Help-seeking behaviours, barriers, and enablers to accessing quality care after sexual and gender-based violence in MSF catchment areas in North Kivu, Democratic Republic of Congo

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Introduction

Access to timely medical care is crucial for the health and well-being of survivors of sexual and gender based violence (SGBV) but there are many barriers to access quality care in North Kivu, Democratic Republic of Congo (DRC). With this mixed method study, we aimed to better understand the perceptions around SGBV, care seeking patterns of survivors, the barriers identified by community members and key stakeholders and how MSF can adapt operational strategies to overcome some of these barriers and increase access to care.

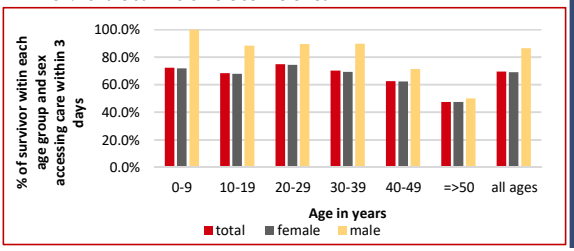
MSF OCA is offering care to survivors of SGBV in the areas of Mweso and Walikale, through semi-vertical Tumaini clinics, where care to survivors of SGBV, family planning, safe abortion care, STI treatments and mental health support is offered, in hospitals and in health centred fully or partially supported by MSF.

Methods

Retrospective register-based data analysis of SGBV survivors accessing care at MSF supported health care facilities in North Kivu during 2014-2018 analyzed using logistic regression models. Focus group discussion (FGD) and in-depth interviews (IDI) held with community members and key stakeholders in 2019, analyzed using content analysis.

Results

- During 1st January 2014 to 31st December 2018, 4684 survivors of SGBV accessed care in the MSF OCA supported structures.
- 66% sought care in the Tumaini clinics
- 70% of survivors accessed care within three days after the event.
- Male survivors accessing care were significantly more likely than females to seek care within 72h.
- Younger age was also significantly associated with higher probability of seeking care within 72h.
- Only 3% of survivors accessing care were male.
- 26% of all survivors were adolescents (10-19 years) and 2% were under 10 years old.
- 51% of the survivors were self-referred.



" Even at night, if you come to Tumaini and the health care personnel know that you have been sexually abused, you are taken care of directly. If they know about the assault, you receive confidential care and medication the same night, and you are given an appointment for follow up." **Female, FGD**

Both sexual violence and intimate partner violence were perceived to be pervasive in the study area. The most common violence was perceived to be perpetrated by men, often part of armed groups, in the field or bush. Women and girls were seen as the most vulnerable. **Many survivors were thought not to seek care due to a range of different barriers.**

"The one who is raped here is considered as someone who is cursed, marginalized at the level of the community; and that makes that the women cannot disclose because there are many consequences of which the first one is: the abandonment of the woman by her husband, what we often observe here, thus divorce." **Male, IDI**

Main barriers for survivors to access care

- Lack of knowledge about consequences of SV/IPV and where to access care
- Stigmatization and fear of social consequences within the communities
- Shame and embarrassment
- Distance to services and cost of transportation
- Gaps in health care provision and harmful attitudes of health care worker
- Normalisation of violence
- Perception that a survivor *must* seek care within 3 days

Key recommendations

- Increase awareness-raising activities using a variety of methods to reach different target groups (men, children, adolescents) and survivors of different types of violence (IPV, conflict related SV etc.)
- Increase support from family and communities
- Improve proximity of services
- Adapt models of care; Expand Tumaini model and community based care models
- Free transport and care provision
- Ensure quality of services and positive attitudes of HCWs.
- Access to support services including legal, protection and financial support

Tumaini models

Most of the survivors accessing care did so in one of the Tumaini clinics and these clinics were well perceived. The likelihood of receiving the full package of care was also higher for survivors in the Tumainis compared to survivors accessing care in the other health facilities. Participants in the FGDs and IDIs recommended an expansion of the Tumaini models.

Community based care model

Community based models for care or support were discussed in the FGDs and IDIs and mostly well-received as a model which can be used complementary to improve access to care. The development of community-based care models should be carefully designed together with the communities, with specific focus on confidentiality as it was raised as one of the concerns.

Conclusion

SGBV is pervasive in the study area and there are many barriers to accessing care for survivors. More efforts need to be put on awareness raising activities to reduce harmful attitudes in the communities and ensure all survivors and potential support persons have knowledge about the need for timely care and how to access the services. The messages have to highlight that there is no time limit for receiving care and support.

The Tumaini model is working well, receiving a high number of survivors and being well perceived by the population. Expansion of the Tumaini model should be considered. To increase access in insecure and hard-to-reach areas a community-based care model would also be welcomed by the communities and should be developed in close collaboration with the communities.

Acknowledgments

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