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Review Paper

Physical, mental and social consequences in civilians who have experienced war-related sexual violence: a systematic review (1981–2014)

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ABSTRACT

Objectives: To identify the health outcomes of sexual violence on civilians in conflict zones between 1981 and 2014.

Study design: Systematic review.

Methods: For the purpose of this study, we defined sexual violence as sexual torture including, individual rape, gang rape, and sexual slavery. All types of conflicts were included (intrastate, interstate, and internationalized intrastate). Quantitative and mixed-method studies, reporting any physical, mental, and social consequences, were retrieved from Medline, Embase, Global Health, Global Health Library, WHOLIS, Popline, and Web of Sciences (n = 3075) and from checking reference lists and personal communications (n = 359). Data were analyzed using Microsoft Excel and MetaXL. Given inherent variation, the means derived from combining studies were misleading; thus, we focused on the range of values.

Results: The 20 studies were from six countries, five in Africa (18 studies), and especially in Democratic Republic of Congo (12 studies). The number of subjects varied from 63 to 20,517, with 17 studies including more than 100 subjects. Eight studies included males. Gang rape, rape, and abduction were the most commonly reported types of sexual violence. Sixteen studies provided data on physical outcomes of which the most common were pregnancy (range 3.4–46.3%), traumatic genital injuries/tears (range 2.1–28.7%), rectal and vaginal fistulae (range 9.0–40.7%), sexual problems/dysfunction (range 20.1–56.7%), and sexually transmitted diseases (range 4.6–83.6%). Mental health outcomes were reported in 14 studies, the most frequent being post-traumatic stress disorder (range 3.1–75.9%), anxiety (range 6.9–75%), and depression (range 8.8–76.5%). Eleven studies provided social outcomes, the most common being rejection by family and/or community (range of 3.5–28.5%) and spousal abandonment (range 6.1–64.7%).

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Conclusions: Wartime sexual violence is highly traumatic, causing multiple, long-term negative outcomes. The number and quality of studies published does not match the significance of the problem. The findings highlight the need for care of the survivors and their relatives and raise concerns about how they and their children will be affected in the long term.

Introduction

Since the end of World War II, 254 armed conflicts have been recorded in 155 locations.[1] For civil wars alone, between 1980 and 2009, 86 civil wars were recorded with 18 conflicts coded as wars with widespread rape and 35 as having many or numerous reports of rape.[2] Sexual violence against civilians has long been part of armed conflict with great variation as to its scale, its characteristics, the targets and whether the violence was strategically planned.

Sexual violence as a weapon of war is a widely used term, especially in advocacy, that describes a systematic pattern of sexual torture perpetrated by combatants against civilians. Studies showed that sexual violence used as a weapon of war is known to be different from the one committed as an isolated act of aggression in terms of severity of the violence, number of perpetrators, number of assaults and its strategic use to terrorize and induce fear and control civilian populations.[3,4]

Sexual violence can be prosecuted as torture, a war crime and a crime against humanity.[5] However, despite the adoption of United Nations Resolution 1820[6] calling for the cessation of sexual violence against civilians in conflict zones, hundreds of victims suffer from wars fought 'on their body'.[7] In ongoing conflicts, this weapon of war continues to 'terrorize communities'.[3] Documents reporting on women kept as sex slaves in camps, raped and forbidden to undergo abortion or of fathers forced at gunpoint to rape their daughters are numerous.[3,8,9]

Establishing the rate of war-related sexual violence is challenging because of insecurity, taboos surrounding sexual violence and the complexities of population-based surveys on this topic. Sexual violence has been reported by 11% of displaced women in Colombia, 19% of women in Burundi, 25% of women in Azerbaijan and 39% of women during the Rwandan genocide.[10,11] In Sierra Leone, 9% of women reported sexual violence,[12] while in Liberia and Cote d'Ivoire, this rate was 35.3% and 0.2%, respectively.[13] In eastern DRC (Democratic Republic of Congo), two surveys estimated the prevalence of the experience of sexual violence to be 16–40% in women and 24% in men.[14,15] Missing from these figures are the cases that remain unreported due to death of the victims, stigmatization, the vulnerability of victims and general insecurity.[16–18] Non-reporting of sexual violence at the time of seeking medical care is as high as 75% and may be higher in conflict settings.[14] In DRC, only 1 in 30 victims officially report sexual violence and more than 50% of victims are unable to access health care.[19] Young women, for instance, are 'more inclined to isolate themselves or relocate after their rape',[20] while male survivors have less tendency to seek health care.[21–24]

Systematic reviews have been published on prevalence of sexual violence in crisis,[25,26] on prevention[27,28] and on management strategies,[29–31] but to our knowledge, no systematic review on the range of consequences of sexual violence in conflict settings has been published. One review considered the prevalence of sexual violence in conflicts in Africa and its effect on human immunodeficiency virus (HIV) incidence[13] and another non-systematic review on fistula.[32] This systematic review sought to identify the health consequences of sexual violence on civilians in conflict zones since 1981.

Methods

Search strategy and selection criteria

A protocol was developed using the PRISMA guidelines (see Table S1 in the Supplementary material).[33] For the purposes of this study, we utilized the description of war-based sexual violence of Lunde and Ortmann[34] including one or more of: (a) violence against the sexual organs, i.e., introduction of objects in the vagina, shooting on the genital parts and various genital mutilation; (b) physical sexual assault, i.e., sexual acts involving direct physical contact between victims and torturer, between victim and victim, between victim and animal, or all of the above; and (c) mental sexual assault, i.e., forced nakedness, sexual humiliations, sexual threats and the witnessing of others being sexually tortured.

We sought data for conflicts that took place from 1981 onwards. This decision was pragmatic although it was influenced by the knowledge that this marked the beginning of the era of HIV/AIDS in modern times.[35] The time of the conflict was based on the Uppsala Conflict Data Program.[36] Studies that used quantitative methods or mixed methods and included a methods section were eligible. The subjects had to be victims/survivors of war-related sexual violence. No exclusion was made by gender, age, or other sociodemographic characteristics. All types of conflicts were included (intrastate, interstate, and internationalized intrastate). The perpetrators could be armed combatants, ex-combatants, or civilians if the sexual violence was war related. If the sexual violence was not explicitly categorized as war related, only those studies where civilians represented less than 25% of the perpetrators were included. This cutoff was used to prevent the inclusion of non–war-related