

# Baseline Study of Gender-Based Violence and HIV in Kinshasa and Kisangani, Democratic Republic of Congo

## OPPORTUNITIES FOR SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

JUNE 2013



Democratic Republic of Congo  
Ministry of Health





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### Authors:

Geeta Nanda, DrPH – scientist, Global Health and Nutrition Programs, FHI360

Joël Nkiama Konde – public health and development scientist, consultant, Kinshasa School of Public Health

Alimasi Okoko – GBV national coordinator, C-Change project/DRC, FHI360

Yaya Drabo, PhD – project director, C-Change project/DRC, FHI 360

Bérengère de Negri, MS, EdD – SBCC Adviser, FHI 360

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**Contact Information:**

C-Change, FHI 360  
1825 Connecticut Avenue, NW  
Washington, DC 20009  
Phone: (202) 884-8000  
Fax: (202) 464-3799  
www.c-changeproject.org

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**ACRONYMS**

AIDS	Acquired Immune Deficiency Syndrome	PLHIV	People Living with HIV
ARV	Antiretroviral	PMTCT	Prevention of Mother-to-Child Transmission
CBO	Community-Based Organization	PNC	Police Nationale Congolaise (Congolese National Police)
DHHS	Department of Health and Human Services	SBCC	Social and Behavior Change Communication
DHS	Demographic and Health Survey	STI	Sexually Transmitted Infection
DRC	Democratic Republic of the Congo	UNAIDS	Joint United Nations Programme on HIV/AIDS
FARDC	Forces Armees de la Republique du Congo (DRC Armed Forces)	UNFPA	United Nations Population Fund
GBV	Gender-Based Violence	UNICEF	United Nations Children's Fund
GEM	Gender-Equitable Men	USAID	United States Agency for International Development
HIV	Human Immunodeficiency Virus	VMMC	Voluntary Medical Male Circumcision
HTC	HIV Testing and Counseling	WHO	World Health Organization
IPV	Intimate Partner Violence		
MTCT	Mother-to-Child Transmission		
OHRP	Office of Human Research Protections		
PEPFAR	President's Emergency Plan for AIDS Relief		
PHSC	Protection of Human Subjects Committee		

## EXECUTIVE SUMMARY

### BACKGROUND

Gender inequality is recognized as an important driver of the HIV epidemic. Unequal gender relations can result in increased risky sexual behavior including transactional sex, having multiple sexual partners, extra-marital sexual relations, and unprotected sex. These behaviors lead to increased risk for HIV transmission among vulnerable populations, particularly women. Gender inequality constrains women's power to make decisions about health and sexuality; limits women's and girls' access to information, financial resources, social capital, and health and development resources; and places them at greater risk for violence. Gender inequality also harms men's and boys' health, especially when gender norms pressure men and boys to be violent, have unprotected sex, have multiple sexual partners, or refrain from seeking health care. As a result of these prevailing gender norms and unequal power relations in the sub-Saharan region, and in Democratic Republic of the Congo (DRC) in particular, rates of gender-based violence (GBV) and different forms of coercive sex are very high.

On the positive side in the DRC, the country has in place a generally favorable legislative environment for promoting gender equity. Some key actions are (1) enactment of a law on sexual violence, passed July 20, 2006; (2) development of a National Strategy and Action Plan against sexual violence and gender-based violence (2009); (3) a National Policy on Gender (2009) and the establishment of a National Fund for Women's Promotion; (4) local and national women councils; (5) Joint DRC Armed Forces/Congolese National Police (FARDC/PNC) Plan against sexual violence (2008) and code of conduct under the FARDC; (6) revision of the Family Code, which is currently with the Parliament.

### OBJECTIVES

In May 2013, a cross-sectional quantitative baseline survey of current attitudes and behaviors related to GBV and HIV was carried out in two DRC cities—Kisangani

(Orientale Province) and Kinshasa (Kinshasa Province)—where the C-Change program has been active. The study objectives were to determine:

- attitudes and perceptions of gender norms, GBV, and gender inequality
- knowledge, behavior, and risks related to sexual and reproductive health
- knowledge and awareness related to HIV and AIDS
- the nature and prevalence of GBV

### METHODS

The survey focused on women and men ages 18–39. The study received IRB approval from the Ethics Committee of the School of Public Health of the University of Kinshasa and the FHI 360 Protection of Human Subjects Committee (PHSC). A local research group was contracted to conduct the study.

### KEY FINDINGS

The research highlighted the following key issues related to GBV and HIV among the study target groups:

#### HIV awareness and knowledge

Although not sufficient by itself, knowledge about HIV and AIDS is a proximate determinant critical for changing behaviors related to HIV prevention and reducing the risk of transmission. Although the large majority of those interviewed in this study had heard about HIV and AIDS, many had major misconceptions about HIV transmission. Overall, the percentage of respondents who correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about transmission was quite low, with only 28 percent giving correct responses to all four related questions.

#### Knowledge of mother-to-child transmission of HIV

The most prevalent source of pediatric HIV infection, which is almost entirely preventable, is mother-to-child

transmission (MTCT). In the absence of any intervention, the risk of MTCT of HIV ranges from 20 percent to 40 percent of mother-child pairs.<sup>1</sup> However, with specific interventions (including use of anti-retrovirals for HIV-positive women), this risk can be reduced to less than 2 percent in non-breastfeeding populations and 5 percent or less in breastfeeding populations.<sup>2</sup> Although the majority of respondents in this study (over 60 percent) were aware of MTCT of HIV during pregnancy, delivery, and breastfeeding, awareness of the existence of drugs for PMTCT was lower—44.6 percent for all respondents and only 35.5 percent for those in rural areas.

## HIV testing and counseling

HIV testing and counseling (HTC) is part of a multi-pronged approach to achieve an AIDS-free generation. It is a key component of the approach and is a gateway to various other core interventions such as Voluntary Medical Male Circumcision (VMMC), PMTCT, and HIV care and treatment.<sup>3</sup> Testing appears rather low in this population, with only 19.3 percent of all respondents reporting that they had an HIV test in the past 12 months. Women were more likely than men to report having been offered an HIV test as part of a health service visit in the past 12 months. A significantly higher proportion of women also reported ever having been tested for HIV and having had an HIV test in the past 12 months.

## Sexual behavior

Certain sexual behaviors place individuals at increased risk for HIV transmission. Among these are early sexual debut, which was common in the study population. The average age at first sex was 16 years, with over one-quarter of respondents reporting they had had sexual intercourse before the age of 15. About 36 percent of women also reported that their first sexual intercourse was forced, coerced, or unwanted. Among the study population, over 35 percent of both men and women indicated they had two or more sexual partners in the past year and almost 20 percent said they had engaged in transactional sex during that time.

## Gender-based violence

The scientific literature has shown a clear association between intimate partner violence (IPV) and HIV transmission. To measure women's reported

experiences of partner violence, the study team adapted the WHO multi-country study tool, which has been tested and validated in a range of cultural contexts.<sup>4</sup> Among women in the study who had been in an intimate relationship, 62.6 percent reported having been exposed to some form of physical violence. The large majority of these women (89.9 percent), also indicated that their husband/partner had exerted control over their personal autonomy in at least one of four contexts. Furthermore, the majority of both men and women respondents (about 50 percent to 80 percent), believed that wife beating is an acceptable way for a husband to discipline a wife for reasons such as refusal to have sex or being unfaithful.

## Gender norms

Gender attitudes were measured using a subscale of the Gender-Equitable Men (GEM) Scale, which asks respondents to agree or disagree with various statements about male/female relationships. Overall, there was a high level of gender-inequitable attitudes among participants in this study, although responses varied widely for the 15 different circumstances posed. For example, 64.6 percent of respondents disagreed that "it is okay for a man to hit his wife if she won't have sex with him." However, only 12.4 percent disagreed that "a man should have the final word about decisions in his home."

## Conclusion

Overall, knowledge was significantly lower among respondents in rural areas, respondents from Kisangani, and among women generally. However, differences were greater by place of residence and province than by gender. Behaviors with regard to sexual experience and practices, and testing for HIV, followed the same pattern. Similarly, acceptability of wife beating was significantly higher for respondents in rural as opposed to urban areas, and in Kisangani rather than Kinshasa; however, differences between genders regarding attitudes to GBV were only significant for the situation in which a wife is unfaithful to her husband/partner. The survey clearly demonstrated that certain negative gender norms are held widely in these areas of the DRC by both men and women, leading to a culture of acceptance that is firmly entrenched.

## INTRODUCTION

### BACKGROUND ON GENDER INEQUALITY AND HIV

Gender inequality is a cross-cutting issue that constrains women's power to make decisions about health and sexuality; limits women's and girls' access to information, financial resources, social capital, and health and development resources; and places them at greater risk for violence. Gender inequality also harms men's and boys' health, especially when gender norms pressure men and boys to be violent, have unprotected sex, have multiple sexual partners, or refrain from seeking health care.

As a result of prevailing gender norms and unequal power relations in the sub-Saharan region, and in the DRC in particular, rates of gender-based violence and forms of coercive sex are very high. The DRC 2007 population-based Demographic and Health Survey (DHS) reported that 64 percent of Congolese women reported having experienced physical violence in their lifetimes (including 49 percent in the last 12 months), while 16 percent reported having been raped (including 4 percent in the last 12 months).<sup>5</sup> A report on sexual violence in the DRC published in June 2013 by the Ministry of Gender, Family, and Children, stated that more than 18,795 cases of sexual and gender-based violence had been reported in the previous two years (2011-2012) in all provinces. Women and girls of all ages were most affected; more than half of victims were girls aged 2 to 17 years.

The true incidence of sexual violence in DRC is possibly even higher than most surveys suggest, given the many disincentives for survivors to report sexual violence—including threat of further violence, stigma, and widespread impunity for perpetrators.

Gender inequality is recognized as an important driver of the HIV epidemic. Unequal gender relations also result in increased risky sexual behavior including transactional sex, having multiple sexual partners, extra-marital sexual relations, and unprotected sex. These lead to an increased risk for HIV transmission among vulnerable populations, particularly women. Moreover, a woman's HIV-positive status may make her more vulnerable to gender-based violence. According to UNAIDS, an HIV-positive woman is nearly three times as

likely as one who is HIV-negative to have experienced a violent episode at the hands of her partner.<sup>6</sup> Thus, the pandemics of HIV and GBV are inextricably linked. Gender inequality and the oppression of women deserve to be addressed for many reasons; only one of these is their link to the problem of HIV and AIDS.

### OVERVIEW OF C-CHANGE PROGRAM IN DRC

In 2012, the C-Change project, with funding from the USAID Mission in DRC, launched social and behavior change communication (SBCC) activities in and around the two major population centers of Kisangani (Orientale Province) and Kinshasa (Kinshasa Province) to prevent and mitigate the impact of gender-based violence and the spread of HIV/AIDS. The project involved both women and men in order to address their differing attitudes and behaviors. It utilized the "Stepping Stones" strategic initiative, which has shown promise in neighboring countries in mobilizing local communities to combat HIV/AIDS and GBV.<sup>7</sup> The initiative has developed a standard training curriculum and tools that were adapted for use in the DRC context.

### RESEARCH OBJECTIVES

The baseline assessment described here was carried out to help inform this programmatic effort. The quantitative study examined attitudes and behaviors related to gender-based violence and HIV in areas where C-Change program activities were planned. The objectives of the research were to provide information about:

- attitudes (of both men and women) regarding gender norms
- perceptions of GBV and gender inequality
- knowledge, behavior, and risks related to sexual and reproductive health
- knowledge and awareness related to HIV and AIDS
- the nature and prevalence of GBV

## STUDY METHODOLOGY AND POPULATION

### STUDY METHODOLOGY

The cross-sectional quantitative survey was carried out in May 2013 in each of the two target provinces in order to assess the magnitude and frequency of GBV- and HIV-relevant indicators and constructs, gather descriptive information, and explore relationships between variables. The survey collected data related to general household information, attitudes related to gender norms; measures of gender equality, knowledge, and behaviors pertaining to sexual and reproductive health and HIV and AIDS; and the nature and prevalence of GBV and its consequences. The survey was administered to women and men ages 18–39 in and around Kisangani and Kinshasa. The study received IRB approval from both the Ethics Committee of the School of Public Health of the University of Kinshasa and the FHI 360 Protection of Human Subjects Committee (PHSC). A local research group was contracted to conduct the study.

### STUDY POPULATION

A total of 845 participants were recruited into the study, including 418 females and 427 males. The mean age of participants was 23.6 years. Almost half (49.5 percent) were 18 or 19 years of age. A large majority of participants resided in urban versus rural areas (72.8 percent vs. 27.2 percent), and in the city of Kisangani (60.8 percent) compared to the city of Kinshasa (39.2 percent). About half (50.7 percent) of participants were married or living with a partner; 44.7 percent were single; and 4.6 percent were divorced, widowed, or separated. Almost half the respondents were part of the Eglise de réveil (47.6 percent), one-fifth were Catholic, 18 percent were Protestant, and a small minority practiced other faiths (14.2 percent). Almost 80 percent of participants reported having some secondary school education or higher. A wide range of occupations were reported. Among all respondents, 11.2 percent said they were homemakers, 11.6 percent were traders, 17.1 percent worked in the private and public sectors, 36 percent reported 'other' as their occupation, and 24.1 percent were unemployed.

## STUDY RESULTS

### HIV AWARENESS AND EXPOSURE TO HIV AND AIDS COMMUNICATION

Table 1 below shows that overall awareness of HIV was high among all respondents, with 95 percent (n=802) of those interviewed having heard about HIV and AIDS. Among those, about 56 percent said they had been exposed to a communication message about HIV and AIDS in the past 30 days, with no significant differences between genders. However, a significantly smaller proportion of respondents in rural as compared to urban areas (42.9 percent vs. 60.3 percent) and in Kisangani as compared to Kinshasa (43.3 percent vs. 73.7 percent), reported having been exposed to messages in the past 30 days (p<.001, in both cases).

### KNOWLEDGE ABOUT HIV PREVENTION

Respondents who said they were aware of HIV and AIDS (n=802) were asked to respond to four questions about HIV transmission. Two of the questions reflected common myths about transmission and two represented facts. Table 2 on the next page, shows correct knowledge about HIV prevention (i.e., those who gave correct responses in contrast to those who

gave incorrect responses or those whose response was “don’t know”). About half (51.7 percent) of respondents agreed (correctly) that people cannot get HIV from mosquito bites, with no significant differences by gender. Levels of correct knowledge were relatively higher for the other three questions. Overall, 74.4 percent of respondents knew that people cannot get HIV by sharing food; 68.5 percent knew that people can reduce their chances of getting HIV by using condoms; and 87.9 percent knew that it is possible for a healthy-looking person to have HIV. However, only 27.6 respondents answered correctly to all four questions/statements.

Overall, knowledge was significantly lower among women, respondents in rural areas, and respondents from Kisangani. For each of the four questions, levels of correct knowledge were significantly lower in Kisangani as compared to Kinshasa. Only 16.1 respondents answered all four questions correctly as compared to 43.8 percent in Kinshasa. There was less difference between urban and rural respondents across the two areas; however, those in rural areas were significantly less likely to know a person cannot get HIV from mosquito bites (41.4 percent vs. 55.3 percent) and less likely to know a healthy looking person can have HIV (75.9 percent vs. 92 percent). Significantly more men than women (73.3 percent vs, 63.5 percent) knew that using condoms regularly could reduce the chance of HIV transmission (p<.01).

TABLE 1. EXPOSURE TO HIV/AIDS COMMUNICATION (AMONG RESPONDENTS WHO HAVE HEARD ABOUT HIV AND AIDS), 2012

EXPOSURE	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL (N=802)
	URBAN (N=599)	RURAL (N=203)	KINSHASA (N=331)	KISANGANI (N=471)	FEMALE (N=397)	MALE (N=405)	
Heard/seen/read HIV/AIDS messages in past 30 days	60.3	42.9***	73.7	43.3***	55.7	56.0	55.9

Chi-square test: \*p< .05, \*\*p<.01, \*\*\*p<.001 (i.e., differences between categories for place of residence, province, and gender)

TABLE 2. CORRECT KNOWLEDGE (PERCENT WHO ANSWERED CORRECTLY) ABOUT HIV PREVENTION (AMONG RESPONDENTS WHO HAD HEARD ABOUT HIV AND AIDS), 2012

HIV PREVENTION KNOWLEDGE	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL
	URBAN (N=599)	RURAL (N=203)	KINSHASA (N=331)	KISANGANI (N=471)	FEMALE (N=397)	MALE (N=405)	(N=802)
Can people get the HIV virus from mosquito bites?	55.3	41.4**	57.4	47.8*	49.6	53.8	51.7
Can people get the HIV virus by sharing food with a person who has AIDS?	75.3	71.9	81.9	69.2***	73.3	75.6	74.4
Can people reduce their chance of getting the HIV virus by using a condom every time they have sex?	70.6	62.1	83.4	58.0***	63.5	73.3**	68.5
Is it possible for a healthy-looking person to have the HIV virus?	92.0	75.9***	94.6	83.2***	87.4	88.4	87.9
Percent of respondents who gave the correct answer to all 4 questions	31.4	16.3***	43.8	16.1***	24.2	30.9*	27.6

Chi-square test: \*p<.05, \*\*p<.01, \*\*\*p<.001 (i.e., differences between categories for place of residence, province, and gender)

## KNOWLEDGE ABOUT MTCT OF HIV

Respondents were asked whether the virus that causes AIDS could be transmitted from a mother to her baby during pregnancy, delivery, or breastfeeding. Table 3 shows that overall, knowledge of MTCT was highest for transmission during delivery (72.1 percent), followed by breastfeeding (64.6 percent), and pregnancy (62.3 percent).

No significant differences were observed by gender. However, there were some significant differences by province and place of residence. For example, a higher proportion of respondents in rural as compared to urban areas (66.0 percent vs. 61.1 percent) were aware of the risk of MTCT during pregnancy (p<.01).

In addition, significantly more respondents in Kisangani as compared to Kinshasa (70.3 percent vs. 56.5 percent) reported that HIV could be transmitted from mother to baby during breastfeeding (p<.001). Although similar proportions of respondents in the two areas reported knowledge about HIV transmission during delivery (71.5 percent in Kisangani and 72.8 percent in Kinshasa) significantly more respondents were unsure (i.e., reported they “don’t know”) in Kinshasa as opposed to Kisangani (19 percent vs. 9.1).

Overall knowledge about the availability of drugs to reduce the transmission of HIV from an HIV-positive mother to her baby was relatively low at 44.6 percent, with significantly fewer respondents in rural areas (35.5 percent) having this knowledge.

TABLE 3. KNOWLEDGE ABOUT MTCT OF HIV (AMONG RESPONDENTS WHO HAVE HEARD ABOUT HIV AND AIDS), 2012

MTCT KNOWLEDGE	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL (N=802)
	URBAN (N=599)	RURAL (N=203)	KINSHASA (N=331)	KISANGANI (N=471)	FEMALE (N=397)	MALE (N=405)	
<b>HIV can be transmitted from mother to baby during:</b>							
Pregnancy	61.1	66.0**	62.2	62.4	61.2	63.5	62.3
Delivery	74.3	65.5	72.8	71.5***	74.3	69.9	72.1
Breastfeeding	65.6	61.6	56.5	70.3***	66.8	62.5	64.6
Special drugs can be given to HIV+ mother to reduce transmission to baby	47.7	35.5**	43.5	45.4	47.6	41.7	44.6

Chi-square test: \*p<.05, \*\*p<.01, \*\*\*p<.001 (i.e., differences between categories for place of residence, province, and gender)

## HIV COUNSELING AND TESTING

According to study results illustrated in Table 4, about half of all respondents (who were aware of HIV and AIDS) had been offered an HIV test as part of a health services visit in the past twelve months (49.9 percent). However, significantly more women than men, urban than rural respondents, and respondents in Kinshasa rather than Kisangani, reported being offered an HIV test as part of a health services visit in the past

twelve months. Only 41.5 percent of respondents reported having ever been tested for HIV, with similar significant differences observed again across place of residence, province, and gender (p<.001 in all cases). With regard to recent testing, just 19.3 percent reported getting tested for HIV in the past twelve months, including significantly more women than men (23.7 percent versus 15 percent, p<.01), and significantly more urban than rural residents (21.5 percent versus 13.7 percent, p<.05).

TABLE 4. HIV COUNSELING AND TESTING, (AMONG RESPONDENTS WHO HAVE HEARD ABOUT HIV AND AIDS), 2012

HIV COUNSELING AND TESTING	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL (N=802)
	URBAN (N=599)	RURAL (N=203)	KINSHASA (N=331)	KISANGANI (N=471)	FEMALE (N=397)	MALE (N=405)	
Offered an HIV test as part of health services visit in past 12 months	53.4	39.4**	58.6	43.7***	55.9	44.0**	49.9
Ever tested for HIV	45.2	30.5***	50.8	35.0***	49.9	33.3***	41.5
Tested for HIV in the past 12 months	21.5	13.7*	21.3	18.1	23.7	15.0**	19.3

Chi-square test: \*p<.05, \*\*p<.01, \*\*\*p<.001 (i.e., differences between categories for place of residence, province, and gender)

## SEXUAL BEHAVIOR

Overall, 94.2 percent (n=796) of respondents reported that they had had sexual intercourse. Table 5 shows that among them, the average age at first sex was 16 years. Respondents in Kisangani and rural areas tended to report significantly younger ages than their counterparts (15.8 years and 15.3 years, respectively). Interestingly, there was no significant difference by gender.

Over one-fourth (25.5 percent) reported having had sexual intercourse before the age of 15, with higher levels reported by those in rural areas (39.3 percent) and in Kisangani (28.8 percent). Again, there was no significant difference by gender.

Over one-third (35.6 percent) said they had two or more sexual partners in the past year. Responses were significantly higher for men than women (54.4

percent vs. 16.6 percent,  $p < .001$ ), and for those in rural as compared to urban areas (42.5 percent vs. 32.9 percent,  $p < .05$ ). A smaller proportion of respondents (19.3 percent) reported having had sex in the context of an exchange for gifts or money in the past 12 months. Again, responses were significantly higher for men than women (27.3 percent vs. 11.3 percent,  $p < .001$ ). Table 5 shows that less than one-third (31.4 percent) reported having used a condom with a partner in the past 12 months, with significant differences reported by place of residence, province, and gender. A significantly higher number of men (37.6 percent) reported condom use in the last 12 months compared to 25.2 percent of women.

Overall about one-fourth (25.4 percent) reported that their first sexual intercourse was forced, coerced, or unwanted, with levels significantly higher for women than men (36.3 percent vs. 14.5 percent,  $p < .001$ ).

TABLE 5. SEXUAL BEHAVIOR, (AMONG RESPONDENTS WHO HAVE HAD SEX), 2012

SEXUAL BEHAVIOR	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL (N=796)
	URBAN (N=577)	RURAL (N=219)	KINSHASA (N=310)	KISANGANI (N=486)	FEMALE (N=397)	MALE (N=399)	
Average age at first sex	16.3	15.3***	16.4	15.8**	16.2	15.9	16.03
Had sexual intercourse before age 15	20.3	39.3***	20.3	28.8**	24.4	26.6	25.5
Had 2 or more sexual partners in past year	32.9	42.5*	34.2	36.4	16.6	54.4***	35.6
Engaged in transactional sex in the past 12 months	18.9	20.5	19.0	19.5	11.3	27.3***	19.3
Used a condom with a partner in the past 12 months	35.2	21.5***	37.7	27.4**	25.2	37.6***	31.4
First sexual intercourse was forced, coerced, or unwanted	24.6	27.4	24.2	26.1	36.3	14.5***	25.4

Chi-square test: \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  (i.e., differences between categories for place of residence, province, and gender)

## PREVALENCE OF INTIMATE PARTNER VIOLENCE

Women in the study who had ever been in an intimate relationship (n=372) were asked about their exposure to intimate partner violence (IPV) (Table 6). Almost 63 percent of these women reported that they had experienced at least one episode of IPV, with responses significantly higher for those in rural areas

(71.8 percent). Types of violence experienced included being slapped (51.1 percent of women overall), being physically forced to have sex (33.1 percent), and being kicked, dragged, or beaten (18 percent). About 8 percent of women reported having been burned or choked and 3.2 percent reported they were threatened with a weapon or had a weapon used against them. Women in rural areas reported significantly higher levels of experience of each type of violence.

TABLE 6. PREVALENCE OF INTIMATE PARTNER VIOLENCE, (AMONG WOMEN WHO HAVE BEEN IN A RELATIONSHIP), 2012

PREVALENCE OF IPV	PLACE OF RESIDENCE		PROVINCE		TOTAL
	URBAN (N=269)	RURAL (N=103)	KINSHASA (N=157)	KISANGANI (N=215)	(N=372)
<b>Did your husband/partner ever:</b>					
... slap you?	47.6	60.2*	52.9	49.8	51.1
...kick, drag, or beat you?	15.2	25.2*	15.3	20.0	18.0
...choke or burn you?	5.9	14.6**	5.7	10.2	8.3
... threaten or use a knife, gun, or weapon?	1.9	6.8*	1.3	4.7	3.2
... physically force you to have sex?	29.4	42.7*	35.0	31.6	33.1
... any of the above	59.1	71.8	61.8	63.3	62.6

Chi-square test: \*p< .05, \*\*p<.01, \*\*\*p<.001 (i.e., differences between categories for place of residence, province, and gender)

## CONTROL OVER WOMEN'S AUTONOMY

The study also aimed to measure to what extent women had experienced efforts to control their personal autonomy in different ways. Women who had ever been in a relationship (n=372) were asked whether their husbands/partners had ever subjected them to any of five kinds of personal control. Table 7 shows that almost 90 percent of these women reported having had at least one such experience. There were no significant differences between women in urban and rural areas.

Specifically, three-fourths of these women reported their husband/partner would be jealous if they talked to other men, with significantly higher levels reported in Kisangani (80.9 percent) as compared to Kinshasa (66.9 percent) ( $p < .01$ ). In addition, 70.7 percent reported their husband/partner insisted on knowing where they were at all times; 48.9 percent said they were frequently accused of being unfaithful; 41.7 percent said their meetings with female friends had been restricted. Over one-quarter (26.6 percent) of women reported that their husband/partner had tried to limit their contact with family.

TABLE 7. EXPERIENCE OF CONTROL OVER PERSONAL AUTONOMY (AMONG WOMEN WHO HAVE BEEN IN AN INTIMATE RELATIONSHIP), 2012

CONTROL OVER WOMEN'S AUTONOMY	PLACE OF RESIDENCE		PROVINCE		TOTAL
	URBAN (N=269)	RURAL (N=103)	KINSHASA (N=157)	KISANGANI (N=215)	(N=372)
<b>Husband/partner is:</b>					
...jealous or angry if you talk to other men	75.1	74.8	66.9	80.9**	75.0
...frequently accuses you of being unfaithful	46.5	55.3	43.9	52.6	48.9
...does not permit you to meet your female friends	39.0	48.5	34.4	47.0*	41.7
...tries to limit your contact with your family	26.4	27.2	25.5	27.4	26.6
... insists on knowing where you are at all times	71.4	68.9	74.5	67.9	70.7
... any of the above	89.6	90.3	90.4	89.3	89.8

Chi-square test: \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  (i.e., differences between categories for place of residence, province, and gender)

## ATTITUDES TOWARD WIFE BEATING

All respondents (N=845) were asked their views on when it would/would not be acceptable for a husband to beat his wife. Interviewers described five different hypothetical scenarios and asked respondents whether it would be “OK to beat his wife,” “OK in certain circumstances,” or “never OK.” Table 8 shows, for each scenario, the proportion who gave either of the two positive responses (as opposed to “never OK”). Acceptability of wife beating was highest for being unfaithful (78.1 percent), with significantly more women than men expressing this opinion

(82.7 percent vs. 73.6 percent,  $p < .01$ ). Acceptability of wife beating for disobeying the husband was also relatively high, at 74.7 percent. Furthermore, 66 percent of survey participants reported it would be acceptable for a husband to beat his wife for failing to carry out domestic tasks; 62.2 percent considered it acceptable if the husband suspected his wife was unfaithful; and 50.5 percent if the wife refuses to have sex. Acceptability of wife beating was significantly higher in all cases for respondents in rural as opposed to urban areas, and in Kisangani rather than Kinshasa ( $p < .001$  in all cases). However, differences between genders were only significant for the circumstance of a wife being unfaithful.

TABLE 8. ATTITUDES TOWARD WIFE BEATING (AMONG ALL RESPONDENTS), 2012

SEXUAL BEHAVIOR	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL (N=845)
	URBAN (N=615)	RURAL (N=230)	KINSHASA (N=331)	KISANGANI (N=514)	FEMALE (N=418)	MALE (N=427)	
<b>Believe that wife beating is an acceptable way for husbands to discipline their wives:</b>							
...if she refuses to have sex with him	43.9	68.3***	32.9	61.8***	51.7	49.4	50.5
... if she disobeys him	70.2	86.5***	67.4	79.3***	77.7	71.6	74.7
...if she does not carry out her domestic tasks	60.6	80.5***	50.2	76.3***	66.8	65.3	66.0
... if he suspects she is unfaithful	56.6	77.4***	43.9	74.1***	64.8	59.7	62.2
...if she is unfaithful to him	73.1	91.3***	66.5	85.6***	82.7	73.6**	78.1

Chi-square test: \* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  (i.e., differences between categories for place of residence, province, and gender)

## ATTITUDES TOWARD GENDER NORMS

All respondents were asked about their gender attitudes via the Gender-Equitable Men (GEM) Scale, and more specifically, using the sub-scale that focused on inequitable gender norms. Table 9 reports the proportion of positive or equitable responses for respondents overall and by place of residence, province, and gender. More specifically, the figures reported include those who disagreed with these statements. In general, there was wide variation in terms of the distribution of equitable responses across these gender attitudes. For example, 64.6 percent of respondents disagreed that ‘it is okay for a man to hit

his wife if she won’t have sex with him’. However, only 12.4 percent disagreed that ‘a man should have the final word about decisions in his home’.

One of the statements in which gender differences were apparent included ‘men need sex more than women do’ with only 11.5 percent of women compared to 24.6 percent of men disagreeing with the statement ( $p < .001$ ). On the other hand, for the statement ‘I would be outraged if my wife asked me to use a condom’, significantly more woman than men reported disagreeing (44 percent and 34.9 percent, respectively,  $p < .01$ ). Significant differences were also observed across many statements with respondents in rural areas and in Kisangani reporting more inequitable gender attitudes.

TABLE 9. PERCENTAGE WITH EQUITABLE RESPONSES ON GENDER-EQUITABLE MEN SCALE (INEQUITABLE GENDER NORMS SUB-SCALE), (AMONG ALL RESPONDENTS), 2012

ATTITUDES	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL (N=845)
	URBAN (N=615)	RURAL (N=230)	KINSHASA (N=331)	KISANGANI (N=514)	FEMALE (N=418)	MALE (N=427)	
It is the man who decides what type of sex to have.	27.6	15.2***	33.8	18.1***	22.7	25.8	24.3
A woman's most important role is to take care of her home and cook for her family.	18.5	8.3***	22.4	11.5***	15.6	15.9	15.7
Men need sex more than women do.	20.3	12.2**	22.7	15.2**	11.5	24.6***	18.1
You don't talk about sex, you just do it.	45.4	31.7***	58.6	30.7***	40.7	42.6	41.7
Women who carry condoms on them are "easy."	47.3	33.5***	55.0	36.2***	46.2	41.0	43.6
Changing diapers, giving the kids a bath, and feeding the kids are the mother's responsibility.	8.9	4.8*	11.8	5.3**	7.2	8.4	7.8

(continued on next page)

TABLE 9. PERCENTAGE WITH EQUITABLE RESPONSES ON GENDER-EQUITABLE MEN SCALE (INEQUITABLE GENDER NORMS SUB-SCALE), (AMONG ALL RESPONDENTS), 2012 (continued)

ATTITUDES	PLACE OF RESIDENCE		PROVINCE		GENDER		TOTAL (N=845)
	URBAN (N=615)	RURAL (N=230)	KINSHASA (N=331)	KISANGANI (N=514)	FEMALE (N=418)	MALE (N=427)	
It is a woman's responsibility to avoid getting pregnant.	29.8	25.7	32.3	26.3	27.0	30.2	28.6
It is a woman's responsibility to avoid getting pregnant.	29.8	25.7	32.3	26.3	27.0	30.2	28.6
A man should have the final word about decisions in his home.	13.8	8.7*	19.9	7.6***	14.1	10.8	12.4
Men are always ready to have sex	15.9	8.3**	16.9	11.9*	12.2	15.5	13.8
There are times when a woman deserves to be beaten.	23.3	21.3	19.6	24.7	22.0	23.4	22.7
A man needs other women, even if things with his wife are fine.	25.4	11.7***	29.3	16.7***	19.6	23.7	21.7
If someone insults me, I will defend my reputation, with force if I have to.	54.3	37.8***	63.7	40.9***	48.8	50.8	49.8
A woman should tolerate violence in order to keep her family together.	43.7	24.8***	47.1	33.1***	41.9	35.4	38.6
I would be outraged if my wife asked me to use a condom.	42.8	30.4**	46.2	35.0**	44.0	34.9**	39.4
It is okay for a man to hit his wife if she won't have sex with him.	67.5	57.0**	71.0	60.5**	65.3	63.9	64.6

Chi-square test: \*p<.05, \*\*p<.01, \*\*\*p<.001 (i.e., differences between categories for place of residence, province, and gender)

## PROGRAM IMPLICATIONS

The survey revealed important gaps in knowledge and behaviors with regard to HIV and AIDS, as well as in attitudes toward GBV. Overall, knowledge was significantly lower among respondents in rural areas, respondents from Kisangani, and among women generally. However, differences were greater by place of residence and province than by gender. Behaviors with regard to sexual experience and practices, and testing for HIV, followed the same pattern. Similarly, acceptability of wife beating was significantly higher for respondents in rural as opposed to urban areas, and in Kisangani rather than Kinshasa; however, differences between genders regarding attitudes to GBV were only significant for the situation in which a wife is unfaithful to her husband/partner. Women as well as men believed that the wife deserves to be beaten in a number of circumstances. The survey clearly demonstrated that certain negative gender norms are held widely in these areas of the DRC by both men and women, leading to a culture of acceptance that is firmly entrenched.

In response, the C-Change project has been implementing social and behavior change (SBCC) activities in the cities of Kinshasa and Kisangani. The Stepping Stones approach is being implemented with 5400 households in Kinshasa and in Kisangani by

several hundreds of community volunteers (RECO) and activists in the various health areas. People living in these households participate in weekly sensitization sessions for five months. The program was launched at the end of 2013 and will continue through project end [March 2015].

Additional activities include technical and logistical support in the fight against GBV for media professionals and the provincial offices of the Ministry of Gender, Family and Children. Awareness activities are being conducted in primary and secondary schools, targeting students (10 to 14 years old), teachers, inspectors, parents, and school officials. Traditional and religious authorities are also sensitized on the prevention of sexual violence in order to involve them in the fight against early marriage and combat social norms conveying gender stereotypes that devalue the girl and woman in the community.

Finally the project is working to raise awareness among civil and military judicial authorities on the importance of responding expeditiously to all cases related to GBV, and working with local media to raise awareness of laws relating to GBV, child protection, and protection for people living with HIV.

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<sup>8</sup> Information about the Stepping Stones approach is available at: <http://www.mrc.ac.za/policybriefs/steppingstones.pdf>.

