WORLD HEALTH ORGANIZATION

SEXUAL GENDER-BASED VIOLENCE AND HEALTH FACILITY NEEDS ASSESSMENT

(MONTSERRADO AND BONG COUNTIES) LIBERIA

By

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DATE: SEPTEMBER 6 - 21, 2004

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Introduction

1. Problem Statement

During Liberia's conflicts, women and girls were subjected to specific forms of violence and abuse, whether they remained in the communities or fled as internally displaced people (IDP) or refugees. It has been reported that members of the fighting forces were the main perpetrators (International Rescue Committee (IRC), 2004)

According to various reports (International Rescue Committee, op.cit.), an estimated two -thirds of the women were subjected to violence during displacement. These acts of violence include random acts of sexual assault, mass rape, sexual slavery and exploitation.

Sexual violence can have serious physical, social, and psychological consequences on the well-being of survivors, families and communities. The exact magnitude of sexual violence against women in Liberia remains to be established. Data on Gender-Based Violence is scarce and very difficult to obtain.

There are some organizations, both national and international, who are involved in sexual gender-based violence (SGBV) control activities; but few have the knowledge, skills and capacity to provide emergency response to survivors of SGBV.

With the collaboration of World Health Organization (WHO) and the support of the Finnish Government, an initial situational analysis in Montserrado and Bong counties was requested with the following issues to be elicited:

1. What is the magnitude of SGBV in Montserrado and Bong counties?
2. What are the consequences of SGBV on the survivors' health?
3. What are the needs of selected health care institutions addressing SGBV in Montserrado and Bong counties?
4. What are the existing coordination mechanisms among the organizations involved in SGBV in the two counties?

2. Objectives

a. General objective

To obtain database or data foundation to develop strategies that can alleviate the scope and extent of women suffering from SGBV.

b. Specific Objectives

- Determine the magnitude of SGBV in Montserrado and Bong Counties.
- Identify the consequences of SGBV on the survivors' health.
- Identify the needs of selected health care institutions and psychological services to give quality care to SGBV survivors and GBV in general.
- Identify existing coordination mechanisms between the organizations involved in SGBV.
- Provide recommendations for next steps and future actions.

In doing this study the researcher hopes to provide database for training of trainers in the clinical management of survivors of SGBV (medical and psycho.social support), supplying equipment and essential drugs to selected health facilities, organizing sensitization and information campaigns for SGBV survivors and communities, and organizing advocacy campaigns at local, national and international levels.

Definitions

For this study, the investigator used the following standard definitions contained in the Reproductive Health Response in Conflict (RHRC) manual:

2.1 Gender refers to the culturally expected behavior of women and men based on roles, responsibilities, attitudes and values ascribed to them on the basis of their sex.

2.2 Gender-Based Violence (GBV): any harm that is perpetrated against a person's will, and the results from power that are based on gender roles. GBV highlights the relationship between women's surbordinate status in society and their increased vulnerability to violence. In this study, gender-based violence is the synonym of violence against women. The focus is on women.

2.3 Survivor, in this study, is a woman or girl who has experienced sexual violence or other acts of violence.

2.4 Perpetrator, assailant or assaulter is a person or group that inflicted sexual violence or other acts of violence on another person (women) against her will.

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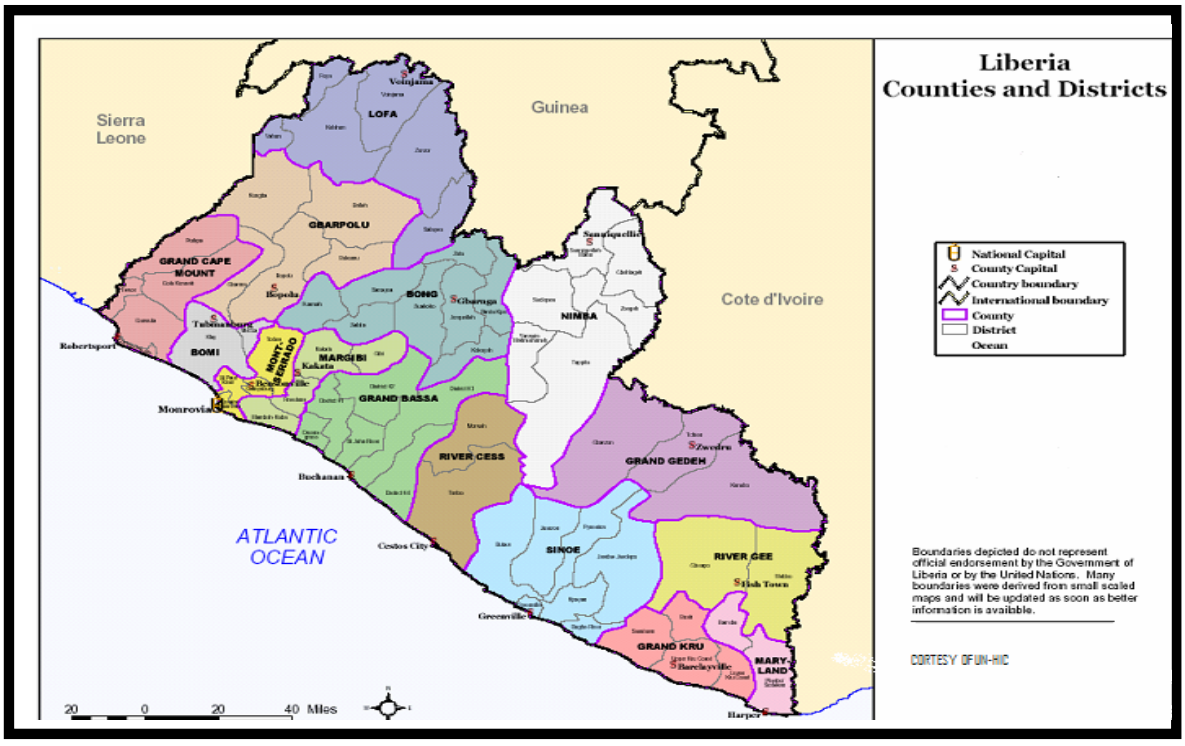
II. Description of Study Setting

Liberia is located in West Africa with a land area of thirty-eight thousand square miles (38,000 sq.miles). Sierra Leone is on the west border of Liberia; Guinea on the north; Ivory Coast on the east and the Atlantic ocean in the south. It is divided into fifteen (15) administrative divisions called counties. The counties are the largest functional units as compared to districts. The counties are further sub-divided into districts, the districts into clans. The clans are also divided into chiefdoms; and the clans contain towns and villages.

Figure 01: Map of Liberia.



In terms of demographic data, the total estimated population is three (3) million, with women and children constituting more than 45%. It is a relatively young population. Approximately 48% of the household population is aged less than fifteen (15) years. The older age group, 65 years and above, is

about 3.4%. The civil crisis led to mass forced migration in and out of the country. Most of these people are still in IDP camps in some of the counties.

Liberia has one of the fastest growing populations in Africa. The growth rate is estimated at 2.6% and the total fertility rate at 6.7%. However, maternal, infant and under-five mortality rates are also high, approximated at 780/100,000, 134/1000 and 117/1000 live births respectively. Contraceptive prevalence rate is estimated at 12.9% nationally (Health Situation Analysis, 2002).

Access to health care is about 10%. The major factors for this poor access include brain drain, damaged/destroyed health infrastruture, poor road conditions, lack of essential drugs and supplies, and prolonged delay in the payment of salaries in the public sector. Consequently, there is migration of health workers from the rural areas to the urban areas, especially in Monrovia, the political and industrial capital of Liberia.

The Liberian economy collapsed during the civil crisis. It consists of large traditional/informal sector and a small modern formal sector. The traditional sector is mainly agrarian and subsistence in nature and accounts for about 70% of the labour force. Output from this sector is low because of poor production techniques. Most farmers rely on rudimentary traditional hand made tools. The inadequate road network further stalls the sale of farming products, worsening the already poor economic status of the population. Employment opportunities are relatively scarce in Liberia. As a result, the informal sector accounts for a significant portion of the active labour force in the Country. The major economic activities of this sector include petty trading, currency exchange and other small service businesses. This is currently the most important primary source of income earning for household heads.

Generally, literacy rate is very low. There is gender imbalance as well. Illiteracy rate is estimated to be as high as 63%, with 73% of females being illiterate as compared to 50% of males. Furthermore, there is also urban-rural disparity. Approximately only 25% of rural inhabitants are literate, compared to 61% of urban inhabitants. The gross school enrollment ratio is calculated at 68% for males and 57% for females.

This study was conducted in two counties, namely, Montserrado and Bong. These two counties account for (1.3M) of the population. *The estimated population of Montserrado County is over one million as Monrovia, the capital city, currently has close to a million inhabitants. Bong County has approximately 300,000 inhabitants.* According to the World Food Programme (WFP) (2003), Liberia counted 365,800 IDP camps distributed among the 15 counties. Montserrado and Bong counties represent 74% of them. NGOs provide the mainstay of relief and other services to the residents of these camps. Notwithstanding, adequate security remains a critical issue in these camps. Gender-based violence often occur; and there are no adequate means of addressing these issues when they do happen.

There is also gender inequality when it comes to decision making in Liberia. Most decision making at the household level is considered to be the right of males in the society. However, a Ministry of Gender and Development has been established to address and mainstream gender issues in development programmes. These efforts by the Government are stregthened through partnerships with relevant stakeholders in and out of the country. Important stakeholders include Government representing the public sector, the Chamber of Commerce representing the private sector, women and youth groups, the Inter-Faith Religious council, professional bodies and interest groups, and NGOs.

At the moment, the country is gradually recovering from the effects of the civil crisis. There is a huge presence of international peace keepers deployed nearly throughout the country. They provide security support to the transitional government put in place about two years ago.

Liberia has a presidential form of government with three branches: an Executive Branch headed by the President, a Legislative Branch headed by the Speaker of the House and the Judicial Branch headed by the Chief Justice. The government is decentralized to the counties. The county governments are headed by County Superintendents.

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III. Methodology

This study is a descriptive study that used three study units: SGBV survivors in the selected communities and IDP Camps; selected functional health facilities in Montserrado and Bong Counties; and selected NGOs involved in SGBV.

- Two selection strategies were used to select SGBV survivors in the community: key informant approach (the snowball sampling) and the random sampling. The key informants were women group leaders, TBAs, etc. These individuals acted as informants and identified other women and girls in their respective communities for inclusion in the study. At least 40 women, per interview day, were later randomly selected for inclusion in the study sample.

- The communities which were accessible to the investigators and the most populated IDP camps were randomly selected: ten communities and two IDP camps for Montserrado and five communities and two IDP camps for Bong County.

- The sampling criteria for inclusion in the study were: a woman or a girl who is a survivor of sexual gender-based violence; who accepts voluntarily to participate in the study; who speaks English or any of the Liberian languages; and who can communicate and respond to questions.

- A triangulation of three methods of data collection was used: personal interviews, focus–group discussion and the use of existing records and available data. In total, four hundred and twelve women and girls were interviewed. Three hundreds and nine (75%) were selected in the communities. One hundred and three (25%) were from IDP camps. Three adapted checklists were used to collect data from two referral hospitals, seven health centers and some NGOs through the interagency committee. One cheklist: "Checklist of Supplies for Clinical Management of Rape Survivors", was taken from WHO/UNHCR (2002) manual on clinical management of survivors of rape.

    1. Personal interviews were organized with: a) the head of health facilities and local or international NGOs using checklists, b) the women in the community using the interview guide. The interview guide is an adaptation of the gender-based voilence tools from the RHCR Consortium, 2004.

    2. Focus-group discussions with fifteen to twenty women in the community and IDP camps were conducted. In total, ten focus-group sessions were held using the discussion guide. The homogeneity of the group in relation to age was respected in

order to get a more homogeneous profile of participants within the groups (children, women of childbearing age and old women). The discussions took place in quiet and private places chosen by the participants themselves. The seats were arranged in a circle to encourage participation and interaction. Most of the respondents were communicative and willing to answer questions openly during face-to-face interviews.

3. Existing records and available data Medicins Sans Frontieres/Belgium and International Rescue Committee and from health facilities were also used.

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- The content validity was done by a jury of experts in the domain of women's health; and the instruments were reviewed and adapted accordingly.

    - The original instrument was in English. It was translated into Liberian English during the training of interviewers. A bilingual health professional reviewed both versions for accuracy of the translation prior to the pilot study.

- A pilot study to assess the adequacy of the measurement instruments, the feasibility of the project and the obtaining of information for improvement was conducted in Montserrado. Fifty women and one health facility who have the same characteristics as the study participants, participated in the pilot study. The instruments were reviewed accordingly. The results displayed guidance for the conduct of the study itself. Indeed, the random sampling was introduced after the snowball sampling. The researcher did not expect to have more than two hundred participants in the selected community, because of the culture of silence surrounding the rape event.. It was difficult to conduct two focus-group discussions and two hundred interviews in one day. The research then randomly selected 30-50 women per daily interview. All the teenagers and adolescents who volunteered to participate in the study were all interviewed. The interviews in the community were held in a private place chosen by the women and the key-informant between 10:00 AM and 4:00 PM. Field notes were written by interviewers during and after each group discussion and individual interview.

    - The data collection was done from 06 – 21 September 2004 by trained interviewers from the Ministry of Health and the principal investigator. The total time per interview ranged from 35-45 minutes, with a mean of 37.5 minutes.
    - For this study, willingness to be interviewed was evidence of consent.

- Quantitative data were coded, checked and processed, cleaned and analyzed using Epi-Info and Microsoft Excel Softwares. Content analysis was used for documentary data and thematic analysis for qualitative data. Checklist data were tabulated quantitatively, and content analysis was then done.

- Findings are limited and generalized only to Montserrado and Bong Counties.

    - There is a limitation because of the use of convenient sampling.The study was limited to women who came voluntarily to the place where interviews were conducted. They were selected by convenience sampling. Selection bias might have been introduced.

The random sampling was used to select thirty to fifty (30-50) participants per day to minimize selection bias.

- There is also limitation because of the geographical accessibility and poor road network in Bong County. Indeed, the data in Bong County were collected within the communities which were accessible to the researcher.

- Security situation necessitated limited and restricted circulation.

- Time constraint (rapid assessment) did not allow the review of related litterature.

- Another limitation was recall bias. The interviews that took place long after the episode had occurred can introduce recall bias (Winikoff, 1981). SGBV survivors' status and physical, social, psychological and economic problems were judged on the basis of women's responses to the interviews. However, no attempt was made to validate the accuracy of women's responses, because of time constraints and especially because of the sensitivity of the topic under study. To minimize recall bias, the researcher used the list containing different types of violence by specific acts developed by RHCR Consortium (2004, op.cit). According to the author, that list helps women recall experiences that might be difficult to recall during the interview. In addition, it helps to reduce the likelihood that women will not report certain types of violence because their culture does not define them as acts of violence.

- The results of this study however give indications of the present SGBV trends in both counties.

IV. Results and Discussion

A. Community Assessment Results

1. Socio-Demographic Data.

a. Age of the Respondents

Table 1: Distribution of the Respondents per Age

Age Group in Full Year	Frequency		Total	Percentage
	Monsterrado	Bong		
<18	32	43	75	18.2
18-44	180	124	304	73.8
45 and above	20	13	33	8.0
Total	232	180	412	100.0

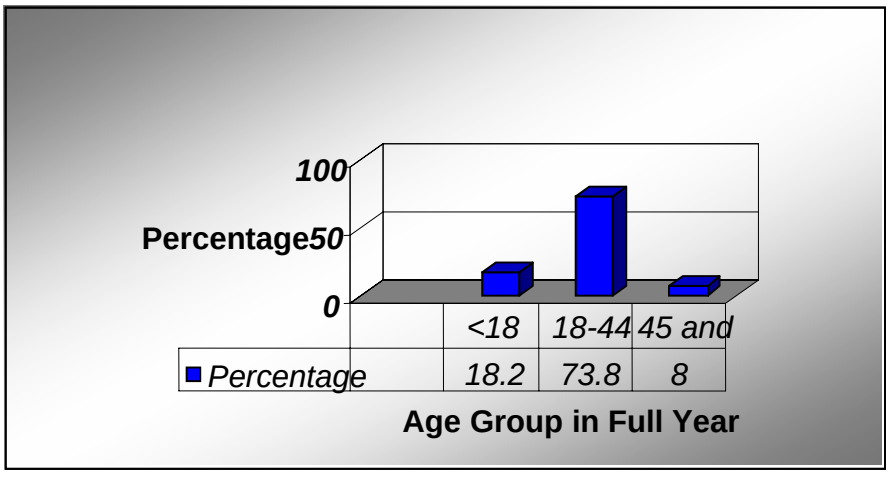

Figure 1. Total Age Distribution for Montserrado and Bong Counties

The age of the respondents ranged from ten to sixty-five (10-65) years, with a mean of 30.8 years for Montserrado County and 30.2 for Bong County.

About eighteen point two percent (18.2%) of the respondents are less than eighteen years old, while 8.0% are forty-five years and above. The respondents that are between the ages eighteen and forty-five years represent 73.8% of the samples. Those less than fifteen years old make up 11.4% of the subjects. According to Liberia Demographic and Health Survey (1999/2000), rape at such premature ages generally lead to tearing and scaring of the vaginal walls, which can have repercussion on the reproductive health of the girl. Furthermore, Human Rights Watch (2002, P.4) quotes the U.S National Institutes of Health, National Institutes of Allegergy and Infections Disease as saying: "the protective vaginal secretions are normally present during willing sexual intercourse unlike in the case of rape". The lining of the genital tract of the girl who has not completed puberty has yet to take on its adult character. Girls are particularly vulnerable. The probability of perforation of the uterus, vesico vaginal fistula and recto vaginal fistula, uninary tract infections, sexually transmitted infections including HIV/AIDS *is high.* Sexually transmitted infections contracted at this age entail a greater risk of permanent damage, such as infertility or ectopic pregnancy later in life.

As regards the 45 years old and above, the rape of an old aged woman after menopause can lead easily to uterus prolapse. One old woman confided:

> I was raped roughly by two boys about the age of my grand son. One year after, I haven't got over it. I am sick. Some thing is coming down there. I don't have money. I don't know what to do.

b. Education

Table 2.: Educational Attainment

Educational Attainment	Frequency		Total	Percentage (round off)
	Montserrado	Bong		
No education	105	128	233	56
Elementary	80	34	114	28
Jr. High	22	10	32	8
Sr. High	22	8	30	7
College	3	0	3	1
Total	232	180	412	100.0

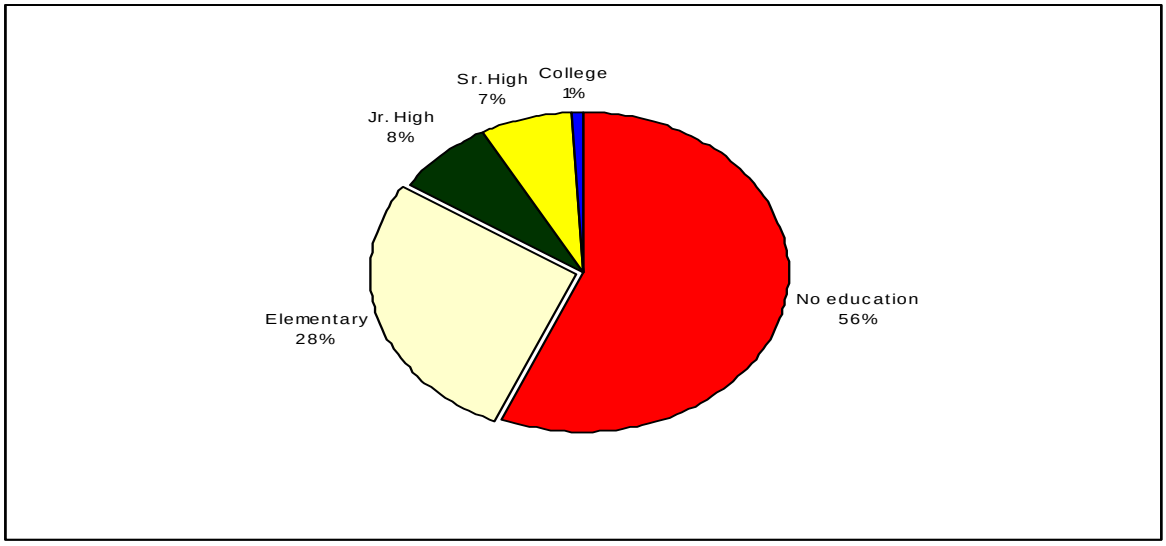

Figure 2. Percentage of Study Participants According to Educational Attainment

Table 2 summarizes educational attainment of the sample. Fifty-six point five percent (56%) of the respondents did not go to school. Twenty-eight percent (28.%) of the respondents attained elementary education; 8% attained junior high school education; while 7% attained senior high school education. Only one percent (1%) of the total sample was going to college at the time of the conflict.

The illiteracy rate (84.9%: no education and elementary combined) is high among the respondents. It is known that education opens possibilities for understanding and seeking solutions for health. Health education must be adapted accordingly. The use of Liberian English during the awareness campaign will help get the message across to the target population.

C. Religious Affiliation

Table 3: Religious Affiliation

Religion	Frequency		Total	Percentage (round off)
	Montserrado	Bong		
Christians	202	170	372	90
Muslims	30	10	40	10
Total	232	180	412	100.0

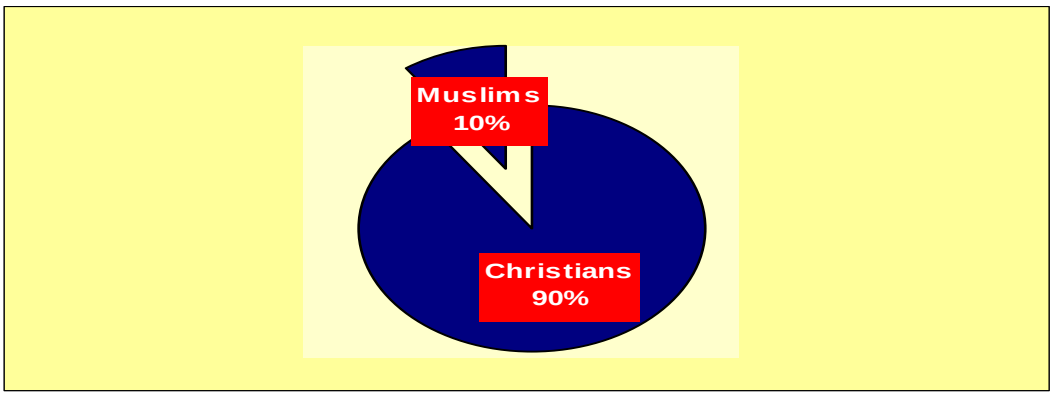

Figure 3. Religious Affiliation

This table shows that the majority (90%) of respondents reported themselves as Christians. Muslims represented only 10% of SGBV survivors in the sample. This predominance can be explained that Liberia is a predominantly Christian country. About 90% of the urban population in Liberia is Christian according to Liberia Demographic and Health Servey (op.cit.). Another explanation is that the mobilization of women and girls in the communities was done by convenience sampling. This could have introduced selection bias. The number of Muslim women and girls is low. That does not mean that Christian women were targeted. Maybe, Muslim women and girls did not want to expose themselves by coming for interview. SGBV and GBV during the conflict concerned all women and girls, regardless of age, tribe, marital status, religion, occupation, and so on.

Religion can affect an individual's attitude towards sex. For Muslims, the chastity and virginity of women are very important. Experience of sexual engagement before marriage is devastating for the family. In this study, Muslim girls devoted time to explaining about someone (a cousin, neighbour or sister) who had had similar experience rather than outrightly disclosing their own experiences. Most of them said that nobody, except their family, knows about what happened to them.

d. Marital Status

Table 4. Marital Status of the Study Respondents

Marital Status	Frequency # 412		Total	Percent (round off)
	Montserrado	Bong		
Single	92	44	136	33.0
Married	71	71	142	35.0
Divorced	47	49	96	23.0
Widow/Widower	22	16	38	9.0

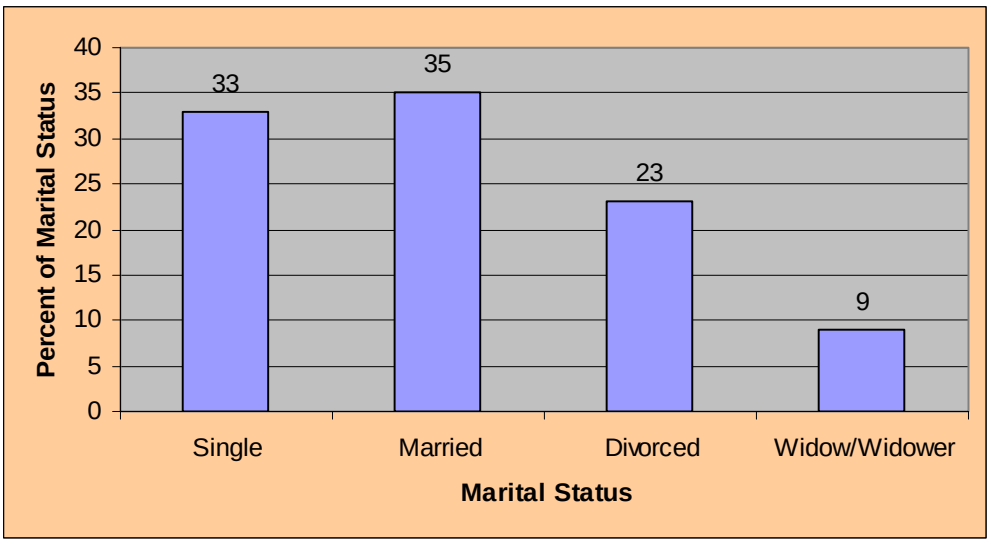

Figure 4. Marital Status

This table shows that the majority (35.0%) of the respondents are married, while 33.0% of them said they were single; and 23.0% of subjects were reported to be either separated or divorced. Widow (38 cases) account for 9.0% of the respondents. Twenty-seven out of 38 survivors (71%) lost their spouses during the conflict.

e. Parity

Table 5: Parity

Parity	Frequency		Total	Percent
	Montserrado	Bong		
0	58	39	97	24.0
1	27	49	76	18.0
2	86	33	119	29.0
More than 3	61	59	120	29.0
Total	232	180	412	100.0

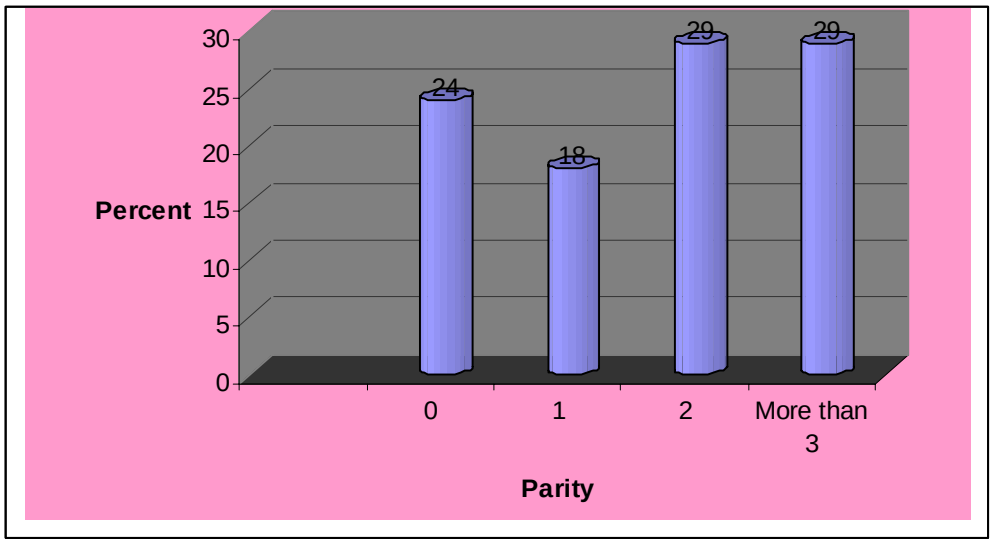

Figure 5. Parity

This table indicates that 24.0% of the respondents have no children. About 18.0% have a child; 29.0% have two children, while 29.0% have between three to ten children.

According to Liberia Demographic and Health Survey (op.cit), the nature of rape in Liberia will have serious consequences and implications for the reproductive health of women affected by it at the reproductive age. It might negatively affect SGBV survivors' fertility with the onset of sexually transmitted infections.

For some women with children, because of the health consequences of the rape, they are too weak and ill to work and take care of their children,especially the very young ones.

F. Ethnic

Table 5.0: Ethnic Group of the Study Respondents.

Tribe	Bong	Montserrado	Total	%
Bassa	3	36	39	9.5
Belleh	2	0	2	0.4
Congo	0	5	5	1.2
Gbandi	12	12	24	5.8
Gbie	1	0	1	0.2
Gio	1	10	11	2.7
Gola	2	23	25	6
Grebo	0	12	12	2.9
Kissi	4	21	25	6
Krahn	0	1	1	0.2
Kru	0	37	37	8.9
Kpelleh	103	28	131	31.8
Lorma	43	17	60	14.6
Mandingo	1	2	3	0.7
Mano	2	5	7	1.7
Mende	0	2	2	0.4
Vai	6	21	27	6.5
Total	**180**	**232**	**412**	**100**

Table 5.0 presents the ethnic groups of the study respondents. The ethnic composition of the sample reflects Liberians' great tribal diversity. Montserrado as cosmopolitan county, offers the advantage of being representative of the different ethnic groups of Liberia.

The location of Monrovia explains the predominance of Bassa. The Bassas are in Margibi and Grand Bassa counties, close to Montserrado county. The three counties have good transportation and relatively good roads; so there is a free flow of the populace between the three counties. Grand Bassa is two to three hours' drive away from Montserrado; and Margibi is one-hour drive away from Monrovia.

2. Variables Related to the Study

A. Community Assessment

1. Types of Acts of Violence Reported by the Respondents

A total of four hundred and twelve (412) women and girls were interviewed; and focus group discussions were conducted in both counties (Montserrado and Bong). Table 6 describes the different types of acts of violence respondents reported to have been subjected to.

Table 6: Description of Types of Sexual Violence Experienced by the Participants

N = 412

TYPE OF SEXUAL VIOLENCE	Montserrado	Bong	Total	Percent
Slapped or hit	83	109	192	50.5
Choked	34	63	97	25.5
Beaten or kicked	90	119	209	55.0
Tied up or blindflolded	54	48	102	26.8
Threatened with a weapon of any kind	153	140	293	71.1
Shot at or stabbed	43	19	62	8.4
Deprived of food water or sleep	124	107	231	60.8
Experienced physical disfigurement of the body	59	29	88	23.2
Detained against your will	161	126	287	75.5
Forced to remove or stripped of your clothing	165	138	303	79.7
Given internal body cavity searches	89	72	161	42.4
Subjected to unwanted kissing	51	79	130	34.2
Touched on sexual parts of your body	177	120	297	78.1
Beaten on sexual parts of your body	69	78	147	36.7
Forced or threatened with harm to make you give or receive oral, vaginal and anal sex	157	137	294	77.4
Penetrated with an object in your vagina or anus	65	34	99	26.0
Compelled to engage in sex in order to receive something such as food, water, protection for your family or other reasons	58	66	124	32.6
Forced to watch someone being physically assaulted	147	92	239	62.9
Forced to watch someone being sexually assaulted	110	83	193	50.8
Subjected to improper sexual comments	133	96	229	60.3
Forced to cook, eat (with the whole family), and sell the husband's or son's body part	3	0	3	0.7

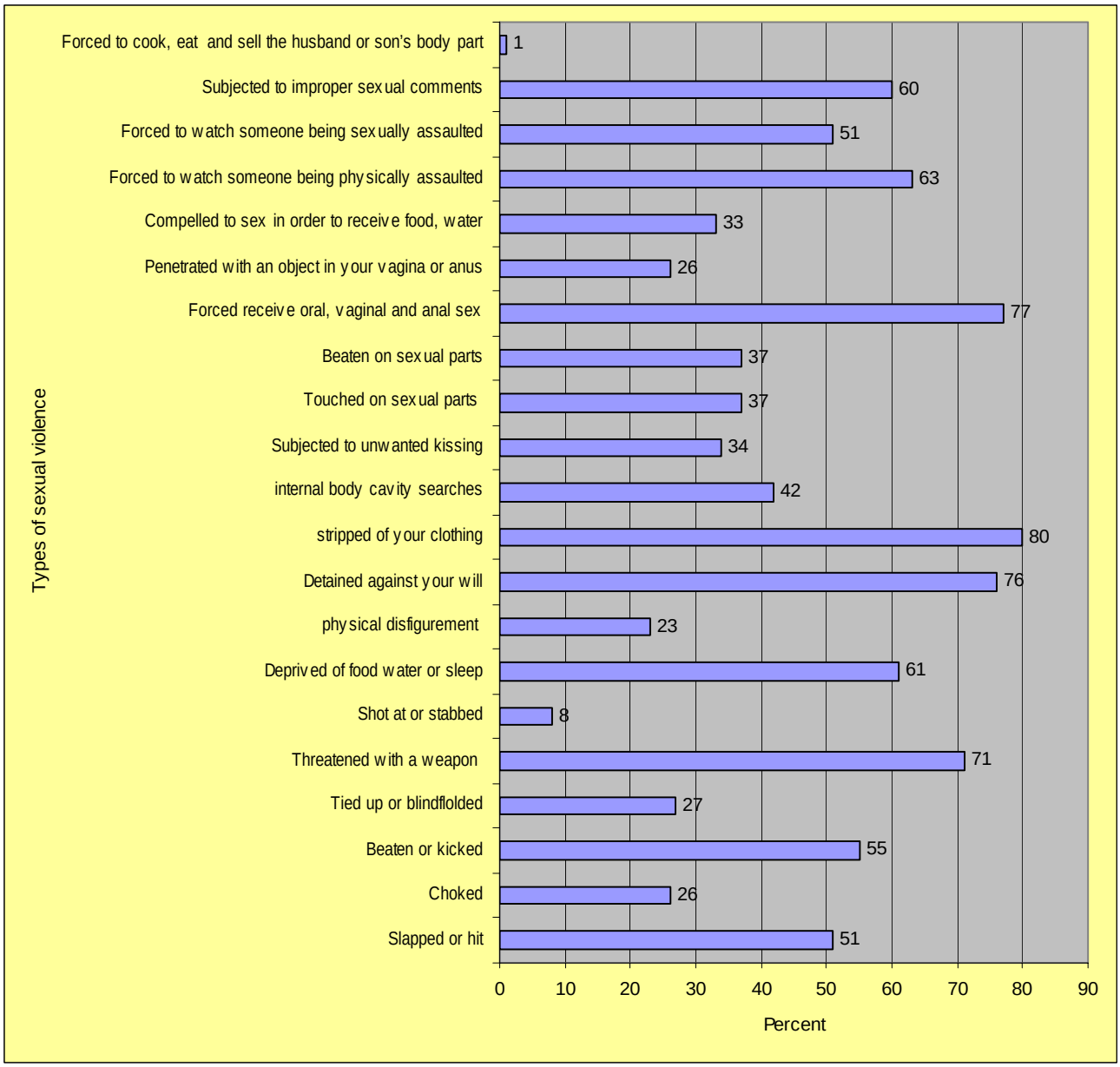

Figure 5: Types of Sexual Violence (round-off percentage)

It emerges from table 6 that all the respondents (100%) reported that they had been subjected to multiple violent acts during the conflict.

The most commonly reported incident of physical assault was being forced to remove or stripped their clothing (79.7%); followed by being touched at sexual parts of the body (78.1%).

Rape, during the conflict, was experienced by 77.4% of respondents; of this number ,seventy one point four percent (71.4%) were respondents from the communities and 28.2% IDP camps respondents. Out of the total rape cases, 64.1% were gang rape committed by multiple perpetrators. In the case of gang rape, the victim was tied up with both legs opened; or held by gang members, family or someone else present at the time and place of crime. Gang members were raping the victim, one by one, until the last member was done. One hundred and forty-six (35.9%) were raped by one assailant per victim.

In total, 283 respondents (68.7%) admitted having a female family member who had also been raped during the conflict. Some female family members (mothers and daughters) were raped during the same incident. Respondents reported being raped between 1990 and February, 2004. A vast majority of the rape cases 288 (69.9%) took place in 2003 during the so-called "Tthird World War".

Forty-two point five percent of the respondents were raped by more than two assailants. Twenty-one point six percent (21.6) were raped by two assailants while 35.4% were raped by one assailant. Gang rape was the most traumatic and humiliating assault experienced by SGBV survivors.

In some cases, two to three assailants were raping the victim at the same time, with one being in the mouth and another in the vagina or anus. The victim was placed in a dairy cow position. During the rape and especially during internal body cavity searches (42.4%), the victims were also subjected to improper sexual comments. One victim said:

> They put their sex in my mouth. I was suffocating. I felt as if I was dying. It was nauseating too and they were insulting me at the same time. Until now, I feel as if something is in my throat.

Concerning body cavity searches, one of the victims stated:

> We were fleeing to another peaceful place and fell into an ambush. All the women were given internal body cavity searches (was mostly done by soldiers). They were manhandling us, putting their fingers roughly inside the vagina looking for money. Many of us bled a lot. From then I usually experience pain during sexual intercourse.

International Rescue Committee (IRC) (2004) stated that one occurrence of sexual assault may be sufficient to create long-lasting effects, especially if the survivor does not receive appropriate support.

Many women also reported having experienced multiple rapes by all forces, who captured a town or a village where the population took refuge.

Concerning anal sex, one of the victims confided:

> I didn't know that sex can be done like that. It was so painful. It is now like it is all opened there. I don't feel like before when stools are coming out.

Three women representing 1% of the total sample, in separate incidents, were raped and forced to cook, eat and sell their husband's or son's dead body. One woman whispered to us her story:

> My son was killed by a group of rebels and the body was cut into pieces and put into a wheelbarrow. They (rebels) gave it to me for sale. I did it because I was afraid to be cut to death.

Another added:

> The soldiers cut my husband's head off after he witnessed powerlessly them raping me. After they cut him into pieces, they put the pieces in the pot and asked me to cook it. After cooking, they forced us to eat. I am not any more the way I was before.

Many of the victims were forced to watch them assault physically and sexually their family members (father, mother, brother or sisters). Some were forced to laugh or dance during the killing of a parent or husband. How really can someone, after going through a rough rape, seeing powerlessly right infront of her the killing of a husband, a father, a son, a mother or all of them, cope with life?

Twenty-six percent (26.0%) of the victims had also brutally been penetrated with objects such as a corn stick, wood stick, barrel of a gun, raw cassava root and flashlight batteries, into the vagina or anus.

One victim reported:

> They asked me to bend on a cut tree trunk and open my legs. They tied both legs up and inserted the barrel of the gun into my anus saying: "you are not worth our sex". Oh! My God… (silence)… It was so, so painful. I blackout. They left me there bleeding. I am sick, I haven't got any help.

Forty-eight point five percent (48.5%) of the respondents in both counties had experienced abduction for one day to three years. The majority of abducted participants (38.1%) were abducted for one week. Abducted women and girls were taken as wives (forced cohabitation) of rebels to provide sexual services and domestic work such as cooking, cleaning, washing… Many of them declared "being tied up with legs open and raped continously by multiple assailants during the abduction period".

What was also more humiliating, in addition to the sexual violence they were subjected to, was the fact that the victims had to beg to engage in sex in order to receive food, water or to protect their families.

One respondent said:

> Before giving me food, I had to first suck his penis and let myself be raped.

2. Health Consequences of Acts of Gender-Based Violence

Information contained in this section was compiled from individual interviews, focus-groups and some existing records from various organizations involved in SGBV.

Thematic analysis identified three categories of SGBV consequences: Physical, Psycho-social and Economic consequences. The information derived from data shows that all the respondents (100%) reported experiencing some ailments and difficulties after being sexually assaulted. Most of the acts of gender-based violence (73.1%) were committed between June and August 2003.

a. Physical /Health Consequences.

There is a range of physical/health consequences resulting from the assault (Table 7). This table shows that the majority (93.5%) of the respondents reported suffering from one or multiple outward symptoms at the same time. Only 6.5% of the total sample declared not having any physical problem related to rape or any other SGBV related problem at the time of the interview.

Table 7 Distribution of Physical/Health Consequences Experienced by the Studied Respondents.

N = 412

Consequences	Montserrado	Bong	Total	Percent
Lower abdominal pain	140	190	330	80.8
Vaginal discharge (smelling)	163	201	364	83.3
Vaginal discharge (watery)	48	45	93	22.6
Vaginal discharge (stool)	32	5	37	16.7
Amenorrhea without pregnancy	45	30	75	18.2
Scars from beating	102	130	232	56.3
Dysmenorrhea	89	68	157	38.1
Irregular menstruation	63	90	90	37.1
Epigastric pain	61	79	140	33.9
Backache	145	163	308	74.7
Uterine prolapse	9	12	21	5.0
Generalized pain	30	36	66	16.0
Vagina itching	179	176	355	86.1
Sores in genital areas	121	130	251	60.9
Ear impairment	1	4	5	1.2
Pregnancy after rape	24	31	55	13.4
Abortion after rape	12	10	22	5.3
Bleeding from vagina	4	25	29	7.0
Dyspareunia	63	89	152	36.9
Asthenia	15	21	36	8.7
No problem	7	20	27	6.5

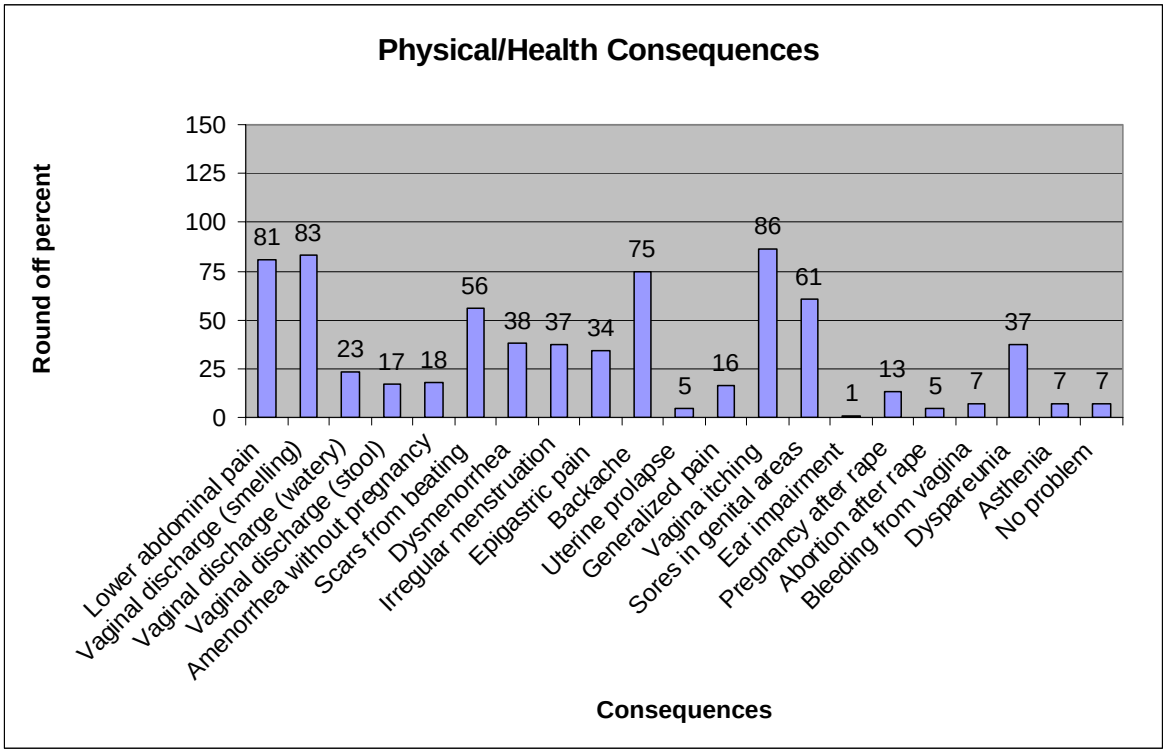

Figure7. Physical Health Consequences (round-off percentage)

These data show that the most visible symptoms the respondents reported experiencing are: vaginal itching (86%), smelling vaginal discharge (83.3%), lower abdominal pain (80.8%), backache (74.7%) and sores in the genital areas (60.9%). The respondents were experiencing multiple symptoms at the same time.

The other signs, in spite of its low percentage, are yet significant. These signs are: dysmenorrhea (38.1%), irregular menstruation (37.1%), dyspareunia (36.9%), watery vaginal discharge: urine (22.6%), amenorrhea without pregnancy (18.2%). Vaginal discharges: stools (16.7%), uterus prolapse (5.0%,) and bleeding from vagina (7.0%).

It can be inferred from the data, that SGBV survivors who participated in the study have serious physical health problems including symptoms of sexually transmitted infections (STI). These women require rapid access to appropriate and adequate health facilities for appropriate management of each individual's case.

Many studies had documented the health consequences of SGBV in IDP camps (IRC, op.cit.). These include sexually transmitted infections including HIV/AIDS among others, unwanted and early pregnancy, vesico-vaginal and recto-vaginal fistula, uterus prolapse, etc.

About STIs, UNHCR (1995 P. 30) stated that army recruits have been recognized as a category tending to show higher rates of STIs than the general population. In the situation of rape during armed conflict, a

high risk of STI transmission should be assumed. HIV has not yet been documented among rape survivors. This is important since the HIV status of the fighting forces is not known. In Congo, according to Human Rights Watch (2002, p 44, French version) more than 60% of fighting forces are sero-positive. HIV is then to be considered among rape survivors in order to take appropriate actions.

Between September 2003 and July 2004, Medecins Sans Frontieres (MSF) Belgium identified and treated eight hundred and twenty-seven (827) SGBV survivors. All of the patients were treated for sexually transmitted infections. These patients were between the ages of 16-35 years and accounted for sixty percent (60%) of the total sample, while those below 15 years represented seven percent (7.0%).

It has also been fully documented that sexually transmitted diseases, if not treated early, can have consequences for women and babies in the case of pregnancy; for example, infertility, puerperal infection for the women and late fetal or neonatal death.

According to UNHCR (op. cit) women who were pregnant at the time of the sexual violence are physically and psychologically more vulnerable. They are susceptible to miscarriages, hypertension and premature births.

Data from this study show that in total 13.3% of the respondents became pregnant as a result of the rape: 24 women in Montserrado sample and 31 women in Bong sample. Women who became pregnant through rape are more likely to want to abort the pregnancy. Twelve (50%) out of 24 SGBV survivors who became pregnant after the rape in Montserrado community had abortion, three (12.5%) had stillbirth; and nine (37.5%) women delivered healthy babies. In Bong, out of 31 women who became pregnant after the rape; twelve (38.7%) had abortion, five (16.1%) had stillbirth, eight (25.8%) delivered healthy babies, and six (19.3%) were still expecting at the time of the interview.

The total of 61 participants were pregnant before the rape. Break down of the participants by counties includes: 37 women in Montserrado sample and 24 women in Bong. Twenty-0ne (56.7%) of them in Montserrado sample had miscarriage as a result of rape. Five (13.5%) of the women had stillbirth and eleven (29.7%) delivered healthy babies. In Bong county, out of 24 women that were pregnant before the rape, twelve (50%) of them had miscarriage; four (16,6%) delivered stillborn; seven (29.2%) got healthy babies; and one (4.2%) girl was still expecting at the time of the interview.

b. Psychosocial Problems

Even if physical problems were minimal for some respondents, all victims of SGBV experienced in general psychological trauma. The analysis of the data related to psychological problems revealed that all of the respondents (100%) of this study admitted suffering from one or more psychological disturbances. It has been proved that distress increases when one encounters multiple stressors, and experiences them for a prolonged length of time (Rahe,1974).

Table 8: Distribution of Psychological Disturbances Experienced by Studied Participants.
N= 412

Problems	Montserrado	Bong	Total	Percent
Insomia	120	180	300	72.8
Nightmare	81	93	174	42.2
Confusion/embarrassment	140	151	291	70.6
Depression	41	56	97	23.5
Feeling of humiliation	180	197	377	91.5
Uselessness of life	45	48	93	22.6
Intrusive memories	39	59	60	14.6
Floating anxiety	60	61	121	29.4
Loss of memory	0	3	3	0.7
Sense of powerlessness	58	33	91	22.1
Sexual aversion	42	44	86	20.9
Emotional instability	26	39	56	13.6
Emotional tension	17	29	46	11.1
Feeling of guilt	43	32	75	18.2
Feeling of rejection	40	57	97	23.5
Loss of appetite	17	31	48	16.5
Migraine headache	38	24	62	15.0
Withdrawal	50	33	83	20.1
Fear and worries about the future	80	30	110	26.7
Hallucination	21	16	37	9.0
Palpitation	77	89	166	40.3
Frustration	63	55	118	28.6
Divorce	66	30	96	23.3
Muscular tension	53	10	63	15.3
Feeling of hatred	63	91	154	37.4
Sadness	50	77	127	30.8

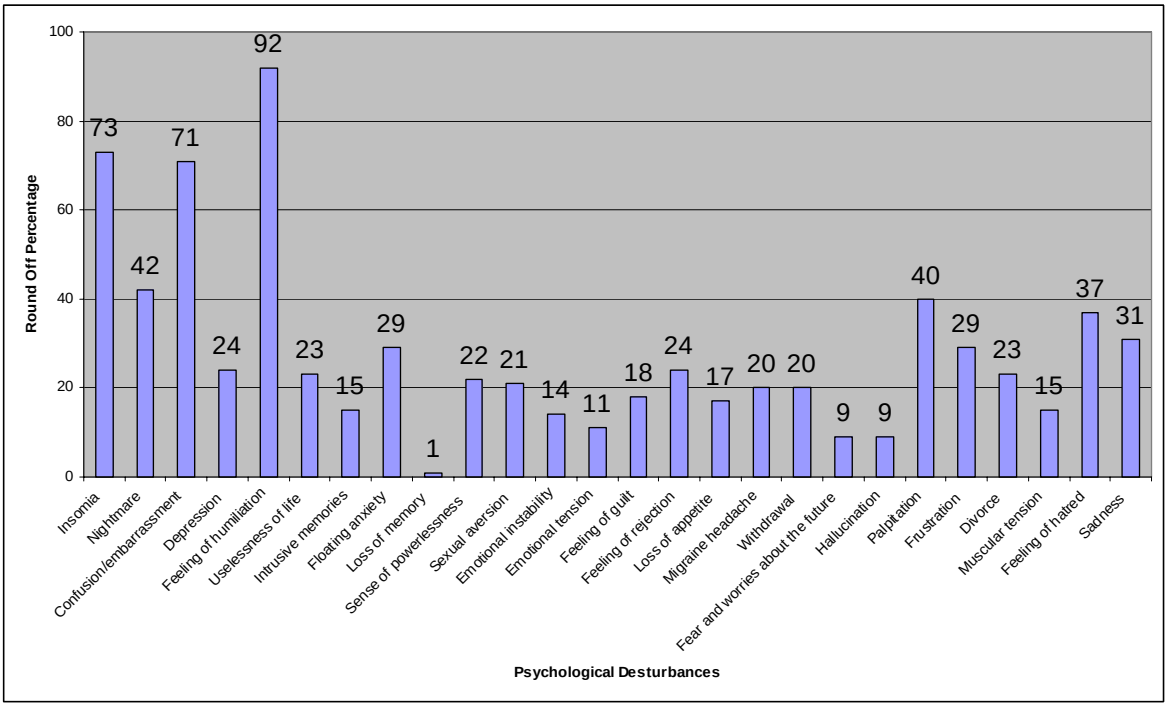

Figure8: Psychological Health Consequences (round-off percentage)

Table 8 shows psychological disturbances experienced by respondents since the rape. It can be seen that 91.5% of the respondents are experiencing feelings of humiliation. Insomnia is felt by 72.8% of the respondents while confusion and embarrassment are felt by 70.6% of subjects. Thirty-seven point four percent (37.4%) expressed feelings of hatred while sadness is felt by 30.8% of respondents. Forty point three percent (40.3%) reported having palpitation.

Other disturbances, although not highly represented among the study respondents, are still serious conditions for the person who lives with them. It is about: frustration (28.6%), fear and worries about the future (26.7%), floating anxiety (29.4%), depression (23.5%), feeling of rejection (23.5%), divorce (23.3%), uselessness of life (22.6%), sense of powerlessness (22.1%) and sexual aversion (20.9%) etc.

Many symptoms such as insomnia, nightmare, fear and worries, floating anxiety, sadness, uselssness of life, powerlessness and so on make a professional think about symptoms of post-traumatic stress disorder (PTSD).

These symptoms can be more or less severe, depending on the survivors' support networks and adequate coping mechanisms they may possess.

According to Soeren Buus Jensen (2002), some of the participants may need no treatment at all, some may recover through social support and community and family interventions, because they have minor

and moderate symptoms, while others with at least one severe mental health problem may need the help of a mental health professional. The author recommends a mental health professional or at least a primary health care professional with some special training in mental health to assess needs for treatment and/or referral of these SGBV survivors.

Concerning feeling of rejection and divorce, some men who witnessed the rape of a spouse or who were informed about the rape, either divorced or rejected the wives.

There are also some husbands and families who compelled their family member SGBV survivors, to keep silent in order to save their marriage; and /or to keep the husband's or family's name and reputation. All the respondents who said that they are still living with their husbands despite the rape, admitted that they are ill-treated by their husbands.

> My husband was forced to hold one of my legs when four men were raping me. He hadn't divorce me because he feels he participated in the rape somehow. We are not sharing the bed. He doesn't even touch me. He said that I am a whore. It pains me a lot. He goes with young women now.

SGBV has a negative effect on women as spouses and mothers. Their social and family reintegration is questionnable. Such women have to deal with the rape and the reaction of the family (husband and in-laws) and the community when the rape occurred in public; 41.2% of the respondents were raped in public, while 58.8% were raped alone in an isolated place.

Besides the physical and psychological consequences, SGBV survivors are facing the stigma from the husbands and also from the communities in which they live. When asked what was the attitude of the community towards you? More than seventy percent (70%) of them said:

> The community called down a curse on us and outcasted us. They laughed at us, they talk about us all around. Some feel sorry for you. Some will not. It depends on the way it happened. If you were wounded, you are a child (silence….).

A fifteen-(15) year-old girl who was raped by the aunt's husband, is blamed by her family.

The girl confided:

> I was sleeping at night. My aunt was away for some days to look for food at a village; my uncle (aunt's husband) got inside the children's bedroom; put his hand hardly in my mouth and raped me. Nobody believes my story. The uncle said I went to him and provoked him to have sex with me. And he is a man. I am now known to be the bad one.

Psychological problems become more critical if the children witness the rape. In this study, 11.0% of the respondents were raped in the presence of their children (male and female). In African culture, children are not supposed to see the nakedness of their parents. The feelings of guilt, shame and embarrassment will be gnawing away at her. Because of the stigma associated with rape in the community, those survivors who were raped in isolated places without witnesses did not disclose their

rape status. It can be said that, the community unknowingly encourages this act of silence to the detriment of its members.

The trauma may have a lifelong effect on the ability of the girls to obtain a normal sexual relationship, to engage in satisfying sex or even to form trusting relationships with males. Also, the risk of a sexually abused girl ending up in prostitution is high. In connection with sexual behavior, one respondent with worries said:

> My daughter was raped last year. She was fifteen (15)years old. Since the incident, she is all the time out sitting at street corner looking at… I don't know what. She doesn't listen to anybody. I am really worried.

One woman said:

> Look at me, I lost my dignity, I lost my possession, I lost my marriage and I lost my womanhood. Do you understand what I am going through? I lost all that I ever owned, and worked for (silence…., tears….).

Supportive interventions (social support and psychological counselling) are really required to enhance SGBV survivors coping mechanisms that will help them alleviate their problems, and give them a new sense to life.

For some SGBV survivors, sexual intercourse becomes a nightmare for them because of lower abdominal pain (80.8% of the subjects) and dyspareunia (36.9%). Other women got sexual aversion (20.9%). In this condition, what will be the future of the couple if the woman is married? If she is not, what will be the future of her reproductive health?

Eight girls interrupted schooling because of the pregnancy; and six other girls interrupted schooling because of constant mocking and stigma from school and classmates.

One 16 years old girl said:

> I was in Jr. High school. I left school because my classmates were mocking me all the time. One of my classmates wrote down on a piece of paper that I was raped, I knew sex, I am a whore and he stuck the paper on my back without my knowledge. I only noticed people pointing fingers at me and laughing. The school did nothing.

c. Economic Consequences

Most of the respondents lost all their possessions, houses, money and clothes during the conflict. The family has, from then, difficulties to perform its economic and health functions.

Women experiencing violence may have a reduced contribution to society as well as to their own potential self realization (IRC, 2004). Some respondents are chronically tired to work (asthenia: 8.7% of the respondents).

One woman said:

> *Look at me, I lost my dignity, I lost my possession, I lost my marriage and I lost my womanhood. Do you understand what I am going through? I lost all that I ever owned, and worked for.*

The economic vulnerability of the women especially girls will force them to exchange sex for goods, food, clothings, money and the like, from men who occupy a powerful and authoritative positions and business men.

3. Health Action after Assault

The analysis of survivors responses showed that all of the respondents (100%) did not seek assistance from a health professional after the assault.

All of them used and are still using warm salty water for vaginal bath and irrigation. Twenty-one point one percent (21.1%) sought help from a traditional healer or Tradittional Birth Attendant (TBA).

Seventy-eight point nine percent (78.9%) used self treatment. The results showed that for the 15.7% of SGBV survivors who later on looked for assistance from a health professional (in health center or hospital), the time between the incident and seeking health care ranged from six months to one year with a mean of 7.5 months. These findings are similar to MSF-Belgium (2004) findings. According to MSF-Belgium, the average delay between the incident and presentation to the clinic is 98.1 days for victims aged 5 to 15 years, 252.7 days (8 months) for victims aged 16 to 35 years; and 389.8 days (12.8 months) for the victims aged 36 years and over.

When asked for the main reasons they did not seek medical care:

- Two hundred and eighty respondents (67.9%) said they did not have any money.
- One hundred and ten respondents (26.7%) reported the lack of transport.
- Three hundred and forty-five of the respondents (84.9%) declared that it was because of the war.
- Two hundred and ninty-one respondents (70.6%) said because they felt so embarrassed.
- One hundred and sixty respondents (38.8%) claimed that they did not know where to go.
- Forty-five of the respondents (10.9%) thought that they would be blamed.
- Two hundred and ten respondents (50%) were afraid of further violence.
- Two hundred and fifty-four respondents (61.6% of the total cases) thought they would be stigmatized after disclosure of their rape incident.
- Sixty of the respondents (14.6% of the total cases) believed that the news would bring bad name to husband's family.

We think that lack of information about how to seek medical treatment was among the many reasons the respondents did not seek medical assistance. All these factors combined means that without intervention women's health status will remain poor. The analysis of health facility situation showed that all hospitals and health centers except Phebe Hospital provide free care (first visit, follow-up and drugs).

Consequently, the lack of money is not a significant reason for not seeking help from a health professional.

According to the responses from the focus-group, the victims did not look for medical assistance because of :

- Lack of confidentiality,
- Lack of empathy,

That characterize many health facilities. These two factors (reasons) discourage the SGBV survivors from coming forward.

The prophylactic approach recommended in these rape cases is practically impossible in such conditions. After one year of living with a sexually transmitted infection, health professionals will then be treating the infection and its complications since the SGBV survivors are sapped by illness for many months even years. These STI; particularly syphilis, gonorrhoea and chlamydia, can have long-term consequences if not treated in the early stages. It seems that survivors do not perceive the severity of their condition to take health action. All this has implications for sexual and reproductive health, and for the planning and delivery of services.

Sensitization and mobilization campaign should be organized to convince SGBV survivors to seek appropriate care from health professionals.

4. Identity of the Perpetrators

Figure 9 shows that fifty-two point two percent (52.2%) of rapes were done by armed members of fighting forces. Thirty-seven point one (37.1%) were raped by the rebels. Four point seven percent (4.7%) were raped by neighbors. Uncle, teacher, step-father, classmate and security men accounted respectively for 0.4 % each in Montserrado.One judge was reported in Bong County (0.5%).

Members of the fighting forces (89.3%) perpetrated most of the acts of violence among studied participants.

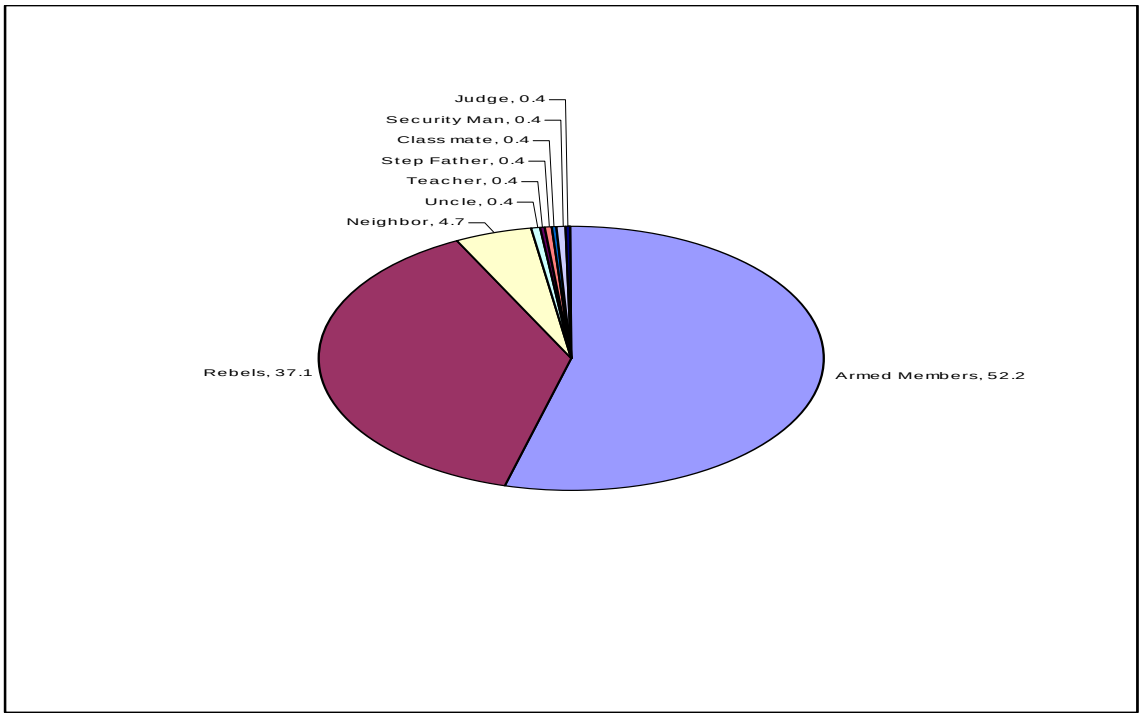

Figure 9: Identity of Perpetrators

When asked how they know that their assailants were rebels (militias) or soldiers, the respondents generally spoke of how these groups were easily identified by their attires (appearance) and behaviors. For example, they said that the rebels (militias) were easily identified by their rough and sarcastic comments, walking, braided head (plast or weaned) with no specific uniform and head usually tied up with mostly red scarf.

The girl who was raped by a classmate, was raped under the influence of alcohol. Alcohol has been shown to play a dysinhibiting role in certain types of sexual assaults . According to WHO (2002), quoting Abby, Ross and Mcduffie` (1995), alcohol has a psycho-pharmacological effect of reducing inhibitions, clouding judgements and impairing the ability to interpret cues (warning signs).

Eighty-six (20.9%) respondents were still seeing their assailants around. In one IDP Camp in Montserrado County, women said that there were posters with names of women who have been raped, placed on the wall every where with threatening words like: “Remember, I raped you the other time? I will rape you again.” With the threats, many victims are living in fear of being assaulted again.

5. Support Network

Of all the people, the family, especially the victims’mothers, (100% of the cases) were found to be the most helpful among various groups of people approached by SGBV survivors regarding their rape experience and other acts of violence against them. Women’s group followed by religious people ranked second (82.1%) and third (78.3%) respectively in helping survivors cope with their experiences.

When asked the question if there were other things that might be helpful to them in coping with their experience, the respondents suggested:

Trying to forget about their experiences (60%); going to the support group (59.2%); talking it over with family (47.8%); and going to religious authority for spiritual counselling (45.2%) .

Medical assisstance was cited by only 31.4% of the respondents. The women feel free to go to the religious authority and women groups because of confidentiality aspect of rape. There, they meet women who share the same experience which make it easier for these women to confide in one another.
According to the respondents, no security measures have been taken to protect women and girls in the community. However, in IDP camps, the respondents reported the existence of security guards, but, they are not enough to ensure security in a place where there is no adequate lighting at night.

B. HEALTH FACILITY SITUATION

B. 1. Referral Hospitals

One Hospital per county was selected. Redemption Hospital was selected in Montserrado and Phebe Hospital was selected in Bong.

B.1.1. Redemption Referral Hospital

Redemption hospital is the only functional public hospital that receives all categories of patients in Montserrado. There are four other private hospitals which refused to participate in the study.

Strengths

- Hospital building in good condition,
- Good equipment condition,
- Good laboratory equipment and trained staff
- Satisfactory accessibility
- Monthly drug supply,
- Medical visit and follow up visit free of charge,
- Patients get free drugs
- Willingness to receive SGBV survivors

Constraints

- Health professionals are insufficiently trained in clinical and psychological management of SGBV survivors
- Rape kit, sanitary supplies, medical chart with pictograms, written medical protocol including all aspects of clinical examination of SGBV survivors, specific consent forms for

SGBV survivors, information pamphlets for post-rape care for survivors are not available.

- Post-exposure prophylaxis of HIV transmission (PEP) and hepatitis B vaccine are not available.
- As referral hospital, Redemption Hospital has only received three SGBV survivors. It is reported that the hospital has received many STI patients. SGBV survivors might have been among these patients, but they did not probably identify themselves, because of the embarrassment associated with being raped and also the reporting of or talking about rape is culturally a taboo.

B.1.2. Phebe Referral Hospital

There are two referral hospitals in Bong County: Bong Mines and Phebe Hospitals. Bong Mines is located in the lower portion of the county and Phebe Hospital is the referral hospital for the central and upper part of the county. The upper part is more populated and the distance from scattered villages to the referral hospital is too far and this affects Phebe Hospital's accessibility. However, the accessibility from Gbarnga, capital of the county is satisactory.

Strengths

- Two hand pumps as water system supply
- Well structured building,
- Good equipment but insufficient (laboratory…),
- Accessibility satisfactory for Gbarnga community only,
- Willingness to receive SGBV survivors
- Has a small generator. A big one is on its way,
- Good laboratory equipment with trained staff.

Weaknesses (Constraints)

- Insufficient number of staff,
- Accessibility problem
- Health professionals have no training at all on the clinical management of SGBV survivors,
- Laboratory materials not sufficient (lack of reagentsf),
- Rape kit for collection of forensic evidence, resuscitation equipment for anaphylactic reactions, drugs for post-exposure prophylaxis of HIV transmission (PEP), hepatitis B vaccine, medical chart with pictograms, forms for recording post-rape care, information pamphlets for post-rape care, safe locked filing space to keep confidential records and a written medical protocol are not available.
- Has received so far five SGBV survivors. It might be because SGBV survivors do not easily identify themselves,
- Patients have to pay for visits and drugs. It is affecting those who have money problems.

B.2.. Health Centers

A total of seven (7) health Centers were selected. In Montserrado (Pipeline Community Clinic, Bensonville Health Center, Robert H. Fergusion center, Bardnersville and Careysburg community clinic) these health centers are located in the urban and sub-urban Monrovia. For Bong (Salala Health center, C-B. Dunbar Clinic) are the selected health centers.

1. Weaknesses

- Insufficient staff in number,
- Health professionals are not trained to manage SGBV cases,
- Accessibility problem for patients in critical condition to get to the referral hospital, because of the long distance between health center to the hospital for Bong County and bad road condition for montserrado County (a rough average of 18.4 miles distance between health centers and Redemption Hospital).
- Drug supply is not enough to respond to the demand,
- Bong health center do not have water supply system nor electricity,
- There is often shortage of drugs (two to three weeks),
- There is no standardized patient referral protocol for Salala and C.B.Dunbar clinic. All Montserrado selected health centers have a standardized patient referral protocol developed by partners.
- There is no autoclave nor other sterilising device.
- Use of antiseptics to sterilize equipment,
- In Montserrado Health Clinics, (Pipeline Health Center, Bardnersville, R.H Fergusion Centers) patients use their own means (transportation) to go to the referral hospital.
- All of them do not have supplies for minimum care for rape suvivors in lower-resource settings.

2. Strengths

- All of them provide free care.
- A monthly drug supply system is in place.
- All health centers have partners who provide drugs, incentives and training.
- A physician assistant is the head in all health centers.
- There is willingness to receive SGBV patients.
- Bensonville Health Center refers patients in an ambulance which is always available.

C. Non-Governmental Organizations

- Numerous National and International organizations are involved in SGBV work in Monrovia. There is no local NGO in Bong County; nor women group network in the community.
- Presently, there is a committee which comprises fifteen organizations that are involved in SGBV control acivities in Monrovia (GBV Interagency Committee).
- The Committee meets weekly to discuss different SGBV issues that arise from members of the organizations.

- The committee has set up a standardized SGBV reporting form. This form will be used for review during the consensus building workshop.
- During the committee's meeting of 30th September 2004, the committee approved WHO proposition of setting collaboration activities within the inter-agency committee.
- Three working groups were then formed:
- Medical Technical Working Group,
- Legal Technical Working Group,
- Psycho-Social including Economic Technical Working Group.

Recommendations from the Inter-Agency Group:

WHO and IRC have to work together and lead the group.
All structures set up will be passed on to the Ministry of Health.

Strength

- The organizations involved in SGBV built coalition.
- All the members of the Inter-agency group have the will and commitment.
- The inter-agency committee set-up collaboration activities (the three technical working group).

Weaknesses

- Coordination mechanisms within the committee and among government and NGOs are still weak.
- There is a big need for capacity building .
- Roles must be clearly defined..
- They are not well prepared to share information about their own organization among themselves (NGO), one of the key elements for the success of the coalition.
- National NGOs lack technical and logistical support

Conclusion

These results show that sexual gender-based violence is prevalent in Montserrado and Bong Communities. The respondents reported a total of twenty-one (21) different acts of violence they had experienced.

The sexual violence impacts the physical and psycho-social wellbeing of survivors long after the abuses are committed. Besides the physical consequences of sexual violence, the study shows that the survivors experience significant disturbances to their psychological and social functioning.

Women are unwilling to look for medical or professional assistance because of the embarrassment associated with being raped compounded with the lack of money, fear of stigmatization, insecurity because of the war and the unavailability of medical care.

The analysis of health facilities shows that they are willing to receive SGB survivors, but they are not prepared to give them quality care because of the insuffiecient equipment and supplies, and also because of the lack of health professional training in clinical and psychological management of SGBV survivors. As for NGOs, the coordination mechanisms are established; but they must be well-defined; because there is still some confusion in roles.

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APPENDICES

Appendix I

INTERVIEW GUIDE

Date of Interview:_____

Time interview began:_____

Setting:_____

Introduction:

I am interested in learning about some of the concerns and needs of people in this community. I am especially interested in trying to understand some of the issues that women and girls have to deal with here. I hope that your answers to my questions will help improve services for women, girls and families in this community and help the health professionals, and others to be more responsive to women in their daily lives.

It is not a test so there are no right and wrong answers. Your own opinion and answers are very important to me. Please feel free to tell me what you really think or know. I offer you a guarantee of confidentiality. The information I am getting from you won't in any circumstances be publicly disclosed in a way that would identify you. At any point during the interview you may ask me to skip a question you cannot or do not want to answer. Your participation is completely voluntary and you may chose to leave at anytime during the interview or discussion.

Do you have any question before we proceed?

1. Now, I would like to ask you some questions about what happened to you if any. I know it may be difficult to acknowledge that any of these things happened to you, but please remember that what you tell me is completely confidential and your answers will help me get a sense of the needs of women in your community.
   During the conflict were you subjected to any of the following violent acts by people such as soldiers, police and community member? Please remember that I am asking if you experienced each act during the period and about the total number of times it happened.

1.	During the conflict (in home county) were you subjected to any of the following violent acts by people such as soldiers, police, or community members? Please remember that I am asking about the TOTAL number of times you experienced each act during the period Beginning _____ and ending _____ How many times during this period were you:	Never	1-2 times	3-5 times	6 or more times	Wkly	Daily	DK	Refuse
	A. Slipped or hit	1	2	3	4	5	6	7	8
	B. Choked	1	2	3	4	5	6	7	8
	C. Beaten or kicked	1	2	3	4	5	6	7	8
	D. Tied up or blindfolded	1	2	3	4	5	6	7	8
	E. Threatened with a weapon of any Kind	1	2	3	4	5	6	7	8
	F. Shot at or stabbed	1	2	3	4	5	6	7	8
	G. Deprived of food, water, or sleep	1	2	3	4	5	6	7	8
	H. Experienced physical disfigurement of your body	1	2	3	4	5	6	7	8
	I. Detained against your will	1	2	3	4	5	6	7	8
	J. Subjected to improper sexual Comments	1	2	3	4	5	6	7	8
	K. Forced to remove or stripped of your Clothing	1	2	3	4	5	6	7	8
	L. Given internal body cavity searches	1	2	3	4	5	6	7	8
	M. Subjected to unwanted kissing	1	2	3	4	5	6	7	8
	N. Touched on sexual parts of your Body	1	2	3	4	5	6	7	8
	O. Beaten on sexual parts of you Body	1	2	3	4	5	6	7	8
	P. Forced or threatened with harm to make you give or receive oral sex or have vaginal or anal sex	1	2	3	4	5	6	7	8
	Q. Penetrated with an object in your vagina or anus	1		3	4	5	6	7	8
	R. Compelled to engage in sex in order to receive something such as food, water, protection for your family, or other reasons (describe) _____ _____	1	2	3	4	5	6	7	8
	S. Forced to watch someone being physically assaulted	1	2	3	4	5	6	7	8
	T. Forced to watch someone being sexually assaulted	1	2	3	4	5	6	7	8
	U. Anything else? (describe) _____ _____	1	2	3	4	5	6	7	8

2.	Who did these things? (circle all mentioned)	1. Soldiers 2. Paramilitary 3. Civil defense forces 4. Police officer or Interrogator 5. Prosecutor or judge 6. Jail or prison guard 7. Health professional (Doctor, Nurse,-----) 8. Teacher 9. Religious worker 10. Humanitarian relief Worker 11. Neighbor/Community Member 12. Unknown to respondent 13. Other _____ 14. Rebels 77. Don't know 88. Refuse	

3.	When did this assault happen?	Month _____ _____ Year _____ _____ _____ _____ 77. Don't know 88. Refuse	
4.	Where were you when the assault took place?	1. In you house 2. At work 3. Elsewhere in you village 4. Elsewhere in your country 5. Other (describe) _____ _____ 77. Don't know 88. Refuse	
5.	Did one person or a group of people mistreat you?	1. One person 2. A group of people 77. Don't know 88. Refuse	

Appendix I continued

6.	Did the assailant(s) threaten to kill you at any time during the assault?	1. No → 2. Yes 77. Don't know 88. Refuse	
7.	Who was with you at the time of the assault (circle all mentioned)	1. Respondent was alone 2. Husband/Partner 3. Children 4. Other woman 5. Other family 6. Someone else_____ 77. Don't know 88. Refuse	
9.	What happened to the other person or people who were with you? (circle all mentioned)	1. Threatened to be killed 2. Beaten 3. Sexually assaulted 4. Forced to watch 5. Killed 6. Escaped 7. Other (describe) _____ 77. Don't know 88. Reuse	
10.	Were you already pregnant at the time of the assault and if so what happened to the pregnancy?	1. Not pregnant 2. Miscarriage 3. Premature delivery 4. Stillbirth 5. Pregnant, and delivered healthy child 6. Abortion 7. Other _____ 77. Don't know 88. Refuse	

11.	Did you become pregnant as a result of the assault if so what happened to the pregnancy	1. Not pregnant 2. Miscarriage 3. Premature delivery 4. Stillbirth 5. Pregnant, and delivered healthy child 6. Abortion 7. Other _____ 77. Don't know 88. Refuse	
12.	What is your attitude and the attitudes of the family and community toward the child you got after being raped? Describe:		
13.	At the time of the incident, did you know the person/people who mistreated you?	1. No 2. Yes 77. Don't know 88. Refuse	

Appendix I continued

14.	Did you seek medical care for you injures? If you sought care for you injuries, whom did you consult for assistance? (circle all mentioned)	1. Did not seek treatment 2. Traditional healer 3. Neighbor/friend 4. Hospital 5. Health center 6. Respondent's family 7. Husband's family 8. Self-treated 9. Other _____ 77. Don't know 88. Refuse	
15.	If you did not have any professional assistance in the beginning, when did you start having medical assistance?		
16.	What was the main reason you did not seek medical care for your injuries? (circle all mentioned)	1. Did seek treatment 2. Did not need medical care 3. Did not know where to go 4. Medical care not available 5. No use/would not do any good 6. Embarrassed 7. Respondent afraid of further violence 8. Would not be believed or taken seriously 9. Respondent though she would be blamed 10. Bring bad name to respondent's Family 11. Bring bad name to husband's family 12. Had no money 13. Had no transport 14. Other_____ 77. Don't know 88. Refuse	

Appendix I continued

17.	Did you tell anyone about what happened during the assault? If you told anyone (other than people who were with you during the assault) whom did you tell? (circle all mentioned)	1. Did not tell anyone → 2. Husband/partner 3. Male family member 4. Female family member 5. Friend 6. Medical practitioner 7. NGO worker 8. UN staff member 9. Police or local authorities 10. Religious authority 11. Women's group 12. Someone else _____ 77. Don't know 88. Refuse	
18.	What was the reaction of the people you told? (circle mentioned)	1. Stigmatized me 2. Ignored me, response 3. Took the information, but no-happened 4. Provided emotional support 5. Referred me to a health worker or clinic 6. Referred me to an NGO 7. Referred me to human rights organization 8. Referred me to a religious authority 9. Referred me to a women's group 10. Other_____ 77. Don't know 88. Refuse	

Appendix I continued

19.	Of the people you told about the episode, who was most helpful? (circle mentioned)	1. No one was helpful 2. Husband/partner 3. Male family member 4. Female family member 5. Friend 6. Medical practitioner 7. NGO worker 8. UN staff member 9. Police or local authorities 10. Lawyer/Judge or traditional justice 11. Religious authority 12. Women's group 13. Someone else _____ 77. Don't know 88. Refuse	
20.	What was the major reason you did <u>not</u> tell anyone about what happened?	1. Feelings of shame 2. Fear of being stigmatized 3. Fear of rejection by family or friends 4. Did not trust anyone 5. Thought nothing could be done 6. Other _____ 77. Don't know 88. Refuse	

Appendix I continued

21.	What has been most helpful to you so far in coping with your experience? (circle all that apply)	1. Support group for women 2. Talking it over with friends 3. Talking it over with family 4. Assistance from NGO workers 5. Legal advice/traditional justice 6. Religious counseling 7. Mental health counseling 8. Medical assistance 9. Trying to forget about experience 10. Other _____ 77. Don't know 88. Refuse	
22.	Are there other things that might be helpful to you in coping with your experience? (circle all that apply)	1. Support group for women 2. Talking it over with friends 3. Talking it over with family 4. Assistance from NGO Worker 5. Legal advice/Traditional justice 6. Religious counseling 7. Mental health counseling 8. Medical assistance 9. Trying to forget about experience 10. Other_____ 77. Don't know 88. Refuse	

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Appendix I continued

23.	Have any of the sisters between the ages of 18-49 ever been physically assaulted by anyone during the occupation or the conflict?	_____ _____ sisters assaulted (00 if no sisters were physically assaulted). 77. Don't know 88. Refuse	
24.	Where any of your sisters between the ages of 18-49 ever sexually assaulted by anyone?	___ ___ sisters sexually assaulted 77. Don't know 88. Refuse	
25.	Who did these things to your sister (s) ?	1. Military 2. Paramilitary 3. Civil defense force 4. Police office interrogator 5. Prosecutor of judge 6. Jail or prison guard 7. Doctor/Medical person 8. Teacher 9. Religious worker 10. Humanitarian relief worker 11. Neighbor/community member 12. Unknown to respondent 13. Other_____ 77. Don't know 88. Refuse	
26.	What are the family and community attitudes towards you?		
27.	What did you loose as possessions (goods) during the conflict?		

Appendix II

FOCUS GROUP TOPIC GUIDE

Indroduction

I am interested in learning about some of the concerns and needs of people in this community. I am especially interested in trying to understand some issues that women and girls have to deal with here.I hope that your answers to my questions will help improve services for women, girls and families in this community. I expect our discussion to last about one hour.

Please feel free to tell me what you really think or know. I offer you a guarantee of confidentiality.The information I am getting from you won't in any circumstances be publicly disclosed in a way that would identify you. At any time during the discussion you may ask me to skip a question you cannot or do not want to answer. Your participation is completely voluntary.

Do you have any question before we proceed?

Now I would like to ask you some questions in connection to what happen to women and girls.

1. What has been done here to improve the safety of women and girls in this community?

2. When and where does sexuals violence occur?

3. Whithout mentioning the names or indicating anyone specific, Who are the perpetrators?

4. Has the problem of sexual violence gotten worse or stayed the same in the last year? What particular types of sexual violence have gotten worse?

5. Without mentioning names or indicating anyone, do you know of women in this community who are forced to have sex with soldiers or any armed gangs against their will? If yes,how do you know about them? What problems do they have?

6. Do women look for help when they experience sexual violence? Do they tell anyone (family member, police, community leader)?

7. What is the attitude of the community towards women who have been raped?

8. Can you speak openly the problem of rape? If no, why?

9. What are the attitudes of family and husband (if married) towards you?

10. What are your attitude and the attitudes of the community, family towards the children, fruit of rape?

Appendix II continued

11. What has been done to help the survivors? What is done in the community to prevent sexual violence?

12. Do women's support networks exist to help the survivors? What social and legal services exist to help address problems associated with sexual violence(health, police, legal counseling, social counseling)? Who provides these services? How could the efforts be improved?

Appendix III

SOCIAL-DEMOGRAPHIC DATA

No.	Age	Parity	Place of assault	Education	Ethnic	Assault In public or alone	# of assail-ant	Physical problem	Behavior (Psychologic) problem	Assailant go or still around	Have you been abdu-cted

Appendix IV.

Referral Hospital Situation

Name of the hospital	
Qualification of the head	
Number of Doctors	
Qualification of the Doctor	
Number of patients coming from health center during the last six months	
Motive of referral	
Cost of medical visit	
Follow up visit cost	
Cost of drugs for the patients	
Drugs supply system	
Existing Partnership	
Physical condition of the hospital	
Equipment	
Accessibility	
Number of SGBV Survivors received	
Are you prepare to receive SGBV Survivors?	
Is the personnel trained on management of SGBV Survivors? How many?	
Qualification of the person in charge of the pharmacy	
Is there a Laboratory for test analysis	
Laboratory material	
Qualification of the person in charge of the Laboratory	
Name the different in- service trainings	
Number of nurses	

Appendix IV continued

Checklist of supplies for clinical management of rape survivors (Referral Hospital)

1. Protocol	Available
- Written medical protocol translated in language of provider	
2. Personnel	Available
- Trained (local) health care professionals (on call 24 hour/day)	
- For female survivors, a female health provider speaking the same language is optimal. If this is not possible a female health worker (or companion) Should be in the room during the examination	
3. Furniture/Setting	Available
- Room (private, quiet, accessible to a toilet or latrine)	
- Examination table	
- Lighting, preferably fixed (a torch may be threatening for children)	
- Magnifying glass (or colposcope)	
- Access to an autoclave to sterilize equipment	
- Access to laboratory facilities/microscope/trained technician	
- Weighing scales and height chart for children	
4. Supplies	Available
- "Rape Kit" for collection of forensic evidence, could include:	
- Speculum (preferably plastic, disposable, only adult size)	
- Comb for collecting foreign matter in public hair	
- Syringes/needles (butterfly for children) tubes for collecting blood	
- Glass sides for preparing wet and/or dry mounts (for sperm)	
- Cotton tipped swabs/applicators/gauze compresses for collecting samples	
- Laboratory containers for transporting swabs	
- Paper sheet for collecting debris as the survivor undresses	
- Tape measure for measuring the size of bruises, lacerations etc	
- Paper bags for collection of evidence	
Paper tape for sealing and labeling containers/bags	
- Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)	
- Resuscitation equipment for anaphylactic reactions	
- Sterile medical instruments (kit) for repair of tears, and suture material	
- Needles, syringes	
- Cover (gown, cloth, sheet) to cover the survivor during the examination	
- Spare items of clothing to replace those that are torn or taken for evidence	
- Sanitary supplies (pads or local cloths)	
- Pregnancy tests	
- Pregnancy calculator disk to determine the age of a pregnancy	

Appendix IV continued

5. Drugs	Available
- For treatment of STIs as per country protocol	
- For post-exposure prophylaxis of HIV transmission (PEP)	
- Emergency contraception pills and/or intrauterine device (IUD)	
- Tetanus toxoid, tetanus immuno-globuli	
- Hepatitis B vaccine	
- For pain relief (e.g. paracetamol)	
- Anxiolytic (e.g. diazepam)	
- Sedative for children (e.g. diazepam)	
- Local anasethetic for suturing	
- Antibiotics for wound care	
6. Administrative Supplies	Available
- Medical chart with pictograms	
- Forms for recording post-rape care	
- Consent forms	
- Information pamphlets for post-rape care (for survivor)	
-Safe, locked filing space to keep confidential records	

Appendix V.

Health Center Situation

Name of the Health Center	
Health district	
Private or Public	
Qualification of the nurse in charge	
Number of patients/month	
Number of survivors of SGBV/month years	
Reasons for consulting for SGBV survivors	
Drug supply system	
Health Center total population	
Number of days: Shortage of essential drygs	
Reasons for the shortage	
Consultation (visit cost)	
Follow-up visit cost	
Number of SGBV received	
Distance between health center and referral hospital	
Average patients referred month	
Reasons for referral	
Existence of a standardized patient referral protocol	
Existing partners	
Domains of partnerships	
Difficulties	
Motivation	
Existence of specific place to received SGBV survivors	
Types of training for nurses and Doctors	
Number of nurses	
Qualification of nurses.	

Appendix V continued

Minimun care for rape survivors in low-resource settings (Health Centers)

Checklist of supplies

1. Protocol	Available
➢ Written medical protocol in language of provider	
2. Personnel	**Availible**
➢ Trained (local) health care professionals (on call 24 hours a day)	
➢ A "same language" female health worker or companion in the room during examination	
3. Furniture/Setting	**Available**
➢ Room (private, quiet, accessible, with access to a toilet or latrine)	
➢ Examination table	
➢ Light, preferably fixed (a torch may be threatening for children)	
➢ Access to an autoclave to sterilize equipment	
4. Supplies	**Available**
➢ "Rape kit" for collection of forensic evidence, including:	
❖ Speculum	
❖ Tape measure for measuring the size of bruises, laceration, ect	
❖ Paper bags for collection of evidence	
❖ Paper tapes for sealing and labelling containers/begs	
➢ Supplies for universal precautions	
➢ Resuscitation equipment for anaphylactic reactions	
➢ Sterile medical instruments (kit) for repair of tears, and suture material	
➢ Needles, syringes	
➢ Cover (gown, cloth, sheet) to cover the survivor during the examination	
➢ Sanitary supplies (pads or local cloths)	
5. Drugs	**Available**
➢ For treatment of STIs as per Country protocol	
➢ Emergency contraceptive pills and/or UID	
➢ For pain reliec (e.g. paracetamol)	
➢ Local anaesthetic for suturing	
➢ Antibiotics for wound care	
6. Administrative supplies	**Available**
➢ Medical chart with pictograms	
➢ Consent forms	
➢ Information pamphlets for post-rape care (for survivors)	
➢ Safe, locked filing space to keep confidential records	

Appendix VI.

Organization involved in SGBV

Name of the organization	
Activities related to SGBV	
Domains of actions	
Suggestions for better collaboration and coordination	

PROJECT STAFF

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