ORIGINAL RESEARCH

"Qualified but not competent enough": Health workers' assessment of their competence in relation to caring for sexually abused women in Eastern Democratic Republic of Congo

Berthollet Bwira Kaboru *[1], Catrin Borneskog[1], Annsofie Adolfsson[1], Edmond Ntabe Namegabe[2], Gunnel Andersson[1]

[1] *School of Health and Medical Sciences, Örebro University, Örebro, Sweden*
[2] *Faculté de Santé et Développement Communautaires, Université Libre des Pays des Grands Lacs (ULPGL), Goma, Democratic Republic of the Congo*

Received: March 2, 2015 **Accepted:** April 29, 2015 **Online Published:** May 14, 2015
DOI: 10.5430/jnep.v5n8p26 **URL:** http://dx.doi.org/10.5430/jnep.v5n8p26

ABSTRACT

The aim of this study was to assess health professionals' opinions of their competence levels in responding to health needs of victims of sexual violence. This study used a cross-sectional design with a descriptive approach. A total of 104 physicians, nurses and social workers participated in the study. The data was collected using a questionnaire consisting of open and close-ended questions. Overall, 75% of the respondents were university graduates, but only a quarter of them felt they have adequate competence to care for these women; 36% had difficulties with general health assessment of assaulted women. The results indicated that nurses are critical professionals in caring for victims of sexual violence, that they see these women more than any other professional category. However, they are more likely than other categories to report being incompetent. Access to continued education was difficult, and more so for clinically-oriented health professionals than for others social professionals. Human resources capacity strengthening and particularly that of nurses will be the key investment in addressing assaulted women's health needs in this region. Clinical researchers are called to identify rapid methods to reinforce nurses' capacity and role in such a context with deprived health systems.

Key Words: Sexual violence, Competence, Nurses, Health professionals

1. INTRODUCTION

War in the Democratic Republic of the Congo (DRC) has had shocking consequences for the population: since 1996 up to 8 million of persons have died,[1] and about 5 million people have been internally displaced, especially in the Eastern provinces of Kivu. Some authors have called this war "the forgotten holocaust".[2] One of the consequences of this recurrent war has been widespread sexual violence against women. Forced sex has been used as weapon in this context. Sexual violence has been described to be strategically linked to the destruction of a population and entire communities.[3]

A study showed that for the North Kivu province, up to 205 per 1000 women of reproductive age reported history of rape, compared to a national rate of 121.[4] In some settings, women of entire villages have been raped by armed groups. Given the persistence of conflicts and insecurity, there has

* **Correspondence:** Berthollet Bwira Kaboru; Email: Berthollet.Kaboru@oru.se; Address: School of Health and Medical Sciences, Örebro University, Örebro, Sweden.

been growing evidence of normalization of sexual violence, i.e. common men in the communities are being accused of perpetrating sexual violence.[5] A significant proportion of victims of sexual violence choose not to disclose their experiences of rape. Health workers who witnessed such phenomenon reported that "there is a lot of violence going on and victims do not report it because it is considered social death".[6,7]

The consequences of rape on the victims' health are numerous. In DRC, clinical data have demonstrated that at least 5% of assaulted women had fistulas.[8] Sexual violence increases women's risk of sexually transmitted infections (STI) such as HIV and limits their ability to adopt elementary preventive measures. This risk is particularly amplified against the background that it has been estimated that the military forces in this African region have one of the highest rates of STI's of any military group in the world. According to estimates, up to 60% of soldiers and other fighters in the region are infected with HIV.[9] Yet studies have shown that only 30% of women victims undergo post-exposure prophylactic (PEP) treatment of HIV.[6]

Commenting about the health situation in Eastern DRC, Wood and Richardson (2003), stated that "nowhere are the barriers to a functional health infrastructure more clearly on display than in this war-torn region".[10] Focusing on one specific health system building block as applied to a difficult setting the one in Eastern Congo, one question to ask is how the overwhelmed health system in this country is responding to the challenge of caring for assaulted women. Human resources being a key pillar of health systems, a proper response to any public health issues, including sexual violence, requires not only availability of equipment and medicines, but also human resources both in terms of quantity and quality. It has been shown that limited clinical competency and negative attitudes among health care providers inhibit care seeking by victims of sexual violence, lead to poor quality services and could extend and perpetuate survivors' feeling of traumatization. Improving health staffs' attitudes and competence was critical to understanding and addressing the health needs of that vulnerable patients' category.[11]

Human resources clinical competence in response to the scourge of sexual violence has not been researched enough in this devastated region where all health indicators are rather troubling, thus the reason behind this study.

Aim

The aim of study was to assess health professionals' opinions of their competence levels in responding to health needs of victims of sexual violence. An understanding of their competence level will help determine ways of improving reproductive health related services for victims of sexual violence.

2. Methods

2.1 Study design

This study adopted a cross-sectional design with a descriptive approach. The study is part of a large baseline study that targeted health and social workers involved in assistance to victims of sexual violence.

2.2 Study population and sampling procedure

As to the strategy, a multistage sampling procedure combined with a convenience sampling method was used to collect data. As a first step, the study requested from the Provincial Health Inspection Office the list of all institutions (health facility or NGO) that were involved in providing care to female victims of sexual violence. The information obtained from this public office permitted the identification of 36 institutions caring for victims of sexual violence, of which 20 health facilities (owned by the state public and by the private sector) and 16 philanthropic organizations (NGOs). It was estimated that in each institution (health facility or NGO), a minimum number 4 to 6 staff members were in permanent professional contact with victims of sexual violence, meaning that our total target population could reach a maximum of 216 staff members. The study aimed to interview all relevant staff members at these institutions, *i.e.,* all available staff involved in caring for victims of sexual violence. But it was realized that this goal was impossible to achieve due to logistical reasons. In fact, shifting work schedules at these institutions would result into the data collection process taking too long to be completed if all staff members were to be interviewed. It was therefore decided that at least 2 health or social workers per institution should be targeted. This implied a minimum targeted sample size of 72 participants.

The practical steps that characterized this process included: (1) identifying the hospitals and health centers that are known to take care of many victims of sexual violence; (2) targeting antenatal consultation centers and/or gynecological and obstetrics' departments in these health centers and hospitals; (3) identifying NGOs conducting activities of support to raped women in the same health districts; (4) selecting and interviewing available (and consenting) health care personnel and NGOs workers.

2.3 Data collection and analysis

The data was collected with the help of a questionnaire made of open and close-ended questions developed for the purpose by the research team made of researchers from the Örebro

University, Sweden and the "Université Libre des Pays des Grands Lacs", Goma, Democratic Republic of the Congo. The multidisciplinary team was made of researchers with different backgrounds, including public health, gynecology and obstetrics, urology and general medicine. The content of the questionnaire included respondents socio-demographic backgrounds, questions on the frequency of encounters between the respondents and victims of sexual violence, on the kind of health related needs that the assaulted experienced, whether the health and social workers perceived themselves as competent or not. In addition, the questionnaire covered other issues beyond the focus of this paper, namely questions regarding specific reproductive health problems and availability of related services, such as abortion, urinary incontinence, etc. Some results have been published elsewhere.[12] The questionnaire consisted of a total of thirty-five questions.

The questionnaire was pre-tested on health staff at the Kirotshe Hospital belonging to a neighboring health district in order to address face validity concerns. The pre-testing did not result into any major changes to the instrument as it was judged comprehensible. Ten research assistants (interviewers) with previous experience in field survey were chosen to conduct the survey; they were trained for two days to become acquainted with the study questionnaire. They were the ones who administered the questionnaire. The data collection process took one week to be completed. The collected data was coded, entered and analyzed in IBM SPSS 20 software. Chi-square and Fisher Exact (F-exact) tests were used to check the significance of statistical differences of categorical variables, with a significance level at 0.05.

2.4 Ethical considerations

The study was approved by the Ethical committee at the "Université Libre des Pays des Grands Lacs" (ULPGL Goma), by the Mayor of the city and by the Chief Medical Officer of the Provincial Health Inspectorate of North-Kivu province. Before any participation in the study, the purpose of the study was presented and explained to the respondents. They were guaranteed that any finding will be handled with highest confidentiality and that their names will not appear anywhere in the data nor the resulting reports. They were also told that they were free to stop their participation and withdraw from the study anytime during the interview. In case of agreement, the respondent was requested to sign on the consent form that was attached to the questionnaire.

3. Results

3.1 Respondents socio-demographic characteristics

A total of 104 health and social workers responded to the questionnaire. This section deals with background data like age, sex, profession, length of experience at work, education level and the type of the working place. The study found that the population was predominantly young with a mean age of 37.9 years. The age-group between 23 to 44 years dominated, with 81.7% of the respondents. Furthermore, the sex-ratio was 3.16 to 1, in males' favor. Sixty-four percent of the respondents worked in primary health care (health centers), 21% in hospitals and 15% in NGOs. The length of the respondents' working experience was in average 5.7 ± 6.7 years (range 1-29 years).

As to the educational level, 75% were higher education graduates. Slightly less than two-thirds of the respondents (70.2%) were nurses (see Figure 1) working in health facilities (84.6%).

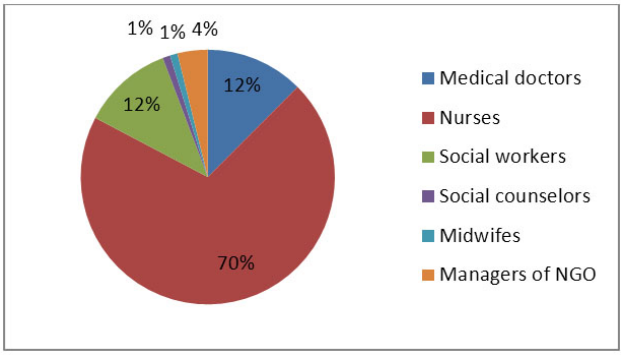

Figure 1. Respondents' distribution by professional backgrounds

3.2 Frequency of clinical encounters with assaulted women

The respondents were asked to state whether they meet assaulted women on a daily basis in their clinical work. Many more nurses reported seeing sexual violence victims as compared to physicians (69.2% versus 11.5%) and other professional categories. The responses from nurses are clearly dominant showing that they constitute the main group of professionals that most frequently see assaulted women (see Table 1).

3.3 Health and social service workers' perception on competence in caring for assaulted women

One set of the questions focused on the extent to which the respondents thought they were competent to provide required care to victims of sexual violence or not. To that generic question, about half of the respondents stated that they were competent but suffered major limitations, *i.e.*, they acknowledged their lack of the necessary skills and the capacity to cater in a professional way to the health needs of the victims of assault. Only one out of four (25%) believed they were fully competent, whereas 27% declared themselves incompetent (see Figure 2).

Table 1. Frequency of clinical encounters with assaulted women

Professional categories	Frequency of encounters			Total
	Very often	Often	Rarely	
Medical doctors	2 (2.0%)	7 (6.9%)	3 (2.9%)	12 (11.5%)
Nurses	3 (2.9%)	51 (50.0%)	18 (17.6%)	72 (69.2%)
Social workers	2 (2.0%)	8 (7.8%)	2 (2.0%)	12 (11.5%)
Social counselors	0 (0%)	1 (1.0%)	0 (0%)	1 (1.0%)
Midwife	0 (0%)	1 (1.0%)	0 (0%)	1 (1.0%)
Managers of NGO	0 (0%)	2 (2.0%)	2 (2.0%)	4 (3.8%)
Missing	-	-	-	2 (1.9%)
Total	7 (6.9%)	70 (68.6%)	25 (24.5%)	104 (100%)

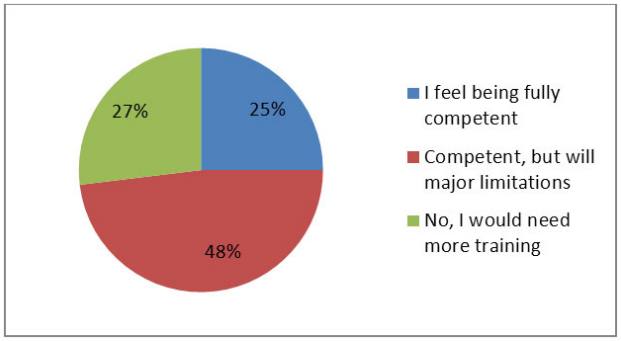

Figure 2. Providers' statements on competence

A closer computation of the distribution of the responses concerning incompetence was performed against the background of various professional categories of the respondents. It was found that nurses more proportionally reported feeling incompetent (34.2%) as compared to physicians (7.7%) and to other professions (4.9%) respectively (Chi-square test value = 10.6, p = .039). Similarly, nurses stated to a higher proportion that they did not feel competent enough to provide the services expected from them and that they needed more training. Indeed, 20% of nurses stated they needed more training; as compared to 4% of physicians and other services providers (F-exact test value = 11.2, p = .020). The questionnaire did not list the type of competencies but the respondents themselves were prompted to raise the issues that they were important to them.

3.4 Domains with perceived gaps competence and access to continued education

The respondents who declared suffering major limitations in competence as well as those who described themselves as not being competent were asked to choose among a set of domains of care the ones in which the gaps were felt. The responses, as condensed in Table 2 below, show that reported deficiencies were mostly to do with general assessment of the health situation of assaulted women (35.9% of responses), and with problems concerning complications following sexual violence (19.2%).

Table 2. Domains of care where providers expressed problems with competence

Domains of caring needs of abused women	Competence but with major limitations	No competence	Combined problematic areas
	Freq. (%)	Freq. (%)	Freq. (%)
General health assessment of these women	13 (46.4)	15 (30.0)	28 (35.9)
Complications due to sexual violence	3 (10.7)	12 (24.0)	15 (19.2)
Gynaecological care	4 (14.3)	9 (18.0)	13 (16.7)
Emergency care	5 (17.9)	1 (2.0)	6 (7.7)
Psychosocial support	3 (10.7)	5 (10.0)	8 (10.3)
Legal assistance	0	5 (10.0)	5 (6.4)
Care and hygiene of fistulas	0	3 (6.0)	3 (3.8)
Total*	28 (100.0)	50 (100.0)	78 (100.0)

*Respondents allowed to mention more than one domain of competency, thus the total number of responses is higher that the number of respondents.

As to access to training or continued education opportunities specific to caring for victims of sexual trauma/assault, half of the respondents declared that they undergone training whereas the other half stated not having had any further train-

ing after formal education. Here too, the statistical difference between professional categories was significant (F-exact test 14.7, $p = .0003$), with social workers reporting more access to continued education than health professionals; and among health professionals higher proportions of nurses reported having accessed training opportunities than physicians.

4. Discussion

The literature on post-conflict reconstruction underscores the complexity of the process, including rehabilitation of health systems functions often due to difficulties in prioritization at policy level, as well as political and administrative constraints. Human resources are always a core part of this problematic development.[13, 14] Such reconstruction process is even more complicated where the context is characterized by a widespread specific health problem evolving as an epidemic. This is the case of sexual violence in Eastern part of the Congo which has been depicted as an epidemic.[15] One study has previously shown how that health services in this area are poorly equipped to face health care needs of victims of sexual assaulted s. Indeed, it was found that out of twenty-three acute care hospitals registered in the Goma area, only four (17%) regularly cared for victims of sexual violence, of which only one hospital had permanently available the required resources to appropriately care for victims of sexual violence.[16]

The present study provides an explorative assessment over the issues of discrepancies between the needs for caring for victims of sexual violence in this particular setting and the perceived competence or quality of human resources at hand to address the problems. The importance of availability and quality of human resources to respond to demands of victims of sexual violence cannot be overstated, considering the multidimensional nature of the needs of these women.[5, 15, 17]

One critical fact worth pointing out is that, as compared to other professional categories, nurses hold a unique position both in terms of numeric majority and of frequency of clinical encounters with assaulted women. In order words, nurses occupy the "driver's seat" in health sector's response to assaulted women's needs. This is partly because nurses are numerous in this setting. Many nurses are in fact unemployed in Congo, partly due to that nursing schools are plenty; but also because migration among nurses is still rare from this part of the country which is isolated. Nursing manpower is therefore cheap. The sheer number of nurses should have important implications on the profession leadership's role in addressing this public health problem. This is not the case because of the lower status of the profession. On the other hand, midwives did not appear as having similar prominent role, which might be an indication of poorly adjusted education system that probably does not produce enough midwives. Such policy inadequacies are common to most post-conflict recovery processes.[14]

With regard to competence, despite overwhelming predominance of academic graduates among service providers (with three quarters being higher education graduates), half of them affirmed experiencing major limitations, and quarter of them stated they were fully incompetent which epitomizes gaps between academic qualification and perceived clinical competence. This finding is quite alarming, considering the overall constraining health care context surrounding care for these women. This shows the important of enhancing competence among health care providers. It also indicates that academic curricula for health professionals' education need to be adapted to the needs of the society.[14]

A further look at discrepancies in reported lack of competence among different categories of service providers indicated clearly that nurses tended to admit that they suffered limitations in competence. Moreover, the results indicate that the domains where competence needs are most felt are common tasks expected from health professionals: general health assessment of abused women and complications consecutive to sexual violence. These domains where staff competence is reported to be limited reveal that establishing systematic clinical screening of women for sexual violence as a routine in this setting according to WHO recommendations[18] is unlikely, consequently many survivors of violence will not be identified and assisted.

Moreover, the simplicity of these responses on deficient competence is striking, but not surprising. Studies from elsewhere showed that nurses may feel incompetent to deal with such an overwhelming problem and that they would even avoid performing essential tasks such as screening survivors of abuse.[19, 20] These expressed problems might reflect more than purely clinical competence issues, but also problems with attitudes, emotions and differential responses, especially when female nurses interact with abused women.[19] Another study found that nurses caring for assaulted women expressed feelings of incompetence but compensated for a lack of training through personal maturity and security within the social context.[21] It is expected that, within their scope of practice, nurses be able to meet the needs and carry out the types of assessments required by women who have experienced sexual trauma, especially in communities where this scourge is becoming endemic.

The results indicate in addition that access to continued education and training is generally limited, especially for health professionals as compared to social workers. However, the small sample size does not allow drawing any strong con-

clusion on this difference. It is critical to test methods and models of strengthening competence among available care giving staff so that they can be able to respond to abused women's multidimensional needs. This recommendation was even formulated earlier in another study.[16] Robust clinical research is called to test different strategies and shed more light on which strategies are likely to increase health staff competence in contexts such the one in Eastern Congo, where not only the health sector but also the education systems face huge challenges. Efforts to prepare health professionals to face such clinical challenges should ideally start early during nursing and medical training.[22]

This study has a number of limitations. First, sampling strategy which was a convenience one implies that there is a possibility that potential respondents were missed. The respondents who were not at their workplace the day the interviewer visited them were simply missed. It is not however possible to tell whether the findings would have been fundamentally different, but the procedure was the best possible we could perform as a total sampling was practically impossible due to resources constraints.

Second, the predominance of males amongst health care providers, including among nurses (77% of nurses were males and 23% females) might have implications on the respondents' perceptions of self-competence. It is possible that women would tend to state being more competent, but we did not test this hypothesis due to the small sample size.

Third, as any finding based on self-reports, the results of this study might be exaggerated in some aspects depending on what respondents would expect from this study. For instance, in settings where workers' salaries are so low and participation to workshops and training are rather seen as ways of earning extra-resources in the forms of per diems and other compensations, staff members might have a tendency to exaggerate their needs for continuous training. Therefore, more clinical research using other methods are called for, including those rating clients' satisfaction.

5. Conclusion

Enhancing health professionals' competence appears to be a priority issue in efforts to address assaulted women's health needs in this region. In other words, human resources capacity strengthening will be the key investment in the concerned health sector. In particular, reinforcing nurses' capacity is critical in this context given their tendency to see more of these victims than other professionals, but also their numerical importance and the high proportions among them reporting poor competence level.

Acknowledgements

The authors are grateful to the Örebro University's Faculty Board of Medicine and Health for funding this study within the framework of its 2013 initiative for support to international collaborative research at the School of Medicine and Medical Sciences.

Conflicts of Interest Disclosure

The authors declare that they have no conflict of interest.

References

[1] Coghlan B, Brennan RJ, Ngoy P, *et al*. Mortality in the Democratic Republic of Congo: a nationwide survey. The Lancet. 2006; 367(9504): 44-51. http://dx.doi.org/10.1016/S0140-6736(06)67923-3

[2] Nyago K. Congo-Kinshasa: the forgotten holocaust. The Monitor. 2003.

[3] Solhjell R. Sexual violence in war - Civilians as battleground. Development Dialogue. 2009; 53(November 2009): 123-35.

[4] Peterman A, Palermo T, Bredenkamp C. Estimates and determinants of sexual violence against women in the Democratic Republic of Congo. Am J Public Health. 2011; 101(6): 1060-7. PMid:21566049 http://dx.doi.org/10.2105/AJPH.2010.300070

[5] Harvard Humanitarian Initiative. "Now the World is Without Me": An investigation of Sexual Violence in Eastern Democratic Republic of Congo. Boston: Harvard Humanitarian Initiative & Oxfam International; 2010.

[6] Wakabi W. Sexual violence increasing in Democratic Republic of Congo. The Lancet. 2008; 371(9606): 15-6. http://dx.doi.org/10.1016/S0140-6736(08)60051-3

[7] Steiner B, Benner MT, Sondorp E, *et al*. Sexual violence in the protracted conflict of DRC programming for rape survivors in South Kivu. Confl Health. 2009; 3: 3. PMid:19284879 http://dx.doi.org/10.1186/1752-1505-3-3

[8] Onsrud M, Sjøveian S, Luhiriri R, *et al*. Sexual violence-related fistulas in the Democratic Republic of Congo. International Journal of Gynecology & Obstetrics. 2008; 103(3): 265-9. PMid:18812246 http://dx.doi.org/10.1016/j.ijgo.2008.07.018

[9] Omba Kalonda JC. Sexual violence in the Democratic Republic of Congo: impact on public health?. Med Trop (Mars). 2008; 68(6): 576-8.

[10] Wood R, Richardson ET. Prioritizing Healthcare Delivery in a Conflict Zone - Comment on "TB/HIV Co-Infection Care in Conflict-Affected Settings: A Mapping of Health Facilities in the Goma Area, Democratic Republic of Congo". International Journal of Health Policy and Management. 2013; 2013(1): 231-2. PMid:24596872 http://dx.doi.org/10.15171/ijhpm.2013.44

[11] Smith JR, Ho LS, Langston A, *et al*. Clinical care for sexual assault survivors multimedia training: a mixed-methods study of effect on healthcare providers' attitudes, knowledge, confidence, and practice

in humanitarian settings. Confl Health. 2013; 7: 14. PMid:23819561 http://dx.doi.org/10.1186/1752-1505-7-14

[12] Andersson G, Kaboru BB, Adolfsson A, *et al*. Health Workers' Assessment of the Frequency of and Caring for Urinary and Fecal Incontinence among Female Victims of Sexual Violence in the Eastern Congo: An Exploratory Study. Open Journal of Nursing. 2015; 5(In Press).

[13] Pavignani E. Human resources for health through conflict and recovery: lessons from African countries. Disasters. 2011; 35(4): 661-79. PMid:21371087 http://dx.doi.org/10.1111/j.1467-7717.2011.01236.x

[14] Kruk ME, Freedman LP, Anglin GA, *et al*. Rebuilding health systems to improve health and promote statebuilding in post-conflict countries: A theoretical framework and research agenda. Social Science & Medicine. 2010; 70(1): 89-97. PMid:19850390 http://dx.doi.org/10.1016/j.socscimed.2009.09.042

[15] Mukwege DM, Nangini C. Rape with extreme violence: the new pathology in South Kivu, Democratic Republic of Congo. PLoS Med. 2009; 6(12): e1000204.

[16] Baelani I, Dunser MW. Facing medical care problems of victims of sexual violence in Goma/Eastern Democratic Republic of the Congo. Confl Health. 2011; 5(1): 2. PMid:21375778 http://dx.doi.org/10.1186/1752-1505-5-2

[17] García-Moreno C, Stöckl H. Protection of sexual and reproductive health rights: Addressing violence against women. International Journal of Gynecology & Obstetrics. 2009; 106(2): 144-7. PMid:19560770 http://dx.doi.org/10.1016/j.ijgo.2009.03.053

[18] WHO. Guidelines for medico-legal care for victims of sexual violence. Geneva: WHO; 2003.

[19] Goldblatt H. Caring for abused women: impact on nurses' professional and personal life experiences. Journal of Advanced Nursing. 2009; 65(8): 1645-54. PMid:19493144 http://dx.doi.org/10.1111/j.1365-2648.2009.05019.x

[20] Davis RE, Harsh KE. Confronting barriers to universal screening for domestic violence. Journal of Professional Nursing. 2001; 17(6): 313-20. PMid:11712117 http://dx.doi.org/10.1053/jpnu.2001.28181

[21] Haggblom AM, Moller AR. On a life-saving mission: Nurses' willingness to encounter with intimate partner abuse. Qual Health Res. 2006; 16(8): 1075-90. PMid:16954526 http://dx.doi.org/10.1177/1049732306292086

[22] Kennedy KM, Vellinga A, Bonner N, *et al*. How teaching on the care of the victim of sexual violence alters undergraduate medical students' awareness of the key issues involved in patient care and their attitudes to such patients. Journal of Forensic and Legal Medicine. 2013; 20(6): 582-7. PMid:23910837 http://dx.doi.org/10.1016/j.jflm.2013.06.010