. Can you describe the situations in which young people presents themselves to your services and you feel obligated to contact his/her parents prior proceeding?
 - What would you do if you are incapable of contacting his/her parents?
 - What would you do if you are unable to proceed with his/her case management?
12. What recommendations do you give to your colleagues for an equal case management of men and women?
13. How may this vary according to the financial means of the patient?
14. With regards to health problems experienced by children, according to your observations, do other health providers follow the same course of action whether the patient is a boy or a girl?
15. In your opinion, what are the principal barriers in the recruitment of women as a member of your community health organization?
16. In your opinion, is it important that there be female health providers? Why?
17. In your opinion, are female health providers able to provide the same quality of service as their male colleagues?

Socio-demographic Questionnaire for Focus Group Participants

Date:.....

Name of the Team Leader :.....

Activity Code:.....

Name of the Facilitator :.....

Province:.....

Name of the Transcriber :.....

Site:.....

Name/Number of the Dictaphone :.....

Age Group :

M18-24

W18-24

M25-47

W25-47

M48+

W 48+

Introduction:

Prior to beginning our group work, we need to collect information from participants on an individual basis. This information will help us to further understand what will be said during the course of the discussion. Filling out this document will only take a few minutes.

Component 1: Socio-demographic

101. What is your education level?

- 1. Did not attend school/None
- 2. Primary
- 3. Secondary
- 4. Tertiary
- 88. Do not know

102. What is your main work/activity?

► Mark only one answer

- 1. Agricultural activities
- 2. Contractual work
- 3. Employee
- 6. Day laborer
- 7. Merchant (shopkeeper, salesman)
- 8. Artisan (blacksmith, shoemaker...)

4. Animal rearing

9. Unemployed

5. Tradesman (mechanic, mason, carpenter) 10. Housekeeping/Domestic work

99. Other

103. How old are you?

Age (years): _____

Do not know

104. What is your ethnic group?

a. Luba

h. Bashi

p. Tetela

b. Bemba

i. Lega

q. Kete

c. Hemba

j. Khunde

r. Lele

d. Lunda

k. Sanga

s. Kanyok

e. Tabou

l. Bazela

t. Bindi

f. Tshokwe

m. Nedembo

u. Lualua

g. Lamba

n. Kuba

v. Other

o. Songue

105. What is your religion?

a. Christian

b. Muslim

c. Animist

d. No religion

e. Other

Component 2: Socio-economic

201. In your household, do you have:

a. Electricity? yes no

b. A radio? yes no

c. A television? yes no

d. A refrigerator? yes no

e. A bicycle? yes no

f. A motorcycle? yes no

g. A car? yes no

h. A telephone? yes no

i. A generator? yes no

j. A solar panel? yes no

k. A battery (car)? yes no

202. How many of the following articles do you have?

1. Chair _____ # chairs

2. Mattress _____ # mattresses

3. Cart _____ # carts

4. Plow _____ # plows

203. What is the principal source of energy that you use on your property to prepare meals?

► **Mark only one answer**

1. Electricity

2. Gas

3. Biogas

4. Kerosene

5. Coal

6. Charcoal

7. Wood

8. Manure/fertilizer

9. Other

204. What is the principal supply source for drinking water in your home?

► **Mark only one answer**

1. Tap water in the home

2. Tap water on the property

3. Public tap water

4. Open well in the home

- 5. Open well on the property
- 6. Public open well
- 7. Covered well in the home
- 8. Covered well on the property
- 9. Public covered well
- 10. River
- 11. Lake
- 12. Canal
- 13. Spring water
- 14. Tank
- 15. Bottled water
- 16. Other

205. What type of latrine do most people in your household use?

► **Mark only one answer**

- 1. A private toilet
- 2. A public toilet
- 3. Private pit latrine
- 4. Public pit latrine
- 5. Private ventilated pit
- 6. Public ventilated pit
- 8. Fields/nature
- 9. Other

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