Refugees from the Democratic Republic of the Congo: Historical, Cultural, and Medical Context of a 30-Year Crisis

Abigail Norwood, MS4
University of Virginia School of Medicine
November-December 2022

Abstract

The Democratic Republic of the Congo (DRC) is a massive country in sub-Saharan Africa that is the site of the deadliest conflict since World War II. Beginning with the first civil war in 1996, violent armed conflict has persisted, involving a rotating cast of internal military and paramilitary groups, neighboring countries, and global powers. The result has been a humanitarian conflict with millions dead and displaced. The prolonged and widespread nature of the crisis in the DRC has created a steady and increasing flow of refugees from the DRC; this group now consistently make up the largest number of annual arrivals, with about 20,000 people arriving between 2019-2021 of the approximately 53,000 total refugees and asylum seekers in that period.[1] They are surpassed only by Afghan parolees arriving in 2021 in the wake of US withdrawal—estimated to be around 70,000 people.[2] In the ten-year period from 2012-2021, the US has taken more refugees from only Burma and Iraq.[1,3]

Refugees from the DRC have spent now as many as two and a half decades in refugee camps in neighboring countries. Common health concerns amongst arriving Congolese refugees include chronic conditions like hypertension, infectious diseases specific to their countries of exit, and mental health concerns. The frequency and nature of the traumas to which they have been exposed, in particular sexual and gender based violence, led to high rates of PTSD, depression, anxiety, and other psychiatric conditions. However, cultural views surrounding recognition and treatment of mental health disorders can limit interest in accessing formal psychiatric care. Understanding the history of the DRC, its people, and the conflict that has affected so many, is paramount to providing appropriate healthcare to these refugees.

Brief History of the Region

Pre-Colonization

Geographically the 12th largest country in the world, the modern borders of the Democratic Republic of Congo were born of 19th and 20th century colonial intervention[4] For most of its history, a variety of tribes, kingdoms, and empires ruled different parts of the modern country. The most well-known of these kingdoms includes the Kingdom of Kongo on the Western coast, which covered parts of what is today the Western DRC with its capital Kinshasa, Angola, and the Republic of Congo.[4] In the eastern regions the Lunda Kingdom traded with the Swahili civilizations in and around modern day Tanzania. These and other kingdoms were part of an extensive sub-Saharan trade network centered around the Congo River, connecting the Atlantic coastal regions to Indian Ocean trade routes.[4] Portugal made contact with the Kingdom of Kongo in the 15th century, eventually ushering in the Atlantic slave trade. An estimated 13 million people in the region were enslaved and sent to the American colonies.

Belgian Colony

In the 19th century Belgium, under Leopold I, took control of the region and negotiated its borders with other Europeans at the Berlin Conference (1884-1885). It was here that the "Congo Free State" was created and given to Leopold II to run as his "private estate."[4] From 1880-1910, "They turned Congo into 'hell' which was described as the 'heart of darkness'... [Leopold II's] rule was so cruel that an estimated number of 10 million people were either killed or crippled."[4] Of the many atrocities committed against native peoples in the region, the policy of cutting off the hands and feet of people who did not produce enough rubber is the best known. So great were the abuses in the Congo Free State under Leopold II that international pressure forced the Belgian government to take control of the region from the King in 1910.[5] However, many oppressive and abusive policies persisted

as the Belgians continued to exploit the region for its natural resources.[4]

Independence & Mobutu

Under growing opposition to colonialism, the Belgian government granted independence to the territory on June 30, 1960. Democratic elections brought Prime Minister Lumumba into power for a brief period but within the year a CIA and Belgian backed separatist group assassinated the Prime Minister. The country's neighbor, Angola, was the site of one of the larger Cold War proxy wars and the US and its allies feared Angola's massive, resource rich neighbor becoming Communist.[4,6] Backed by the CIA, authoritarian Mobutu Sese Seko rose to power and renamed the country Zaire. Mobutu's rule lasted from 1961-1996, ushering in three decades of immense corruption–he was at one point the richest man on earth–albeit in relative peace.[4]

First & Second Civil Wars

In the wake of the Rwandan genocide (1994) over a million Hutus entered the eastern forests of Zaire.[4] Among these refugees were Rwandan Interahamwe–Hutu militia members who were the main perpetrators of the genocide of Rwandan Tutsis. Ugandan and Rwandan military forces followed, and eventually forced Mobutu into exile.[6] These forces brought Laurent-Désiré Kabila into power in 1997, who changed the name of the country from Zaire to the Democratic Republic of Congo.[4] However,

> "In 1998, after Kabila got too friendly with the Interahamwe, Uganda and Rwanda invaded Congo again, triggering what became known as Africa's first world war. The scramble for power and resources dragged in forces from at least eight African neighbors, spawned a myriad of Congolese factions and set off campaigns of ethnic cleansing. Kabila…was shot dead by one of his bodyguards in 2001. His son Joseph, 29, assumed power. One year later, after some arm twisting by continental power South Africa… the young leader and most of the rebel groups and foreign forces in the country signed a peace deal."[6]

The Second Congolese War remains the second deadliest war in history. As many as four million people are thought to have died.

Though the war technically ended in 2003, the DRC remained unstable. From 2003-2008 violence continued, perpetrated by both the Congolese military and various rebel groups. The byproducts of war–malnutrition, disease, poverty–continued to ravage the population, and claimed over a thousand lives a day.[6] Eventually, President Kabila and his supporters achieved some consolidation of power and stability. However, the eastern regions, with their valuable mines, remain at the center of violence from rebel groups and neighboring countries such as Rwanda.[7,8] Regions of the DRC are in a perpetual state of war, and

> "it is neither an ideological nor a liberation conflict…but rather an ongoing strategy of the authors and planners of the Rwandan genocide… This ongoing armed conflict, cyclical, chronic, and unresolved to date, is facilitated by a weak central government, by the involvement of neighboring countries and by the failure of international diplomacy."[9]

Thus, the violence and the resultant flow of refugees appears to have no chance of abating any time soon.

Current State of the DRC

As of December 2021, over five million people have become internally displaced persons (IDPs) due to the conflict in the DRC. Of these, about a million have returned to their homes, while another million reside abroad, most of them in bordering countries such as Uganda, Rwanda, and Tanzania.[10] Additionally, the DRC itself hosts about half a million refugees from neighbors such as the Central African Republic, Rwanda, Burundi, and South Sudan, contributing to the complexity of the situation.[11]

Violence continues to break out throughout the eastern provinces and has ramped up in the wake of COVID. Indeed, kidnappings of and attacks on aid workers have increased in frequency.[12] Beyond the violence, the region continues to face malnutrition, disease, and natural disaster. COVID, Ebola, and measles outbreaks as well as a volcanic eruption in 2021 contribute to the instability and suffering.

Foreign intervention, from both regional neighbors and global powers such as the US and China, shows no signs of

abating any time soon. Currently, the global demand for clean energy has made cobalt one of the most coveted resources, and the DRC sources two-thirds of the world's supply.[13] As the clean energy industry explodes, the demand for cobalt threatens to make the DRC the center of an economic battle between foreign powers that will have major impacts on the governing and stability of the country.[14]

Congolese Refugees in the United States

Demographics

During war or another destabilizing, such as environmental disasters, the management of refugee groups happens in stages. The primary goal for all refugees is return to their home country, though this is not always possible. The secondary goal is regional integration into neighboring countries, where language, culture, and religious practices are hopefully similar enough so as to promote easier adjustment to their new country. However, conflicts that produce large numbers of refugees often overwhelm neighboring countries and their ability to provide for refugees. Only after exhausting the primary and secondary outcomes do refugees arrive at the tertiary outcome of resettlement.[15,16] The protracted nature of the conflict, now nearly 35 years long, and the scale of the refugee and humanitarian crisis has meant that many Congolese refugees are now eligible for resettlement. Priority for resettlement is often given based on length of stay in the host country, the person's originating province, and demographic factors such as single parent families and people with medical needs.[17]

The majority of the refugees from the DRC come from the eastern provinces of the country, notably Nord-Kivu, Sud-Kivu, Ituri, Kasai, Haut-Katanga, and the Tanganyika provinces (see map below).[10] Though roughly 80% of the population are Bantu peoples, there are over 200 ethnic groups and languages in the country.[19] The official language of the DRC remains French, but there are four other national languages, Swahili, Lingala, Tshiluba, and Kikongo. Many refugees arriving in the

United States speak Kinyarwanda. While French is taught in secondary schools, many refugees did not receive this level of formal education. Additionally, children born, raised, and educated in refugee camps in other African countries learn the languages taught there. English, for example, is taught widely in Tanzanian schools.

From the Atlantic Council [18]

The ethnic and tribal distinctions that may be opaque to outsiders lie at the center of ongoing conflicts in the DRC. Indeed, the land conflict between the Hema and Lendu people in the Ituri province has made the area one of the most dangerous places to live in the country for decades.[7,20] These differences can keep Congolese communities abroad separate, and impede efforts to unify resettled communities in the United States.

Given that about 70% of people in the DRC are Christian, the vast majority of the refugees coming to the United States are Christian. The arrivals who are Christian tend to be Protestant, specifically Pentecostal and Seventh Day Adventist. A small percent of Congolese refugees are Muslim. Traditional, non-Christian belief structures are also woven into religious practice.[21]

Health & Healthcare

CDC Recommendations for Refugees from the DRC

Among the CDC recommendations for care of new arrivals from the DRC is consideration of infectious diseases. Many people receive presumptive treatment for malaria prior to departure, but those refugees who have not been treated should be screened or presumptively treated upon arrival. Rates of malaria will reflect the rates in the person's country of departure; for example, Rwanda has much lower rates of

malaria given its altitude as compared to Tanzania, Uganda, and other countries hosting Congolese refugees. *Strongyloides* is another common infection in that part of the world, and the CDC recommends presumptive treatment or test and treatment upon arrival. Treatment is typically an oral dose of ivermectin 200 µg/kg daily for two days. Consideration should be given to the prevalence of *Loa loa* in the country of departure, as treatment with ivermectin in someone co-infected with *Loa loa* could lead to severe encephalopathy. If there is concern for *Loa loa*, testing can be done first or presumptive treatment (without testing for *Loa loa)* can be provided with albendazole 400 mg bid for seven days. *Strongyloides* infections can be asymptomatic, and can persist for decades. All refugees departing from sub-Saharan Africa receive praziquantel for presumptive treatment of *Schistosomiasis*, however, the presence of signs and symptoms, including an elevated eosinophil count should prompt further evaluation.[21]

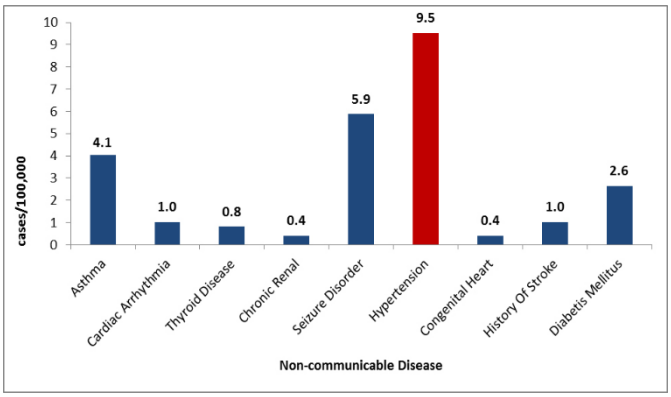
Sexually transmitted diseases should also be considered in new arrivals, especially if signs and symptoms are present. All arriving refugees should receive HIV and Hepatitis B screening. For refugees from the DRC, rates of syphilis are not high enough to warrant extra screening as long as they were previously screened pre-departure; screening and testing should follow regular guidelines based on risk factors and symptoms.[21] Screening for chlamydia is recommended in women 25 years or younger and for all refugees with known risk factors or who have signs of infection.[21]

Anemia is more common in people from the DRC, and can be due to a number of factors including nutritional deficiencies, parasite infections, and hemoglobinopathies such as sickle cell disease and thalassemias. Further, an estimated 19% of the population in the DRC have G6PD deficiency.[21] Thus the differential for anemia in a new arrival from the DRC requires a broad differential and workup.

Trauma & Mental Health

The wars and violence in the DRC have been noted to have produced very high rates of trauma. War atrocities abound, such as torture, mass executions, disappearances, and sexual and gender based violence (SGBV). Studies on the trauma and its outcomes on those exposed vary widely, but the general consensus is the same: refugees from the DRC have high rates of exposure to traumatic events and demonstrate high rates of symptoms of PTSD. One small study conducted by Ainamani et al. assessed the exposures of refugees based on a 25 point checklist, and then rated participant PTSD symptom severity based on a scale. It found that every person in the study had experienced at least one traumatizing event, and that 89% of the 325 people sampled fulfilled DSM-IV criteria for PTSD.[22]

In addition to the psychiatric toll taken by exposure to traumas, there are the physical manifestations to consider. There is growing evidence supporting the link between psychiatric disorders, traumatic exposures, and chronic medical conditions such as hypertension. The prevalence of hypertension has been increasing in the DRC, and hypertension is noted to be one of the most common non-communicable diseases among Congolese refugees.[21,23]



From the CDC: Non-communicable diseases as reported by Congolese refugees during overseas medical examinations at panel physician sites, 2008–2012 (N=4,938)[21]

A study by Achille et al. in Bukavu, DRC, examined the exposures to traumatic events among outpatient internal medicine patients with and without hypertension. Bukavu lies on the Rwandan border and thus in the middle of now three decades of violence. The same population was also screened for depression, PTSD, and alcohol use disorder. The authors found that having PTSD was associated with the strongest odds of having hypertension, more so than

traditional metabolic risk factors such as elevated BMI and fasting plasma glucose. Man-made trauma too had a stronger association with hypertension, as compared other sources of trauma such as natural disasters.[24]

Refugees from the DRC are at high risk for PTSD, depression, and anxiety. However, diagnosis and treatment of these conditions can be impeded by many different factors. First, though mental health conditions have fundamental cross-cultural similarities, there is concern about the validity of screening tools used outside of the context in which they were developed. Greene et al., in a small sample mixed-methods study, characterized three problems described by female Congolese survivors of intimate partner violence living in a refugee camp in Uganda. The participants described the states of *huzuni* (deep sadness), *msongo wa mawazo* (too many thoughts), and *hofu* (fear), all of which had significant symptom overlap with depression, anxiety, and PTSD. Subsequent screening of the participants using symptoms taken from the Hopkins Symptom Checklist and the Harvard Trauma Questionnaire, revealed extensive overlap.[25] Thus, though specific diagnoses may not equate one-to-one across cultures, symptom based screenings are still effective ways to identify patients experiencing psychological distress.

A second impediment to provision of mental health care in cross-cultural settings is the person's conceptualization of and attitudes toward mental health care. Focus groups conducted among Congolese refugee women resettled in Massachusetts demonstrated several barriers in that community. Overall, the women described a framework in which only extreme symptoms such as "removing their clothing [in public]" were identified as mental health problems, whereas more subtle symptoms of distress and hardship were not. The women in the study also pointed to beliefs of witchcraft and spirits as etiologies for mental health problems, though this varied between the individuals.

A third impediment, also described in these focus groups, was the means of coping with distress. The women overall stated that community support, such as that from friends and family, is expected to help people cope with their traumas. One woman stated that “the idea of talking to a stranger, not from the culture, is difficult to accept and generally frowned upon.”[23] Rather than turning to psychiatrists, who are strangers, the women believed that their social networks are best supports as they navigate hardship. Religious leaders such as pastors also hold positions of great influence in these communities and are seen as acceptable pillars of support. However, the women in the focus groups differed in their opinions on whether ‘treatment’ for psychological distress would be effective.[23] Another study on the use of culturally modified, trauma focused, group CBT in a population of teenaged survivors of SGBV in the DRC demonstrated a significant reduction of trauma symptoms in the group exposed to CBT, as compared to the control group.[26] This implies that, with cultural modifications, validated treatment tools can be effectively targeted at communities that have not had prior exposure to such therapies.

Though specific barriers to mental healthcare access have cultural specificities, there are overarching themes including but not limited to knowledge about psychiatric disorders and potential treatments. Studies in other refugee populations have demonstrated that, as people become educated about mental health and the role of healthcare providers, rates of resettled refugees accessing mental healthcare increases.[27] For example, in a study of Iraqi refugee mental healthcare patterns, “those who recognized PTSD symptoms [in themselves] were, unsurprisingly, more likely to seek mental health care.”[28]

Sexual and Gender Based Violence (SGBV)

Women apparently demonstrate greater rates of PTSD in epidemiologic studies, but what this is attributable to remains unknown and subject to debate.

Some argue that women are more likely to experience rape, which is the trauma most likely to cause PTSD. Others argue that women in conflict zones experience an overall higher trauma burden, with a somewhat linear relationship between the number of traumas experienced and the likelihood of developing PTSD.[22,29] Rape and other forms of SGBV are common in conflict zones, and have been documented at high rates in the DRC conflict.[30,31] There is, however, a dearth of research on the prevalence of sexual violence as a tool of war though it is a known military tool and a means of ethnic violence. While the UN reported around one thousand cases of sexual violence in the DRC in 2020, numerous barriers to reporting lead many to estimate the true number to be many times higher.[9] Primary among these barriers is the stigma associated with sexual violence that can cause survivors to suffer from spousal abandonment, ostracism, inability to marry, and other consequences.[21] Further, the lack of justice or any real response to SGBV from people in power means that survivors have even less reason to come forward.[9]

With these barriers, studies on the rates of SGBV are few and difficult to conduct. However, those that have tried note high rates of sexual violence. A survey of one thousand households in the eastern DRC conducted by Johnson et al. in 2010 found that 39.7% of women and 23.6% of men had been exposed to sexual violence.[24] Nor are people safe from SGBV after escaping conflict zones. Though military and paramilitary groups are the main perpetrators in war zones, sexual violence also occurs in refugee camps, with intimate partner violence taking a larger share of the cases.[21,32]

As noted, rape and other forms of sexual violence are associated with the highest risk of developing PTSD among traumatic exposures. PTSD has its physicals tolls such as hypertension, described above. There are also the consequences of sexual violence on physical health. Physical injuries, pregnancy, HIV and other STDs, sterility,

and fistulas are all potentially devastating consequences of sexual violence.[21,32] With these risks, it is important for providers to know if their patients have been exposed SGBV. However, given the stigma around sexual violence in this community, the CDC and other experts recommend that providers defer such questions until trust as developed between them and their patient.[21]

Conclusion

Refugees arriving from the DRC have experienced high levels of violence, sexual violence, and instability making rates of PTSD and related mental health concerns prevalent. However, the community's beliefs and practices around mental health concerns are often oriented towards community and religious support, as compared to seeking help from therapists and psychiatrists who would be strangers. What research exists in this area indicates some potential inroads for providers.

Across refugee communities, indeed across the general population, people tend to seek mental healthcare more when they are educated about mental health disorders and their treatment. Primary care providers are well situated to provide sustained education with every health visit. Folding mental health education along with the other health education provided at well visits, for example, might normalize conversations about mental health with professionals. Primary care practices should also continue to participate in known best practices, such as providing mental healthcare in the same spaces as other forms of healthcare. Doing so communicates the relationship between mental and physical health, de-emphasizes perceived differences between the two, and helps provide some anonymity to those who seek mental healthcare but fear community stigma.

Further, there are screening tools that have demonstrated cross cultural success generally, and specifically in the Congolese refugee population. The Hopkins Symptoms Checklist (HSCL 25) is one such tool. Further, the Harvard Trauma Questionnaire (HTQ) was developed for

refugees, initially those arriving from Vietnam, Laos, and Cambodia, and has now been translated into six languages and altered to the specific contexts of each refugee group.[33] Versions specific to the Congolese refugee population have been used in camps abroad to some effect. Adapting the HTQ to the Congolese refugee population provides healthcare professionals with a screening tool specific for and validated within refugee populations. Screening for SGBV is difficult, especially given that expert and CDC guidance currently recommends *against* asking questions about SGBV unless this information has imminent medical necessity. Again, primary care and family practice providers will hopefully, with time, form a trusting relationship with the patient to create a space to have those conversations as medically indicated.

By understanding the cultural context and beliefs of the Congolese refugee population also provides potential avenues for treatment. As Congolese people primarily turn to their community and social networks to cope with suffering, group based CBT and other group therapies might be more culturally acceptable.

References

1. Baugh R. *Fiscal Year 2020 Refugees and Asylees Annual Flow Report.* Department of Homeland Security; 2022. Accessed November 20, 2022. https://www.dhs.gov/sites/default/files/2022-08/2022_0308_plcy_refugee_and_asylee_fy2020v2.pdf
2. Tens of thousands of Afghans have resettled across the U.S. Now, the challenge is making a home. PBS NewsHour. Published February 3, 2022. Accessed December 11, 2022. https://www.pbs.org/newshour/nation/tens-of-thousands-of-afghans-have-resettled-across-the-u-s-now-the-challenge-is-makinga-home
3. Baugh R. Refugees and Asylees: 2021.; 2022. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiOntH8tcz7AhWUF1kFHdkDDN8QFnoECAkQAQ&url=https%3A%2F%2Fwww.dhs.gov%2Fsites%2Fdefault%2Ffiles%2F2022-10%2F2022_0920_plcy_refugees_and_asylees_fy2021.pdf&usg=AOvVaw2QfkOx3PN3saUEGX2sYSOi
4. Bobineau J, Gieg P. *The Democratic Republic of the Congo. La République Démocratique Du Congo: Problems,*

Progress and Prospects. Problèmes, Progrès et Perspectives. LIT Verlag Münster; 2016.
5. The horrific consequences of rubber's toxic past. *BBC News.* Published July 23, 2019. Accessed November 30, 2022. https://www.bbc.com/news/business-48533964.
6. Robinson S, Walt V. The Deadliest War In The World. *Time.* Published online May 28, 2006. Accessed November 30, 2022. https://content.time.com/time/subscriber/article/0,33009,1198921-3,00.html
7. Dobbins J, Miller LE, Pezard S, et al. Democratic Republic of the Congo. In: *Overcoming Obstacles to Peace.* Local Factors in Nation-Building. RAND Corporation; 2013:179-204. Accessed November 30, 2022. /stable/10.7249/j.ctt3fgzrv.16 https://www.jstor.org
8. Recent surge in violence in DRC's Ituri province worsening already desperate situation for children. Accessed November 30, 2022. https://www.unicef.org/press-releases/recent-surge-violence-drcs-ituri-province-worseningalready-desperate-situation
9. Kabengele Mpinga E, Koya M, Hasselgard-Rowe J, Jeannot E, Rehani SB, Chastonay P. Rape in Armed Conflicts in the Democratic Republic of Congo: A Systematic Review of the Scientific Literature. *Trauma, Violence, & Abuse.* 2017;18(5):581-592. doi: 10.1177/1524838016650184
10. DRC situation. Global Focus. Accessed November 30, 2022. http://reporting.unhcr.org/drcsituation
11. Refugees UNHC for. Democratic Republic of the Congo. UNHCR. Accessed November 30, 2022. https://www.unhcr.org/democratic-republic-of-the-congo.html
12. Reuters. Kidnapped Red Cross workers freed in eastern Congo. Reuters. https://www.reuters.com/world/africa/kidnapped-red-cross-workers-freed-eastern-congo-2021-12-11/. Published December 11, 2021. Accessed November16. 30, 2022.
13. Barbaro M, Johnson MS, Krupke E, et al. The Global Race to Mine the Metal of the Future. *The New York Times.* https://www.nytimes.com/2022/03/18/podcasts/the-daily/cobalt-climate-change.html. Published March 18, 2022. Accessed November 30, 2022.
14. Searcey D, Forsythe M, Lipton E, Gilbertson A. A Power Struggle Over Cobalt Rattles the Clean Energy Revolution. *The New York Times*. https://www.nytimes.com/2021/11/20/world/china-congo-cobalt.html. Published November 20, 2021. Accessed November 30, 2022
15. UNHCR - Resettlement. Accessed December 11, 2022. https://www.unhcr.org/resettlement.html
16. UNHCR. UNHCR Resettlement Submission Categories. Presented at: /url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjWqrHr6PH7AhWxKFkFHWRUDFIQFnoECBUQAQ&url=https%3A%2F%2Fwww.unhcr.org%2F558bff849.pdf&usg=AOvVaw1mUSwgr9uFgsU90ZF7uvPR
17. *Congolese Refugees: A Protracted Situation.* UNHCR; 2014:8.
18. Lilley K. Below the surface, a game changer in Congolese politics. *Atlantic Council*. Published July 16, 2018. Accessed December 2, 2022.

https://www.atlanticcouncil.org/blogs/africasource/below-thesurface-a-game-changer-in-congolese-politics/
19. Language data for the Democratic Republic of Congo (DRC) -. Translators without Borders. Accessed November 30, 2022. https://translatorswithoutborders.org/language-data-for-the-democratic-republic-of-congo-drc/
20. Fragile hopes of peace in DRC's conflict-scarred Ituri province. Accessed November 30, 2022. https://www.aljazeera.com/features/2020/9/28/fragile-hopes-in-dr-congos-ituri-province-scarred-by-conflict
21. Congolese Refugee Health Profile | CDC. Published March 26, 2021. Accessed November 30, 2022. https://www.cdc.gov/immigrantrefugeehealth/profiles/congolese/index.html
22. Ainamani HE, Elbert T, Olema DK, Hecker T. Gender differences in response to war-related trauma and posttraumatic stress disorder – a study among the Congolese refugees in Uganda. *BMC Psychiatry*. 2020;20(1):17. doi: 10.1186/s12888-019-2420-0
23. Piwowarczyk L, Bishop H, Yusuf A, Mudymba F, Raj A. Congolese and somali beliefs about mental health services. *Journal Nerv Mental Dis.* 2014;202(3):209-216. doi: 10.1097/NMD.0000000000000087
24. Bapolisi A, Maurage P, Pappaccogli M, et al. Association between post-traumatic stress disorder and hypertension in Congolese exposed to violence: a case–control study. *Journal of Hypertension.* 2022;40(4):685-691. doi: 10.1097/HJH.0000000000003061
25. Greene MC, Ventevogel P, Likindikoki SL, et al. Why local concepts matter: Using cultural expressions of distress to explore the construct validity of research instruments to measure mental health problems among Congolese women in Nyarugusu refugee camp. *Transcult Psychiatry.* Published online September 16, 2022:13634615221122626. doi: 10.1177/13634615221122626
26. O'Callaghan P, McMullen J, Shannon C, Rafferty H, Black A. A randomized controlled trial of trauma-focused cognitive behavioral therapy for sexually exploited, war-affected congolese girls. *J Am Acad Child Adolesc Psychiatry.* 2013;52(4):359-369. doi: 10.1016/j.jaac.2013.01.013
27. Jung S, Kim EJ. Association of Refugees' Knowledge of Mental Illness and Their Attitudes Toward Mental Illness. Asia Pac J Public Health. 2021;33(1):117-120. doi: 10.1177/1010539520968457
28. Kronick R, Jarvis GE, Kirmayer LJ. Refugee mental health and human rights: A challenge for global mental health. Transcult Psychiatry. 2021;58(2):147-156. doi: 10.1177/13634615211002690 2.
29. Johnson K, Scott J, Rughita B, et al. Association of Sexual Violence and Human Rights Violations With Physical and Mental Health in Territories of the Eastern Democratic Republic of the Congo. *JAMA.* 2010;304(5):553-562. Doi: 10.1001/jama.2010.1086.
30. *The War Within the War: Sexual Violence Against Women and Girls in Eastern Congo*. Human Rights Watch; 2002. Accessed November 30, 2022. https://www.hrw.org/report/2002/06/20/war-within-war/sexual-violence-againstwomen-and-girls-eastern-congo
31. Torture and impunity widespread in DRC's conflict areas – UN report.

OHCHR. Accessed November 30, 2022. https://www.ohchr.org/en/press-releases/2022/10/torture-and-impunity-widespread-drcs-conflict-areas-un-report

32. Lugova H, Samad N, Haque M. Sexual and Gender-Based Violence Among Refugees and Internally Displaced Persons in the Democratic Republic of the Congo: Post-Conflict Scenario. *Risk Manag Healthc Policy*. 2020;13:2937-2948. doi: 10.2147/RMHP.S283698
33. Harvard Trauma Questionnaire | Harvard Program in Refugee Trauma. Accessed December 11, 2022. https://hprt-cambridge.org/screening/harvard-trauma-questionnaire/