WORLD HEALTH ORGANIZATION

SEXUAL GENDER-BASED VIOLENCE AND HEALTH FACILITY NEEDS ASSESSMENT

(LOFA, NIMBA, GRAND GEDEH AND GRAND BASSA COUNTIES)
LIBERIA

By

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LIST OF ABBREVIATIONS

AFELL	Association of Female Lawyers of Liberia
HRW	Human Rights Watch
IDP	Internally Displaced People
IRC	International Rescue Committee
LUWE	Liberian United Women Empowerment
MSF	Medecins Sans Frontières
NATPAH	National Association on Traditional Practices Affecting the Health of Womn and Children
NGO	Non-Governmental Organization
PEP	Post-Exposure Prophylaxis
PTSD	Post-Traumatic Stress Disorder
RHRC	Reproductive Health Response in Conflict
SGBV	Sexual Gender-Based Violence
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

Recommendations

To: The Liberia Government (Ministries of Health and Gender)

- Take concrete preventive measures to prevent occurrence of sexual gender based violence in the community.
- Strengthen punitive measures against the perpetrators
- Ensure the training of healthcare providers on the clinical and psychological management of SGBV survivors.
- Organize awareness and sensitization campaign in Liberia, (in the15 counties), in order to minimize the stigma associated with rape and clarify SGBV definitions.
- Develop SGBV national plan of action to prevent SGBV and care for the survivors.
- Extend logistical support for equipment supply to the referral hospitals and health centers to provide quality care to SGBV survivors.
- To supply the referral hospitals and health centers with essential drugs.
- Support International and National NGOs to adhere to nationally developed established guidelines and protocols on SGBV.
- Develop or adapt the training modules for the management of SGBV survivors by health care workers at the community level.
- Introduce the clinical management of SGBV survivors in the curricula of formal health education in Liberia

To: U.N and WHO

- Provide logistical support for the training of all stakeholders in the management of SGBV survivors.
- Streamlining surveillance and assessment activities in the Counties.
- Support the NGO to adhere to nationally established guidelines and protocols on SGBV
- Support the local NGOs to mobilize and sensitize SGBV survivors, family and Community to reduce the stigma associated with SGBV.
- Give logistical support for equipment supply to the selected referral hospitals and health centers to provide quality care to SGBV survivors.

Provide technical support for the development and the implementation of SGBV modules in the formal health education in Liberia

Problem Statement

An initial rapid SGBV assessment and health facility needs to give quality care to SGBV survivors was conducted in September 2004, covering two counties, Montserrado and Bong. The results showed that all women and girls who participated in the study were subjected to one or multiple acts of abuse and/or sexual violence during the conflict. The consequences suffered by the victims were mainly physical health problems, psychological/mental disturbances and socio-economic stress.

- Ninety-three point seven percent (93.7%) of the study respondents presented minor or moderate or severe physical health problems stemming from SGBV.
- All the respondents experienced various degrees of psychological health disturbances.
- The SGBV survivors in the study, who were raped in public or those whose rape status was disclosed, in general, were facing the stigma from the family and the community.
- Children borne as result of rape were also stigmatized.
- All studied respondents did not seek the assistance of a health professional after the rape. They treated themselves or consulted a traditional healer or Tradition Birth Attendant (TBA).

Although these two counties are said to have large proportions of population and most of the ethnic groups, information gathered cannot be generalized to the rest of the country. In order to allow the country develop an appropriate National Plan Of Action for the prevention and management of SGBV, a comprehensive SGBV assessment covering four counties Lofa, Nimba, Grand Gedeh and Grand Bassa was conducted from September 9th-29th, 2005.

I.1 Research questions:

1. What is the magnitude of SGBV in the selected counties in Liberia?
2. What are the consequences of SGBV on the survivors' health?
3. What are the needs of selected health facilities to give quality care to SGBV survivors?
4. What are the existing coordination mechanisms among the organizations involved in SGBV central activities?

I.2. Objectives

a. General objective

- To obtain database or data foundations to develop a national plan of action for the prevention of SGBV and the care of survivors of SGBV.

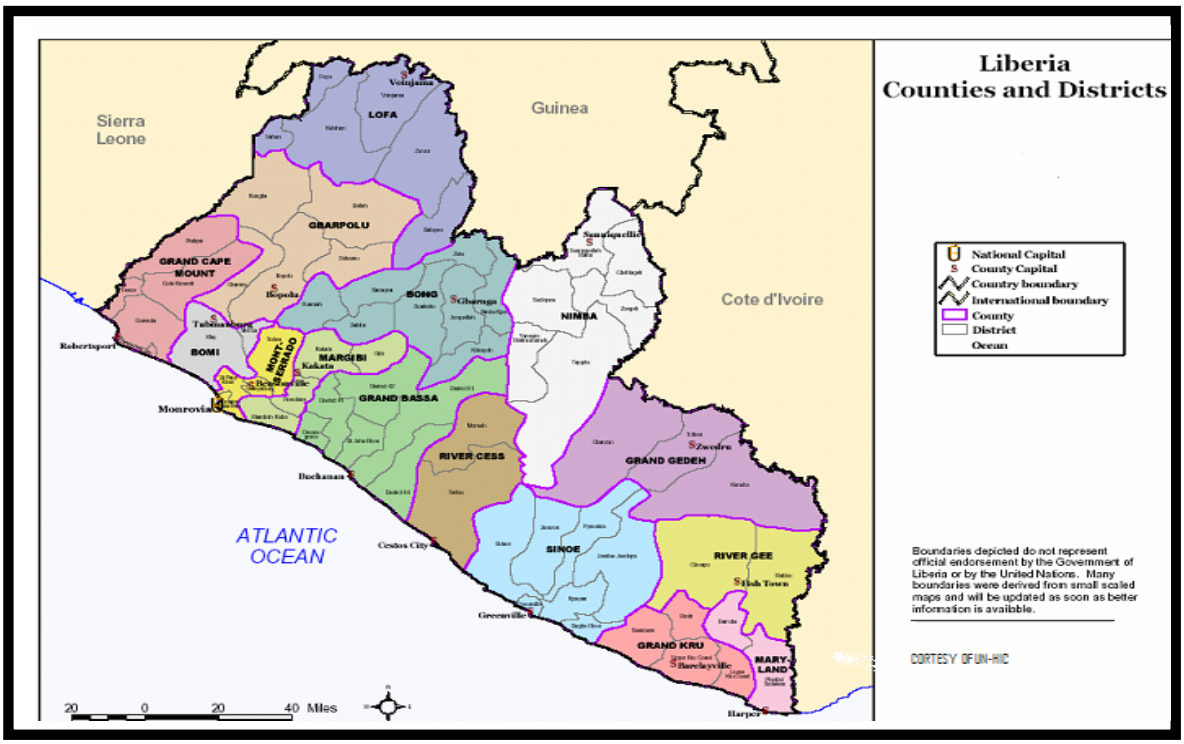
b. Specific objectives

- Determine the magnitude of SGBV in Nimba, Grand Gedeh, Grand Bassa and Lofa Counties.
- Identify the consequences of SGBV on the survivors' health
- Identify the needs of selected health facilities to give quality care to SGBV/GBV survivors.
- Identify existing coordination mechanisms between the organizations involved in SGBV control activities.
- Provide recommendations for the next steps and future actions

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 and to 84 districts. 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 returning home.

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 infrastructures, 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 labor 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 labor 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 four rural counties, namely, Lofa, Nimba, Grand Gedeh and Grand Bassa. These four counties account for approximately 882.404 of the population. This population is likely to increase because people who fled to other counties or countries are returning home. Notwithstanding, adequate security remains a critical issue in these camps. Gender-based violence often occurs; 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 strengthened 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 peacekeepers deployed nearly throughout the country. They provide security support to the transitional government put in place about two years ago. Presidential election took place in November 2005. A woman president was elected, the first woman president in Africa.

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.

Lofa County is at 456 kilometers from Monrovia in the North of Liberia and is sandwiched between Sierra Leone. It shares borders with Bong and Gbarpolu on the southern part of the county. Lofa County has fourteen (14) clinics and two referral hospitals. Twelve of these clinics are functional and in charge of the international non-governmental organizations. The two-referral hospitals were burned down. Two smaller

buildings were constructed both in Voinjama, capital of Lofa County and In Zozor, which are being used as referral hospitals.

Nimba County is at 209 kilometers from Lofa County. It has common boundaries with Guinea and Ivory Coast, and with Bong Grand Bassa and Grand Gedeh Counties. It has an estimated population of 220,000. Seventy five percent (75%) of the total population is illiterate. There are three referral hospitals and six clinics including two health centers which all are managed by the international NGOs. Two referral hospitas are functional but one is operating as a health center. The Nimba women are well organized. They have a women center. Most of the women have attended meeting related to SGBV and others have sat in SGBV workshops. They are more open to discuss issues related to SGBV.

Grand Gedeh County is at 251 kilometers from Nimba County. It has common boarders with Ivory Coast, and Nimba, Sinoe and River Gee Counties. It has an estimated population of 80,297. It has one referral hospital, two health centers and 15 clinics. Eight of these clinics are functional and being managed by international NGOs.

Grand Bassa is at 650 kilometers from Zwedru, capital of Grand Gedeh, and Grand Gedeh County. It is at three-hour drive from Monrovia. It has an estimated population of 382,107. It comprises two referral hospitals, one health centers and 19 clinics. Fourteen (14) clinics are functional. The 14 clinics and the two health centers are managed by the international NGOs. The health center is private and manages by the Catholic Church.

III Review of Literature

This review includes a discussion on the current trends of SGBV with an emphasis on SGBV in Liberia.

III.1 Definition of concepts

For this study, the researcher used the following standard definitions from RHRC (2004) and UNCHR (2003).

1. Gender-Based Violence (GBV), according to RHRC (2004) is any harm that is perpetrated against a person's will, and its results from power that are based on gender roles. This concept is used to distinguish common violence from violence that targets individuals or groups of individuals on the basis of their gene.
2. 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 (RHRC op.cit). These social characteristics are, according to UNHCR (2003), constructed on the basis of different factors, such as age, religion, national, ethnic and social origin. The author stated that gender is learned through socialization. It is not static or innate but evolves to respond to changes in the social, political and cultural environment.
3. Survivor/victim in this study is a woman or a girl who has experienced sexual violence or other acts of violence.
4. A 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. Perpetrator is in a position of real or perceived power, decision making and/or authority and can thus exert control over their victims.
5. Violence against women refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual and psychological harm to women and girls, whether occurring in private or in public. Violence against women is a form of GB and includes sexual violence.
6. Sexual violence, including sexual exploitation and abuse, refers to any act attempt or threat of a sexual nature that results, or is likely to result, in physical, psychological and emotional harm. It is a form of gender-based violence.

III.2 Types of Sexual and Gender-Based Violence.

UNHCR (2003) describe five more common forms of sexual and gender based violence. It is 1) sexual violence which include: rape and marital rape; child sexual abuse, defilement and incest; forced sodomy/anal rape; attempted rape or attempted forced sodomy/anal rape; sexual abuse; sexual exploitation; forced prostitution; sexual harassment and sexual violence as a weapon of war and torture: 2) Physical violence including physical assault and trafficking/slavery; 3) emotional and psychological violence including abuse/humiliation and confinement; 4) harmful traditional practices which include female genital mutilation (FGM), early marriage, forced marriage, honor/willing maiming, infanticed and/or neglect and denial of education for girls or women; and 5) socio-economic violence including discrimination and/or denial of opportunities, services; social exclusion/ostracism based on sexual orientation and obstructive legislative practice.

According to the same author, SGBV can be perpetrated by husbands/partners; family members, close relatives and friends; influential community members; security forces and soldiers, including peacekeepers; humanitarian aid workers; and institutions (discriminatory practices in the delivery of social services).

Concerning the consequences of SGBV, UNHCR (op.cit.) stated that there are serious and potentially life threatening health outcomes with all types of SGBV. The author pointed out three major consequences. Physical and reproductive outcomes such as: injury, diseases, gastrointestinal problems, infections, gynecological disorders, unwanted pregnancy, menstruation disorders, pregnancy complications, sexual disorders, unsafe abortion, miscarriage, and etc.; emotional and psychological outcomes including pot traumatic stress disorders, mental illness, suicidal thoughts and behaviors, shame, insecurity, self-hate and self blame, and etc.; social consequences including social stigmatization, social rejection and isolation, loss of roles/functions in society, the blaming of the victim, feminization of poverty and increased gender inequality, and etc. All these consequences have resulted to the increase of maternal morbidity.

III.3 SGBV in Liberia

According to the study conducted by IRC (2004) regarding Liberian refugee women living in Sierra Leone, 74% of Liberian women of reproductive age (15-49 years of age) who were living in three selected refugees camps in Sierra Leone, reported being subjected to at least one incident of sexual violence and 71% experienced at least one incident of physical violence before displacement. These percentages decreased during the displacement period from 71% to 66.1%.

The same study conducted a series of focus-group discussions and individual interviews with women and men in 7 IDP camps in Montserrado County. The results showed that IDP women and girls experienced four types of gender-based violence. The first is sexual violence perpetrated by members of the fighting forces. The second type is sexual and domestic violence perpetrated within the IDP camps. The third one is sexual exploitation which women referred to as “you lack, I have, and you need”. The perpetrators are men in positions of power and authority. The fourth is forced marriage of young girls by parents or relatives to avoid sexual corruption.

The study pointed out some problems faced by women as result of sexual assault. It includes gynecological and reproductive health problems.

Another study conducted by WHO/country office in collaboration with MOH/SW (2004), using a series of focus-group discussions and face-to-face interviews with 412 women and girls in the selected communities and IDP camps, showed that sexual assault was high (nearly 80%) during the conflicts. Twenty-one (21) different acts of violence were inflicted on women and girls. All the victims who participated in the study experienced at least one incident of sexual and physical violence during the conflicts. Some women reported multiple acts of violence on separate occasion or during the same incident. The author pointed out that victims had suffered great hardship. The physical health consequences experienced by the victims were predominantly sexually transmitted infections with its complications. The psychological and mental consequences included feeling of humiliation, loss of self-esteem, an aversion to sex, depression. Stigmatization, high divorce rate, unwanted pregnancy and poverty predominated social and economic consequences of SGBV.

The study investigated the needs of selected health facilities to give quality care to SGBV survivors in Bong and Montserrado Counties. It was found that the selected health facilities were not sufficiently equipped and lack trained health professional in clinical management of SGBV survivors.

IV. Methodology

It is an ex-post facto descriptive design; the counties were selected using purposive sampling: Lofa, Nimba, Grand Bassa and Grand Gedeh.

IV.1 Sample

Two units of analysis were used: health facilities and women and girls in the selected communities.

a. Selection strategy and data collection techniques

a.1. Health Facilities

Six functional hospitals and nine functional health centers accessible to the researchers were selected. Self-administered questionnaires were conducted in the health facilities, using personal presentation of questionnaires to individual respondents who were the head of health facilities. The assistant researcher was all the time available to explain and clarify the purposes of the study and particular difficult questions to the head of health facilities. He or she (depending on the county) had to pick up the completed questionnaires two days later. This yielded a high rate of returned questionnaires. One (1) referral hospital out of seven (7) did not participate in the study. The response rate was 85% for referral hospitals and 100% for health centers.

a.2 Local Interviewers (selections and training)

In each county, contact was established upon arrival with the County Health Team and Director of Nursing of the referral hospital. These meetings were sought to explain the purposes of the study and to get their approval and collaboration to conduct the study in their counties.

In collaboration with them, five (5) women from various organizations were selected per county: Gender Coordinator focal point, women development center, International Rescue Committee (IRC) SGBV focal point and nurses from the referral hospital.

The training of local interviewers was organized in each selected county. This training included the philosophy of data collection, how to follow question wordings, how to record responses, how to probe for responses when it is appropriate and how to present oneself in an interview situation. The interview schedule was also examined in details, question by question.

During the first day of data collection, demonstration interviews and return demonstration by the trainees helped to gain confidence when interviewing.

a.3 Women in the community

Upon arrival, after meeting with the County Health Team, a meeting was sought with women leaders in the communities. The aim of the meeting was to mobilize women and girls to be interviewed.

A total of 1,216 women and girls randomly selected were interviewed (for an equal number of 304 women and girls per county)

Selection criteria: sampling criteria for inclusion in the study were women or girls aged 15 years and above, who spoke English or any of the Liberian languages, and who accepted to voluntarily participate in the study.

Face to face semi-structured interviews using an interview guide were followed by focus group discussions of 15 to 20 women and girls using a discussion guide.

Data collection took place in quiet and private places from 9:00 AM to 5:00 PM.

- Lofa County: September 9th – 13th, 2005
- Nimba County: September 14th – 18th, 2005
- Grand Gedeh County: September 19th – 23rd, 2005
- Grand Bassa County: September 24th – 28th, 2005
- Every evening the cleaning of data was done.

- A meeting was held frequently in the morning to discuss troublesome issues rose during the interview process and the data collection.
- Selection of the participants was done, first by network sampling using women group leaders, and after by random sampling. All the participants at the market place were selected by random sample.
- Triangulations of data collection techniques were used: personal interviews, focus group and the use of existing records and available data.
- An interview guide (semi-structured interview) was used during face-to-face interviews. A discussion guide (unstructured questionnaire) was used during the focus-group discussions.
- With regard to the utility of the questionnaire as a tool, it was found useful for the designed purposes. It is the same questionnaire used in World Health Organization study on SGBV in 2004. The domains and content were similar and it yielded similar results.

IV.2. Limitation

- Bad road conditions limited movement to only accessible towns and villages. Conducting the interviews at the market places during the major market days minimized this limitation.
- Limited time to train local interviewers. We tried to minimize it by allocating trainees to experimented interviewers from Monrovia for two (2) demonstration interviews and two (2) return demonstration interviews by trainee local interviewers on the first day of interviews in each county.
- Election campaign and bad weather condition (heavy rains in Nimba County) made it difficult to mobilize women. Conducting the two last days' interviews at the market place during the major market day minimized this limitation.
- Recall bias was introduced. Indeed, Winikoff (1981) pointed out that the interviews that take place long after the behavior had occurred can introduce recall bias. All the problems reported by the respondents were evaluated on the basis of women responses to the interviews. The use of semi-structured interviews help the investigator to use probes with a view to clear up vague responses or ask for elaboration of incomplete answers. In addition, The use of the checklist of types of violence according to specific acts developed by RHCR Consortium (2004) helped women and girls recall experiences that would have been difficult to recall. All that minimized recall bias.

V. RESULTS AND DISCUSSION

A. Community Assessment Results

A.1. Socio-Demographic Characteristics of the Respondents

A.1.a. Age

The age distribution is shown in table 1. The participants ranged in age from eight to ninety-five (8-95) years. The general mean age is 33.7 years. The mean age is 36.2 years for Lofa; 34.6 years for Nimba; 32.0 years for Grand Gedeh and 32.3 years for Grand Bassa.

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Table 1: Age* Distribution of the Respondents

County / Age Group	Lofa		Nimba		G. Gedeh		G. Bassa		Total	
	n	%	n	%	N	%	n	%	n	%
<18	26	8.5	15	4.9	56	18.4	26	8.5	123	10.1
18-44	209	68.7	241	79.3	207	68.1	244	80.3	901	74.0
45 and above	69	22.7	48	15.8	41	13.5	34	11.2	192	15.7

** Age sexual assault took place*

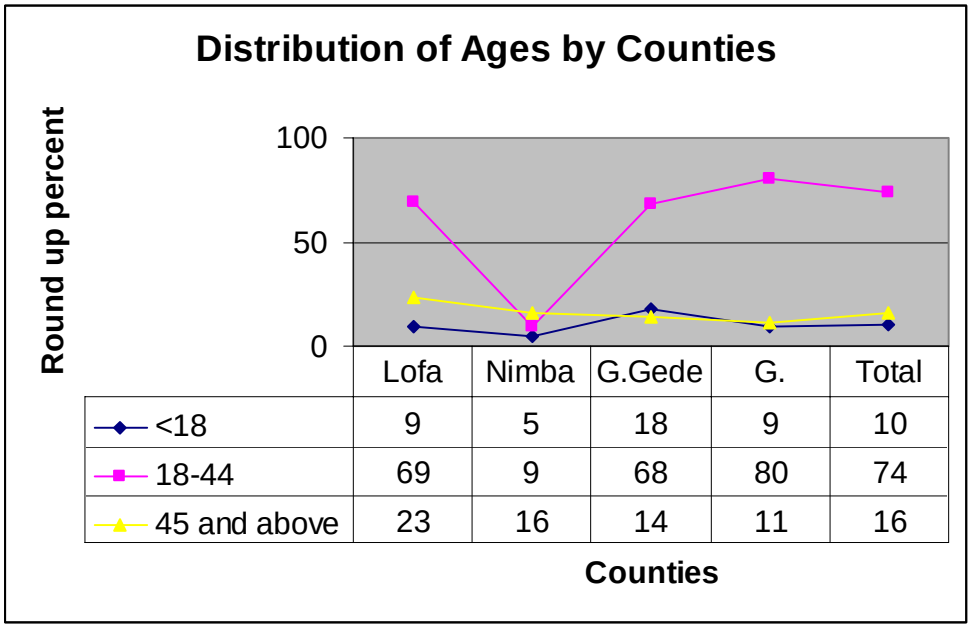


Figure 2: Age distribution of study participants per county

More than two-thirds of the respondents (74.0%) are aged 18-44 years. Ten percent (10%) are aged less than 18 years old and 15.7% are more than 45 years old. When comparing the group age among counties, Grand Gedeh sample represents the highest number in regards to the less than eighteen years old (18.4%) while Lofa and Grand Bassa accounted for 8.6% each. In Nimba, this age group represents 4.9% of the Nimba sample.

For the 45 years old and above, Lofa County sample accounts for 22.7% Nimba, Grand Gedeh and Grand Bassa counties account for about 15.7%, 13.4% and 11.2% respectively. Breaking down the less than 18 years old, it shows that the less than 15 years old make up 3.1% of the total sample while the respondents that are between the ages fourteen (14) and seventeen represent 6.9%. This analysis shows that the majority of the respondents, (∑ of age groups: 15-17 = 6.9% and 18-45 =74%), are in the reproductive age group (80.9%). This can have a negative impact on the reproductive health of girls and women in Liberia, later on in life.

Participants stated that women and girls of all ages were raped throughout the country. They said that young girls, babies and old ladies were raped. The assailants preferred seven (7) to eleven (11) years old girls because they are free of sexually transmitted diseases and are still virgins. Experiencing the first sexual intercourse at such a young ages and in such traumatic conditions can lead to multiple reproductive and behavioral health problems such as perforation of uterus, vesico-vaginal fistula (VVF), recto-vaginal fistula (RVF), sexually transmitted infections (STIs) including HIV, sexual aversion, disgust for marriage, protitution, problems in forming trusting relationships with males, and etc.

The consequences of SGBV will be discussed in another section.

A.1.b. Education

The education levels for different counties are listed in Table 2.

Table 2: Level of Education (highest level attended) of the respondents

County / Education	Lofa		Nimba		G. Gedeh		G. Bassa		Total	
	n	%	n	%	n	%	n	%	n	%
No education	222	73.0	173	56.9	143	47.0	171	56.2	709	58.3
Elementary	64	21.1	71	23.4	98	32.2	88	29.9	321	26.3
Jr. High	12	3.9	35	11.5	45	14.8	25	8.2	117	9.6
Sr. High	5	1.6	25	8.2	17	5.6	16	5.2	63	5.1
Skill Training	1	0.3	0	0	0	0	1	0.3	2	0.2
College	0	0	0	0	1	0.3	3	1.0	4	0.3

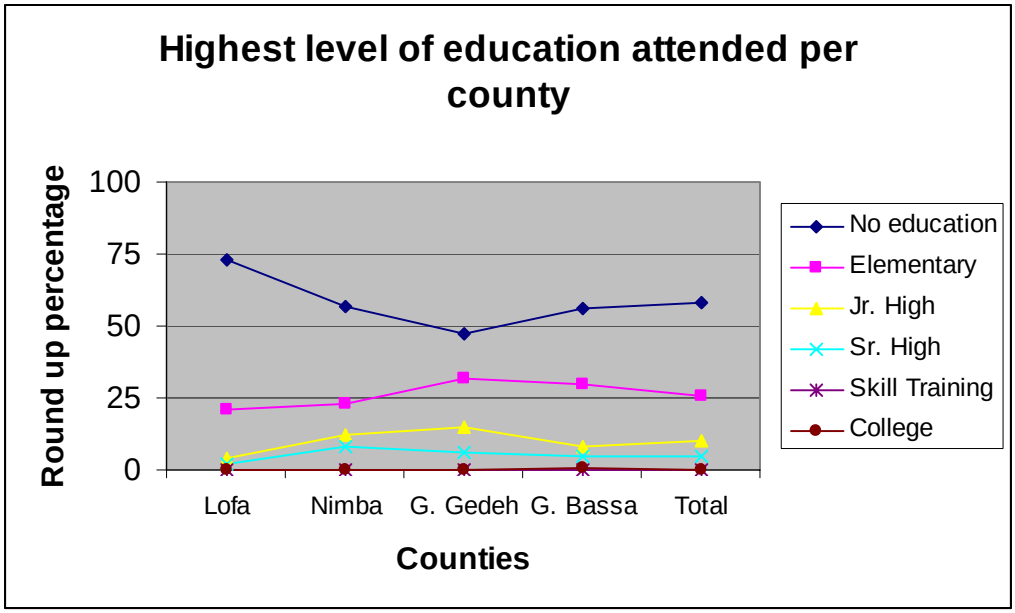


Figure 3: Level of education attended per county

Illiteracy rate is high among the study respondents. No education and elementary education combined accounted for 84.6% of the total sample. Lofa County predominates with 94% of illiteracy rate followed by Grand Bassa (85.1%); Nimba (80.2%); and Grand Gedeh with 79.2%.

Respondents who attended Junior High school education represents 9.6% of the subjects: Lofa County accounts for 3.9%, Grand Bassa 8.2%, Nimba 11.5% and Grand Gedeh 14.8%.

Five point two percent (5.2%) attained senior high school education. Lofa County has the lowest attendance (1.6%). College and skills training represent 0.3% and 0.2% respectively.

This low literacy can be explained. First the four selected counties are rural counties. According to Liberia demographic and Health Survey (op.cit) the level of education is low for female in rural areas in Liberia (80%). One in eight females in rural areas could read and write. Secondly, young girls discontinue school because of pregnancy and early marriage. The age of the first sexual intercourse is very low, 15.5 years for girls and 17.8 years for boys. Girls are sexually active too early. The same report shows that by the age of 17 years, 70% of girls are sexually active. 32% or more out of every three girls age 15-19 years leave school.

The third reason could be attributed to the disruptions of schooling caused by 14 years of civil war. Many school buildings were destroyed during the war. All the teachers deserted schools for security reasons. The majority of women in the study were between 8 to 20 years when the civil war was raging. At such a young age, to undertake the usually long journey to school on foot would have been dangerous. Indeed, the distance from many villages to schools is far and thus can affect school attendance in rural areas. The fourth reason could be the lack of financial and parental support. Parents, especially in rural areas would prefer the boys to go to school than the girls. Some parents find school unnecessary for girls. Girls stay at home to help with the household and field work and prepare themselves for marriage.

Good educations equip people to live a productive life. It also equips them with the tools to lead a socially rewarding life.

A.1.c Religious Affiliation

Religious affiliation is, according to Liberia Demographic and Health Survey (op.cit., p.16), an important background variable in the analysis of socio-economic and demographic behavior. Religion can affect one's attitude towards education, sex, marriage, divorce, contraception, abortion, female genital mutilation (FGM), the use of contraception or the type of contraception as well as authority and decision-making.

table 3: Religious Affiliation of the study Participants

Religion / County	Christian		Muslim	
	n	%	n	%
Lofa	240	78.9	63	20.7
Nimba	280	92.1	24	7.8
Grand Gedeh	292	96.0	12	3.9
Grand Bassa	289	95.0	15	4.9
Total	**1101**	**90.5**	**114**	**9.4**

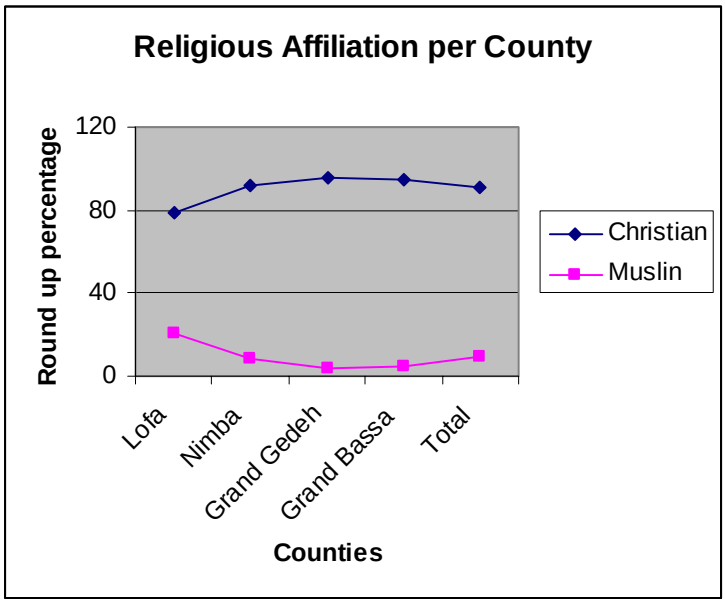


Figure 3: Religious Affiliation per county

About 90.5% of the total sample is Christian. Muslims were represented at a rate of 9.5%. The proportion of Muslims is higher in Lofa (20.7% of Lofa County sample) compare to the other counties, which accounted for 7.8% for Nimba, 4.9% for Grand Bassa and 3.9% for Grand Gedeh. The predominance of Muslims in Lofa County could be explained by its location. Indeed, Lofa County is located in the Northwest of Liberia and is sandwiched between Guinea and Sierra Leone. Lofa is known to have a higher Muslim population (Liberia Demographic and Health Survey, op.cit). In general, the predominance of Christians over Muslims can be explained. Firstly, about 78% of the rural population in Liberia is Christian and Liberia itself is predominantly a Christian Country. Secondly, selection bias could have been introduced.

Indeed, the different ethnic groups known to be predominantly Muslim are not or are poorly represented in this sample. It is about the Mendes (0.0%), the Golas (0.08%), the Mandingos (1.8%) and the Gbandis (2.3%). This is because besides Lofa County, the other Counties where Muslims are mainly found were not among the selected counties (Grand Cape Mount, Bomi and Bong Counties). It should be noted that the selection of counties was done by the use of purposive sampling with the assumption that SGBV prevalence may be higher in the counties, which share a border with Sierra Leone, Guinea and Ivory Coast, which are also ravaged by war. Nevertheless, the percentage of Muslims (9.5%) in the study can allow extrapolation of results to Muslim population in the rural areas of Liberia since 19.1% only of the total rural population is Muslim (Liberia Demographic and Health survey, op.cit).

A.1.d Ethnic Affiliation

Fourteen (14) out of sixteen (16) of Liberia's officially recognized tribes were represented in the study sample with variations between counties in the ethnic composition of the study respondents. The Bassas are majority in the sample. They represent 22.2% of the total sample. They live mainly in Grand Bassa and account for 83.9'% of Grand Bassa County sample. The Manos are second and represents 20.6% of the total sample and are majority in Nimba (72.4%). The Lormas are predominant in Lofa County (76.3%) while the Krahns are mainly in Grand Gedeh County (77.6%).

Table 4: Ethnic Affiliation

County / Tribe	Lofa	Nimba	Gr. Gedeh	Gr.Bassa	Total	Percent
Bassa	1	7	7	255	270	22.2
Belle	1	0	0	0	1	0.08
Congo	0	0	0	0	0	0
Gbandi	28	0	1	0	29	2.3
Gio	0	47	3	0	50	4.1
Gola	0	1	0	0	1	0.08
Grebo	1	4	26	4	35	2.8
Kissi	3	1	2	4	10	0.8
Kpelleh	3	20	1	20	44	3.6
Krahn	2	0	236	2	240	19.7
Kru	0	0	2	9	11	0.9
Lorma	232	3	7	1	243	19.9
Mandingo	21	0	2	0	23	1.8

Mano	12	220	13	6	251	20.6
Mende	0	0	0	0	0	0
Vai	0	1	4	3	8	0.6
Total	**304**	**304**	**304**	**304**	**1216**	**99.46**

A.1.e Parity

Table 4 represents the distribution of the respondents according to the number of children they said they have.

Table 5: Parity

COUNTY / PARITY	Lofa		Nimba		Gr. Gedeh		Gr. Bassa		Total	
	n	%	n	%	n	%	n	%	N	%
0	39	12.8	32	10.5	73	24.0	20	6.5	164	13.4
1	34	11.1	54	17.7	48	15.7	21	6.9	157	12.9
2	45	14.8	36	11.8	53	17.4	10	3.2	144	11.8
More than 3	186	61.1	182	59.8	130	42.7	253	83.2	751	61.7

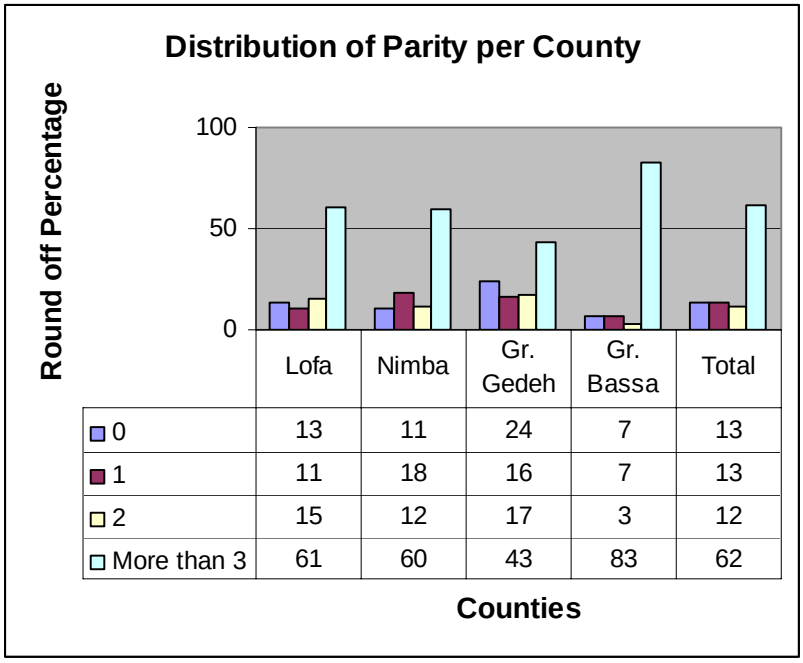


Figure 4: Parity

It can be seen from Table 4 that sixty one point seven percent (61.7%) of the respondents have more than two children. When breaking down this percentage, the majority of the respondents (82.2%) who

have more than two children are from Grand Bassa County; 61.2% are from Lofa; 60% from Nimba and Grand Gedeh represent 42.8%.

Thirteen point four (13.4%) of the total respondents have no children. The highest proportion of childless women (12.8%) is in Grand Gedeh, followed by Lofa (12.8%), Nimba (10.5%) and finally Grand Bassa with 6.6%.

An average of 12.9% of the total respondents has one child. Nimba sample accounts for 17.8% of the mean percentage followed by Grand Gedeh (15.8%); Lofa (11.2%) and Grand Bassa (6.9%).

Physical health consequences stemming from SGBV can jeopardize the reproductive health of these childless women. The corollary of this is psychological problems due to the infertility caused by STIs consequence of SGBV.

A.1.f. Marital Status

Table 6: Distribution of the Respondents According to Marital Status

COUNTY / MARITAL STATUS	Lofa		Gr.Gedeh		Nimba		Gr. Bassa		Total	
	N	%	n	%	n	%	n	%	n	%
Single	71	23.4	64	21.1	63	20.7	68	22.4	266	21.1
Married/Consensual Union	75	24.7	55	18.1	89	29.3	97	31.9	316	26.0
Divorced/separated	104	34.2	95	31.2	81	27.6	61	20.1	344	28.3
Widower	33	10.8	50	16.4	55	18.1	26	8.5	164	13.5
Living with a man on no permanent basis	21	6.9	40	13.2	16	5.3	52	17.1	129	10.6
TOTAL	**N=304**		**N=304**		**N=304**		**N=304**		**N= 1216**	

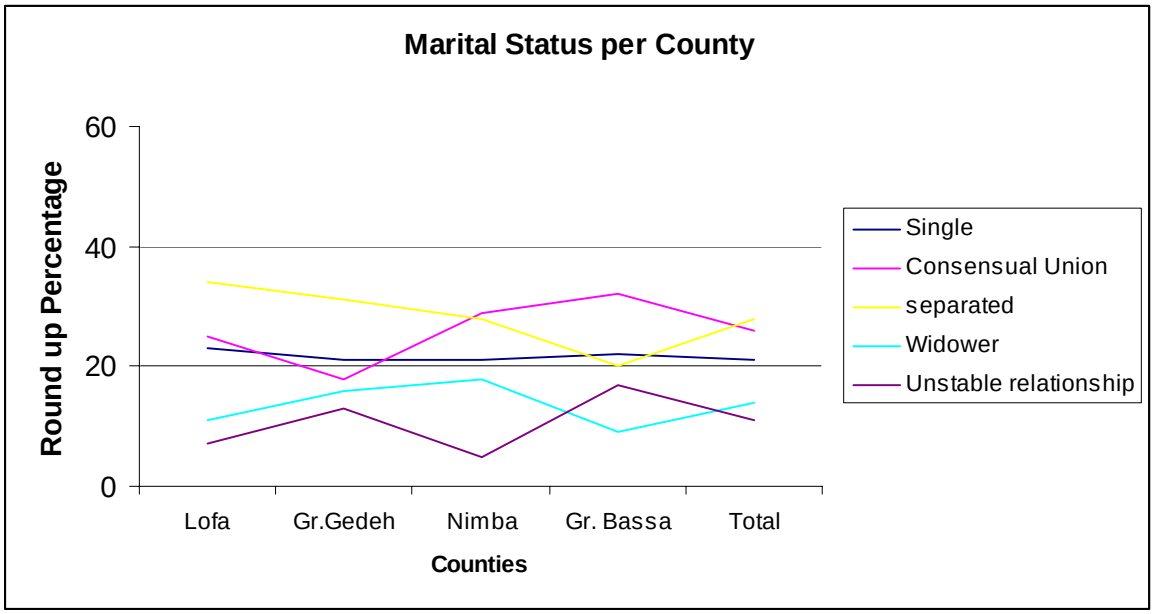


Figure 5: Marital Status of the Study Respondents per County.

The majority of women who participated in the study reported being divorced/separated (28.3%), but 50% of them are living with a man in a sort of interim relationship. Twenty-six percent (26%) declared that they were married. This number combined with women who are living in common law marriage and consensual union, where the couples are in a sort of permanent or long-term sexual union.

Twenty-one point nine percent (21.9%) of the participants are single and about 10.6% are living with a man in interim or non-permanent relationship. These women have never been married. Thirteen point five percent (13.5%) claimed to be widowed. Most of the women who are widows said that their husbands were killed during the war or they died from the consequences of the war.

A.2. Variables related to the study:

A.2.1. Types of Sexual Violence

Table 7 represents different types of acts of violence experienced by the participants during and after the conflict.

Counties / Violence	Lofa		Nimba		G. Gedeh		G. Bassa		Total %	
	n	%	n	%	n	%	n	%	n	%
Slipped or hit	175	57.4	215	70.8	221	72.5	218	71.8	829	68
Choked	104	34.2	113	37.2	145	47.7	221	39.8	483	39.6
Beaten or kicked	199	65.6	229	75.2	239	78.5	225	74.0	892	73.4
Tied up or blindfolded	123	40.5	94	30.9	166	54.6	123	40.5	506	43.8
Threatened with a weapon of any kind	225	74.0	86.2		256	84.3	232	76.3	975	80.1
Shot at or stabbed	65	21.3	262	24.4	100	32.8	90	29.7	329	27.1
Deprived of food water or sleep	183	60.2	74	71.9	211	69.4	218	7I.9	832	68.4
Experienced physical disfigurement	92	30.1	119	39	147	48.4	134	44.0	492	40.4
Detained against your will	224	73.9	275	90.5	262	86.2	244	80.3	1005	82.8
Subjected to improper sexual comments	186	61.1	226	74.3	228	74.8	230	75.6	870	71.5
Forced to remove or stripped of your clothing	212	69.7	224	73.6	247	81.1	215	70.6	898	73.8
Given internal body cavity search	133	43.6	173	57.9	166	54.6	151	49.6	623	51.4
Subjected to unwanted kissing	148	48.8	135	44.9	186	61.2	155	51.0	624	51.3
Touched on sexual parts of your body	157	51.8	157	51.6	170	55.9	162	53.3	646	53.1
Forced or threatened with arm to make you give oral sex, anal sex or vaginal sex	206	67.6	234	76.8	223	73.4	215	70.5	878	72.1
Penetrated with an object in vagina or anus	85	27.8	67	22.1	83	27.1	59	19.4	294	24.1

Compiled33333333 to engage in sex for food, water and protection	139	45.8	113	37	141	46.3	151	49.6	544	44.7
Forced to watch someone being physically assaulted	174	57.3	210	69.0	199	65.3	201	66.1	784	64.4
Forced to watch someone being sexually assaulted	142	46.8	166	54.6	163	53.6	149	49.0	620	51
Forced to cook human meat, forced drink my Father's blood	12	3.9	7	2.3	7	2.3	0	0	26	2.1
Domestic violence/raped/beaten	120	39.5	70	23.0	89	29.2	136	42.8	414	34.3
F G M	25	8.2	8	2.6	11	3.6	23	7.6	67	5.5
Forced marriage	32	10.5	13	4.3	26	8.5	25	8.2	96	7.9
Nothing happen	79	26.1	29	9.5	42	13.8	74	24.3	224	18.4

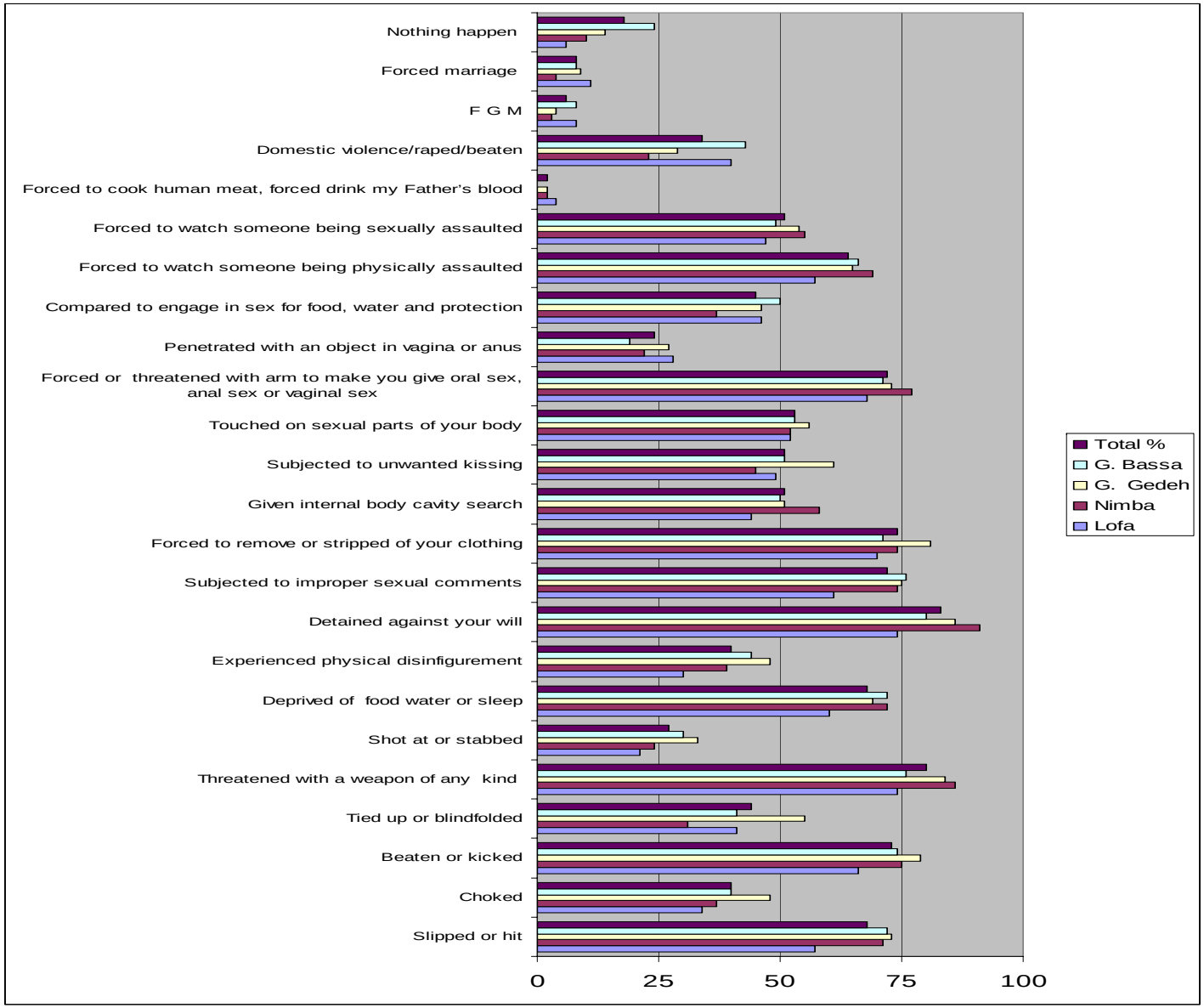

Nothing happen
Forced marriage
F G M
Domestic violence/raped/beaten
Forced to cook human meat, forced drink my Father's blood
Forced to watch someone being sexually assaulted
Forced to watch someone being physically assaulted
Compared to engage in sex for food, water and protection
Penetrated with an object in vagina or anus
Forced or threatened with arm to make you give oral sex, anal sex or vaginal sex
Touched on sexual parts of your body
Subjected to unwanted kissing
Given internal body cavity search
Forced to remove or stripped of your clothing
Subjected to improper sexual comments
Detained against your will
Experienced physical disinfigurement
Deprived of food water or sleep
Shot at or stabbed
Threatened with a weapon of any kind
Tied up or blindfolded
Beaten or kicked
Choked
Slipped or hit
0
25
50
75
100
Total %
G. Bassa
G. Gedeh
Nimba
Lofa

Table 7 represents different types of acts of violence experienced by the participants during and after the conflicts.

Out of 1,216 women and girls who participated in the study, 992 or 81.6% reported that they were subjected to one or multiple violent acts during and after the conflict. Only 18.4% reported not having experienced any physical, sexual or social acts of violence during or after the war. The study participants reported a total of 24 acts of violence. The ten most commonly reported acts during the conflict are: detained against a woman's will (82.8%); being threatened with a weapon (80.1%); beaten or kicked (73.8%); forced or threatened with arm to make you give oral sex, anal sex or vaginal sex: rape (72.1%), out of this percentage, 70.1% is gang rape committed by more than one assailant. Subjected to improper sexual comments accounted for 71.5%, deprived of food, water or sleep (68.4%); hit (68%). The proportions of these eight acts of violence are also highly reported in each county. However, in Lofa, there are lower compared to other counties. It varies from 3% to 10% depending on which act of violence.

Despite that the information about sexual violence was directly canvassed, some respondents in Lofa County, reported mostly knowing somebody else who had been raped than disclosing their own experience. It shows the unwillingness to report rape. Women and girls were more open in other counties and were more willing to share their experiences. It was also obvious that in general women and girls were more open with interviewers from Monrovia than with local interviewers. With local interviewers they were more willing to share their information with a local woman who works with women group than with any one else from the same community or hospital. There must be mass mobilization and awareness creation about SGBV to decrease the stigma associated to sexual assault.

Other reported acts of SGBV although lower proportions, yet significant are: penetrated with an object such as green banana, wood stick, barrel of a gun in the vagina or anus, hot water, cloth, mud, motor pestle, dried batteries flash and hot pepper.

Forced marriage and early marriage accounted for 7.9%; forced to cook human meat and forced to drink human blood were reported by 2.1% of the respondents; and domestic violence including marital rape/beaten (34.3%).

Concerning the penetration of an object in the vagina or anus, some of the women confided:

> They used green banana and put into my vagina many times. There are things they did cannot speak about them. Since then, I cannot conceive, I am having back and lower abdominal pain.
>
> …After being raped by five men, they stretched me apart and inserted a motor pestle in my vagina. Until now, I still have pain inside me.
>
> I refused to be raped. I fought but he was stronger than me. He raped me savagely. After the rape, he rubbed hot pepper in my vagina to punish me for my refusal to have sexual intercourse willingly. It was very painful.
>
> After raping me, I was bent over and they inserted in my rectum the edge of a bottle. My sister was raped to death; they inserted an empty bottle in her vagina.

I was raped; after they tied me up and they put ants in my vagina to bite me.

They opened my legs and inserted cassava root as a penis. It was so painful. They told me that if I scream, they would shoot and kill me.

As for forced and early marriage, some young women said:

I was forced to marry this man because he has money and can help my family. I marry young at the age of 15 years.

Another said:

My parents forced me to marry a soldier man so as to bring food and items to the house. I didn't like the idea but I had to do it. I was 14 years old.

The consequences of early marriage include early and frequent childbearing, discontinuation of schooling and loss of access to education.

Concerning cannibalism, one woman revealed:

I was forced to watch them open a pregnant woman stomachs and the baby taken out, butchered and cooked. They forced me to share the meat with them.

Another said:

The rebels in Nimba abducted me. I was forced to cook human meat especially young babies. They raped me several times and, just before I was released, they inserted a stick in my vagina. As a result, I had an operation and they removed my womb. I am only 20 years old. I don't have any chance to have a child of my own.

Another young woman added:

I was raped, stabbed and forced to watch my father being killed and I was forced to drink the blood from his neck. Imagine I was only sixteen years old at the time.

Concerning domestic violence, 34,3% of respondents reported sexual and physical abuse from the husbands/partners. Grand Bassa reported the highest rate of domestic violence (42.8%), followed by Lofa County (39.5%); Grand Gedeh (29.2%) and Nimba County (23%).

The abused women reported in these terms:

I am all the time beaten up by my husband each time I do some thing wrong. One day, he kicked me and stepped on my chest. I can still feel pain all over my body from his beatings.

My parents forced me to marry a rebel. The man is abusing me every day; beating me if I don't do want he wants. He gives my parents gifts so they force me to stay with him

> My husband was killed during the war. My new husband is ill-treating me. He insults me all the time and beats me up anytime he wants. I lost two teeth from his beatings.
>
> My husband can kick me on the back and the stomach. He broke my leg one day.

The private practice of beating wives into submission is a gross injustice carried out worldwide. Spousal abuse is a serious global health hazard in Liberia. A number of respondents reported living in fear of injury and death at home. Abusive men typically control their wives with violence and they silence them with death threats.
Indeed, it is well known that there is a tendency, even among people who abhor other form of violence, to trivialize, ignore, or justify violence perpetrated by husband.

One woman said:

> My husband usually beats me when he is drunk. But he is a good man. He takes care of the children and brings me gifts after the fight.

Also, outside his home the abusive husband may appear to be charming; one woman said:

> When we are out or when we have visitors, my husband is an angel. But when we are alone at home, he gets angry for nothing. He beats me as if I was an animal. Many times, I wanted to leave him but I am afraid; he threatened to kill me if I leave him.

Home becomes the most dangerous place for women and frequently the site of cruelty and torture.

Number of assailants per victim

Number	Lofa		Gr. Gedeh		Nimba		Gr. Bassa		Total	
	N	%	N	%	N	%	N	%	N	%
1	87	28.6	78	25.6	79	26.0	110	36.4	355	29.0
>1	215	70.7	222	73.0	223	73.3	193	63.6	853	70.1
Refused	2	0.6	5	1.6	2	0.6	O	0	9	0.7
Total	304		304		304		304		1216	

This table shows the number of assailants the study respondents had to face during the assault. Twenty-nine point two percent (29.2%) of the respondents were sexually assaulted by one assailant, per victim, while more than one assailant raped 70.1% others. Gang rape perpetrated by many assailants was according to the respondents, the most traumatic, degrading and humiliating sexual assault of human kind experienced by SGBV survivors. (Grand Bassa reported the lowest percentage of gang rape (63.6%) while in other counties the proportions of gang rape are between 70.7% and 73.3%)

Identity of the perpetrators

When ask the question to know the perpetrators of SGBV incidents, women and girls reported the following:

The rebels committed 47.1% of sexual assault; armed members of fighting forces perpetrated 42% of SGBV. The highest proportion of incidents committed by the rebels is found in Grand Bassa with 59.7% of the cases; followed by Nimba County with 51% and Grand Gedeh with 43.6% of cases; Lofa County represented the lowest percentage with 33.6% of the incidents committed by rebels.

The soldiers were the most common perpetrators in Lofa County (56.1%); they perpetrated 43.9% of cases in Nimba County sample and 40.8% in Grand Gedeh. Grand Bassa sample reported the lowest percentage of incidents committed by the fighting forces.

Husbands and intimate partners accounted for 34% of SGBV cases. Grand Bassa reported more cases of domestic violence, followed by grand Gedeh. It is important to note that some women reported experiencing SGBV during the conflict and at home. Uncle was reported by 3.4% of respondents; civil defense force and neighbor accounted for 1.4% each. Police officer, prison guard, teacher were reported at a respective rate of 1%, 0.9% and 0.2%. Humanitarian and judge accounted respectively for 0.3% each.

A.2.2. Informing somebody about the incident

Seven hundred and thirty seven (60.6%) out of 1216 respondents did not tell anyone about what happened to them. When asked why they did not tell anyone about the assault, they gave the reasons summarized on table 8.

Table 8: Reasons for not telling anyone about what happened

COUNTY / REASONS	Lofa		Gr. Gedeh		Nimba		Gr. Bassa		Total	
	n	%	n	%	n	%	n	%	n	%
Feeling shame/embarrass	109	63.4	92	47.7	117	60.0	75	64.1	393	58.1
Fear of being stigmatized	53	30.8	50	25.9	68	34.9	42	35.9	213	31.5
Fear of rejection by family/comm.	43	25.0	36	18.6	45	23.1	29	24.8	153	22.6
Did not trust anyone	75	43.6	62	31.1	83	42.6	65	55.5	285	42.1
Thought nothing could be done	40	23.3	34	17.6	39	20.0	30	25.6	143	21.1
Fear for more violence if perpetrator hears	11	6.4	6	3.1	13	6.7	14	12.0	44	6.5
Don't know	3	1.6	2	1.2	1	0.5	0	0	6	0.9
	193		172		195		177		677	

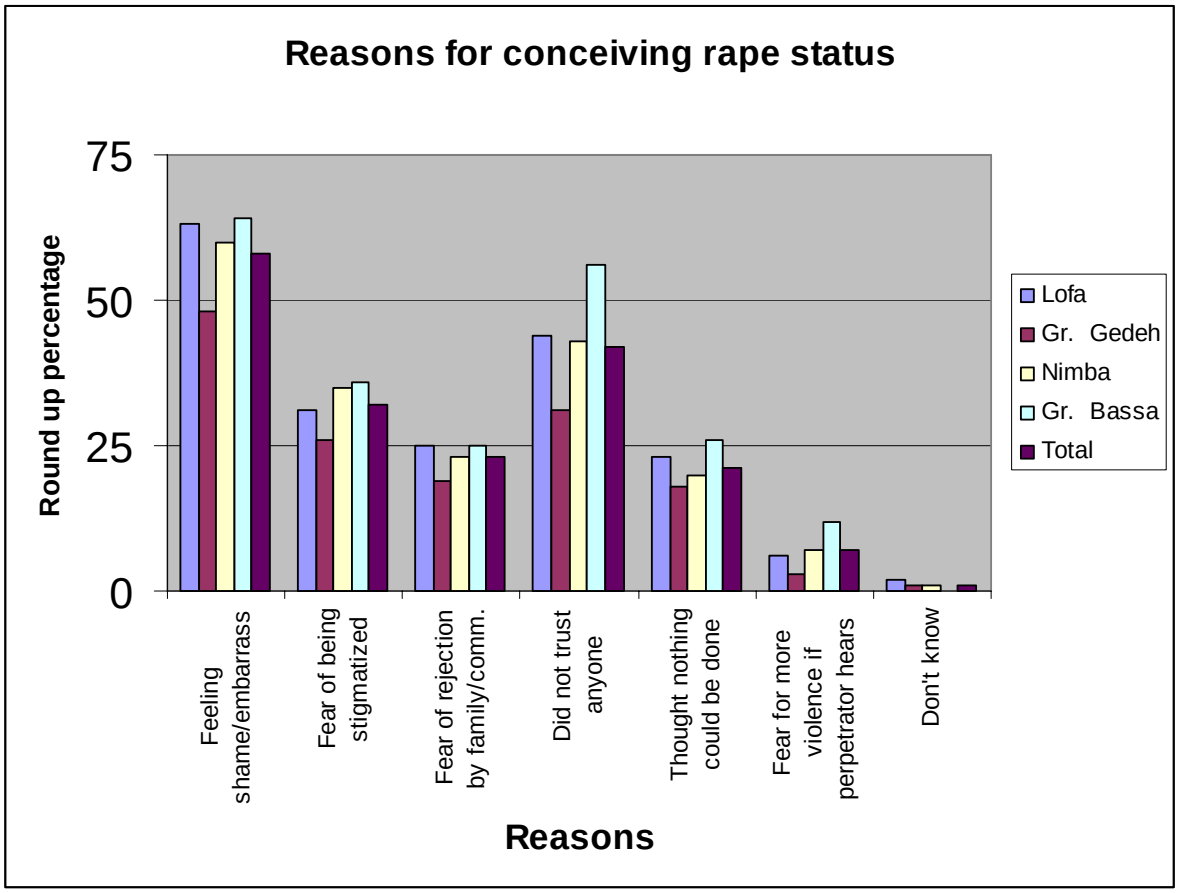


Figure 7: Reasons for not disclosing the rape status

Table 8 summarizes the different reasons the victims reported for not telling anyone about what happened to them. It can be seen that feeling of shame and the embarrassment associated with the sexual assault (58.1%) was the major reason SGBV survivors kept silent about their condition. The lack of trust to anyone was the second reason suggested by the respondents (42.1%). Fear of stigmatization was the third on the line (31.5%). Fear of rejection by family/community was reported at a rate of 22.6%. The combination of fear of stigmatization and fear of rejection by family and community gives a rate of 54.1%.

Twenty-one point one percent (21.1%) thought nothing could be done because it does not change their status of being sexually assaulted.

Thirty nine point four percent (39.4%) disclosed what happened to them. The table 9 summarizes all participants' answers related to the reactions of people they told about their situation.

Table 9: Reactions of people the victims told about the assault

COUNTY / REACTIONS	Lofa		Grand Gedeh		Nimba		Grand Bassa		Total	
	N	%	N	%	N	%	N	%	N	%
Stigmatized me	120	62.2	123	71.5	98	54.9	84	71.8	425	62.8
Took the information but nothing happened	37	19.1	52	30.2	32	16.4	55	47.0	176	26.0
Provided emotional support	82	42.5	71	41.3	76	39.0	66	56.4	295	43.6
Referred me to a health worker	37	19.1	59	34.3	39	20.0	26	22.2	161	23.8
Referred me to a NGO	6	3.1	9	5.2	4	2.1		2	21	3.1
Referred me to human rights organization	1	0.5	1	0.5		0		1	3	0.4
Referred me to Religious authority	4	2.1	8	4.6	1	0.5		5	18	2.7
Referred me to Women's group	5	2.6	16	9.3	8	4.2		2	31	4.6
TOTAL	**193**		**172**		**195**		**117**		**677**	

When quizzed about the reactions of people the survivors told about the assault, the respondents gave the following responses: they stigmatized me (62.8%); this social rejection usually results in further emotional damage including shame, self-hate, withdrawal, depression. Nimba has the lowest percentage (54.9%) of participants who reported being stigmatized by people who learnt about their rape status. Grand Gedeh and Grand Bassa reported the highest percentage of respondents who where stigmatized. The referral to a health worker was cited at a rate of 23.8%.

It should be noted that those survivors who sought help from health workers a few days after the assault were mostly children. As said previously, many sexual assaults took place three years before the survey. Some respondents were then aged between 8 to 15 years. The parents or families usually take the bleeding and traumatized girls to health personnel.

They referred me to a NGO, a religious authority and to a human rights organization were reported fairly at a rate of 3.4%; 2.7% and 0.4% respectively.

"They took the information but nothing happened" was reported by 26.0% of the respondents. Referred me to women's group was expressed by 4.6%.

Awareness and sensitization campaigns are necessary to decrease the stigma and discrimination associated with SGBV.

3. Health Action taken after the assault

All the study participants who were assaulted during the conflict did not look for the help of a health professional after the assault. They were self-treated (92.4%) or/and sought help from a traditional healer or a Traditional Birth Attendant (TBA) (63.3%). Thirty five point two percent (35.2%) looked later on for assistance from a health professional but the interval between the time the incident took place and the time they sought healthcare ranged from one month to five years (1 month-5 years) with a mean of twenty months (20) or one year and seven months.

For the respondents who were assaulted after the conflicts only 23.8% were taken to a health worker for treatment. They are mostly girls' victims of SGBV taken by parents or family members to a health center.

The respondents were asked the reasons underlining their decision for not seeking medical care. Table 10 summarized all the responses to the question.

Table 10: Reasons for not seeking medical care

County / REASONS	Lofa		Gr. Gedeh		Nimba		Gr. Bassa		Total	
	n	%	n	%	n	%	n	%	n	%
Did not need Medical care	31	16.1	11	6.4	17	8.7	20	17.1	81	12.0
Did not know where to go	112	58.2	86	50.0	89	45.6	101	86.3	388	57.3
Medical care not available	140	72.5	150	87.2	164	84.1	95	81.2	549	81.1
Would not do any good	2	1.0	4	2.3	2	1.0	1	0.9	9	1.3
Embarrassment	56	29.0	69	40.1	78	40.0	82	70.0	285	42.1
Afraid of further violence	40	20.7	38	22.1	55	28.1	25	21.4	158	23.3
Would not be believed	4	2.1	6	3.5		0	6	5.1	16	2.5
Thought she would be blame	16	8.2	12	7.0	6	3.1	6	5.1	40	5.1
Bring bad name to Respondent's Family	4	1.3	15	8.7	9	4.6	6	5.1	34	4.9
Bring bad name to husband's Family	3	1.5	4	2.3	5	2.6	3	2.5	15	2.2
Had no money	113	58.5	122	70.9	175	90.0	96	82.0	506	74.7
Had no transport	78	40.4	81	47.1	85	43.5	69	59.0	313	46.2
War	100	51.8	110	63.9	142	72.8	96	82.1	448	66.2
	N= 193		**N= 172**		**N= 195**		**N= 117**		**N= 677**	

In the four Counties, medical care not being available coupled with lack of money appeared to be the main reasons why survivors did not seek medical care. About 81.1% of survivors, who did not look for the help of a professional, did it because there was no medical care available to respond to their health

needs. Seventy-four point seven percent (74.7%) never sought health professionals because of lack of money to pay for medical expenses.

“Because of the war” (66.2%) was another reason survivors never sought help from a health professional. Indeed some women were assaulted on their way to a safe haven, so they decided to stay where they were for fear of further violence. Grand Bassa represented the highest proportion of survivors who did not look for the assistance of a health professional because of the war. Fifty seven point three percent (57.3%) said that they did not know where to go for medical care.

Many health facilities were destroyed during the war, health personnel deserted the health facilities because of violence and many survivors sought refuge in the bush far away from towns or villages where health centers or hospitals are located. There, they could not find transportation (46.2%) to take them to the hospitals or health centers, survivors had to walk long distances to find medical assistance. It was too risky to undertake the long journey to a hospital or a health center on foot.

Embarrassment was reported at a rate of 42.1%. Some survivors lacked confidence in the healthcare providers in disclosing their rape status. According to the responses from focus groups, the lack of confidentiality, lack of apathy, delayed assistance, and insensitive behaviors that characterized healthcare providers in many settings discouraged the survivors from coming forward. As health professionals, they should recognize the rights and needs of SGBV survivors as pre-eminent in terms of access to respectful and supportive services, guarantee of confidentiality and safety.

There are other reasons reported at low proportions: would not do any good (2.5%). Survivor thought she would be blamed (5.1%); bring bad name to respondent’s family (4.9%); and bring bad name to husband’s family (2.2%). All are also feebly reported in each county.

Twelve percent (12%) of the total respondents reported that they did not need medical care and that is the reason why they did not look for medical care.

L’analyze of the reasons participants reported being the underlining cause for not seeking assistance from a health professional showed that most of the respondents misjudged or ignored the severity of their symptoms to take health actions. According to WHO (2004), the management of SGBV survivors depends on how soon the survivor presents to the health service after the incident. It is advisable to present within 72 hours of the incident even if there is no visible physical problem. It is then important to sensitize women and families on the importance of medical care after being raped. For instance, the emergency contraceptive treatment to avoid unwanted pregnancy, PEP for the prophylaxis of HIV, and so on.

A2.3. Consequences of Sexual and Gender-Based Violence experienced by respondents

The interviews revealed that SGBV survivors were suffering from many kinds of ailments as result of sexual violence. They presented many symptoms that were categorized in four groups: physical, psychological, social and economic consequences.

Understanding the potential consequences of sexual gender-based violence helps develop appropriate strategies to respond to these after-effects and prevent further harm (UNHCR, 2003).

A.2.3 Physical Health Consequences

Table 11: shows the physical health problems reported by participants in the study

County / HEALTH PROBLEM	Lofa		Gr. Gedeh		Nimba		Gr. Bassa		Total	
	n	%	n	%	n	%	n	%	n	%
Vaginal itching	212	70.0	250	82.2	240	79.0	190	62.5	892	73.4
Vaginal smelly discharge	190	62.5	201	66.1	220	72.4	196	64.5	807	66.3
Backache	180	59.2	200	65.8	201	66.1	201	66.1	782	64.3
Dysmenorrhea	112	36.8	140	46.1	84	27.6	62	20.4	398	32.7
Irregular Menstruations	240	78.9	169	55.6	146	48.0	116	38.1	671	55.1
Amenorrhea with Pregnancy	60	19.7	47	15.5	65	21.4	51	16.8	223	18.4
Dispareunia	39	12.8	45	14.8	60	19.7	34	11.2	178	14.6
Urinating without knowing	20	6.6	31	10.2	21	6.9	30	9.8	102	8.4
Lower Abdominal Pain	190	62.5	204	67.1	163	53.6	140	46.1	697	57.3
Vaginal bleeding	5	1.6	9	3.0	3	0.9	6	2.0	23	1.9
Uterine prolapse	9	3.0	4	1.3	3	0.9	3	0.9	19	1.5
Bloody stools	5	1.6	2	0.6	0	0	3	0.9	10	1.3
Oozing of rectum	45	14.8	62	20.4	70	23.0	56	18.4	233	19.2
Sores in genital areas	100	32.8	86	28.3	116	38.1	99	32.6	401	33.0
Asthenia	70	23.0	65	21.4	60	19.7	55	18.1	250	20.5
No problems	31	10.2	25	8.2	16	5.2	28	9.2	100	8.2

n = 304

N = 1,216

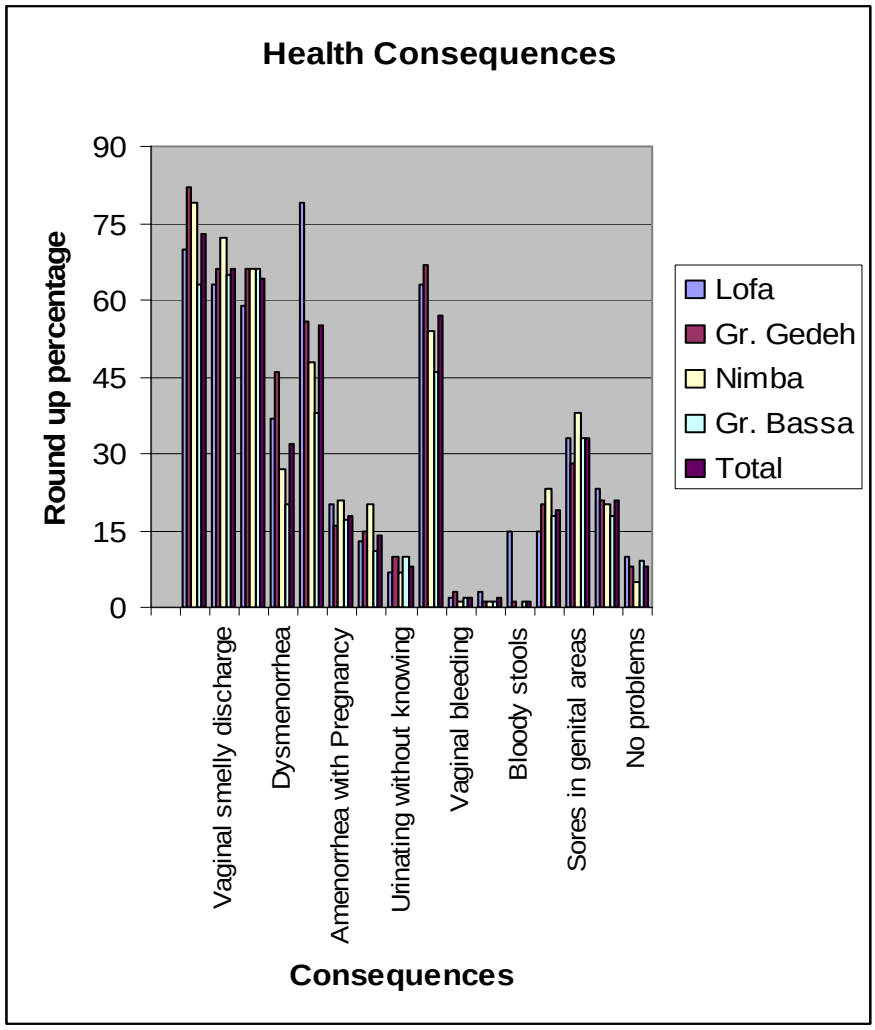


Figure 10: Health consequences

The most common symptoms reported by all participants are: vaginal itching (73.4%), smelly vaginal discharge (66.3%), backache (64.3%), lower abdominal pain (57.3%) and irregular menstruation (55.1%). The Grand Gedeh sample has a higher proportion of women experiencing vaginal itching (82.2%) while the Grand Bassa sample reported the lowest proportion of women and girls experiencing vaginal itching (62.5%). The table points to higher rate of smelly vaginal discharge in Nimba County

(72.4%) while Lofa shows slightly lowest rate (62.5%). The highest rate of lower abdominal pain is observed in Grand Gedeh (67.1%) while the lowest rate is in Grand Bassa (46.1%).

The proportion of the study respondents experiencing backache is about the same in the four counties. An average of 55.1% of studied participants had irregular menstruation with the highest rate being in Lofa (78.9%) and the lowest proportion being in Grand Bassa (38.1%) Thirty-three percent (33%) of respondents reported developing sores in their genital areas. The highest genital sores rate is observed among Nimba participants (38.1%) and the lowest among participants in Lofa (13.2%).

In general, participants presented several symptoms of sexually transmitted infections. The most important pathological condition associated with a discharge from the genitals is gonorrhea. Genital sores can mean Herpes or Syphilis. These conditions can also be responsible for backache, lower abdominal pain, irregular menstruation and etc.

Sexually transmitted infections can affect women's reproductive health if medical treatment is not received from a health professional. Oozing of rectum represented 19.5% of the respondents. Lofa reported the lowest percentage (23.0%). Amenorrhea without pregnancy accounted for 18.4% of the respondents. This amenorrhea is not related to lactation amenorrhea. It can be assumed that the amenorrhea the respondents are experiencing can probably be linked to psychological problems (stress) or STIs or a pathologic state stemming from SGBV and its consequences.

Only 9.2% of the total respondents did not report experiencing any physical health symptoms, at the time of the interviews. This problem of high rate of sexually transmitted infection symptoms among women in the four counties is a very serious one.

Indeed, sexual activity is high in Liberia and, having multiple sexual partners is a common sexual behavior in Liberia, especially among youths. These compounded with lack of understanding the meaning of safe sex (Demographic and Health survey, op.cit.), expose sexually active people and their multiple partners to risk of infections and quick spread of STIs including HIV/AIDs in the community.

Eight point four percent (8.4%) are experiencing symptoms of vesico-vaginal fistula (VVF), 1.9% vaginal bleeding, 1.5% uterine prolapse and 1.3% bloody stools. The respondents seemed not to worry about all these symptoms or maybe the stigma associated with being infected with a STI and the reluctance of talking about sex and the genitals compounded with the knowledge of the condition one is in stems from rape, they are reluctant to talk about it.

About the vesico-vaginal fistula (VVF) and recto-vaginal fistula (RVF), one woman described:

> Seven men raped me in the vagina, anus and mouth. After, one of them said that he wasn't satisfied and had to use a stick and penetrated in my vagina. Since than, I have urine coming out anytime.

Another woman reported:

> I was raped by a group of men who caught me when I was running away. The two last men sexed me in the anus until I started bleeding from the anus. I can no longer control my toilet.

Another woman revealed:

> My vagina and anus are out and feces can come out anytime.

Another added:

> Three men abducted me for two years. They sexed me almost every day in the anus, vagina and mouth. I have since developed irregular menstruation, pain in my throat and oozing of the anus.

2.b Psychological and Emotional disturbance of SGBV

County	Lofa		Grand Gedeh		Nimba		Grand Bassa		Total	
Disturbances	N	%	N	%	N	%	N	%	N	%
Feeling of humiliation	182	59.8	198	65.1	214	70.3	174	57.2	768	63.1
Fear /worries	91	32.2	66	21.7	50	16.4	35	11.5	242	79.6
Shame	127	41.7	103	33.8	140	46.0	63	20.7	433	35.6
Anxiety	92	30.2	107	35.1	33	10.8	65	21.3	297	24.4
Palpitation	118	38.8	137	45.0	123	40.4	110	36.1	488	40.1
Insomnia	189	62.1	223	73.3	211	69.4	152	50.0	775	63.7
Nightmare	101	33.2	122	40.0	87	28.6	70	23.0	381	31.3
Uselessness of life	35	11.5	61	20.0	32	10.5	97	31.9	225	18.5
Feeling of guilty	185	60.8	154	50.6	129	42.4	149	49.0	617	50.7
Feeling of rejection	70	23.0	90	29.6	78	25.6	92	30.2	330	27.1
Sadness	79	25.9	92 30.2		55	18.0	62 20.3		288 23.6	
Frustration	35	11.5	47	15.4	85	27.9	48	15.7	216	17.7
Withdrawal	92	30.2	76	25.0	48	15.7	60	19.7	276	22.6
Divorce	79	25.9	88	28.9	120	39.5	57	18.6	344	28.3
Feeling of hatred	93	30.5	91	29.9	108	35.5	103	33.8	395	32.4
Sexual aversion	38	12.5	64	21.0	45	14.8	42	13.8	189	15.5
Confusion and embarrassment	213	70.0	194	63.8	230	75.6	199	65.4	836	68.7
No Problem.	128	42.1	26	8.5	17	5.5	21	6.9	92	7.5

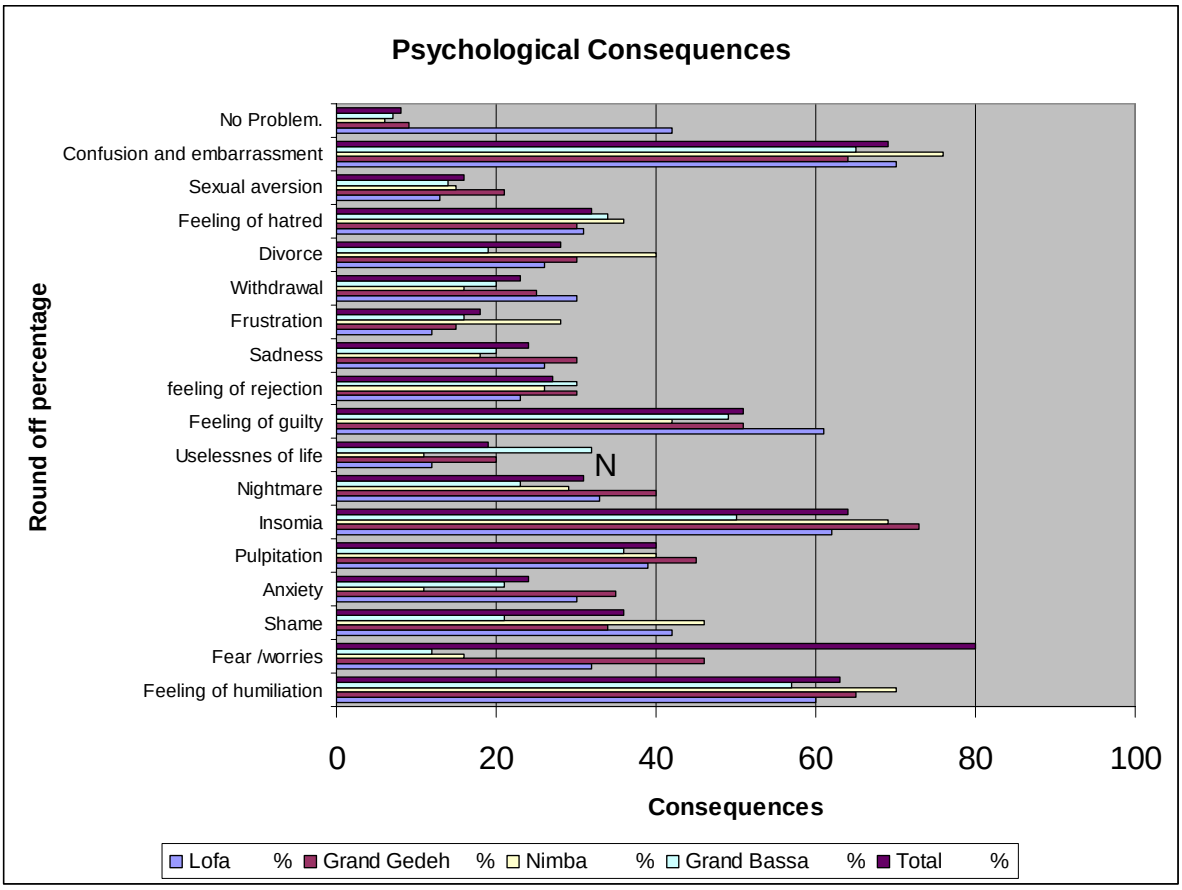


Figure 10: Psychological and emotional consequences

Table and figure 10 shows the psychological and emotional disturbances experienced by the study respondents. Nine two point five percent (92.5%) of the respondents reported suffering from one or more psychological and emotional disturbances. These outward symptoms are more severe for some women and relatively moderate or severe for others.

Table 10 pointed out that, in general, fear/worries dwelled in 79.6% of the respondents; confusion and embarrassment are experienced by 68.7% of the victims who participated in the study; feeling of humiliation is felt by 63.1% of the victims; insomnia is suffered by 63.7% of the respondents; feeling of guilty is expressed by 50.7% of the subjects while feeling of hatred is expressed by 32.4%. Nightmares continue to haunt 31.3% of the respondents while shame is felt by 35.6%

Other symptoms are not highly represented, yet serious conditions. It is about anxiety (24.4%); sadness (23.1), withdrawal (22.6%); frustration (17.7%); sexual aversion (15.5%) and depression (12.6%).

Like in Montserrado and Bong results, the psychological disturbances are dominated by symptoms of post-traumatic stress disorders (PTSD). The severity of these symptoms was proportional to the number of encounters and the length of time suffered. In this regards, one woman said:

> My two sons were forced to have sex with me in the presence of their father; after they killed three of them (my husband and sons). They abducted me for seven months to be their cook. They were beating me often and raping me time to time. I am an old woman; I cannot have children anymore. Who will take care of me in my old age? Now I am like some body that didn't have children in her life. I am a sick and useless woman.

Another women confided:

> The boys who raped me wee very small that they couldn't carry their guns. They raped me during one week. I am twice their mother. I feel ashamed to disclose what happened to me. I also feel that they laid a curse on me.

Another woman recalled:

> They cut off my son's body parts (his sex) and give it to me to eat. After, they stoned him to death and threw him in the river. Since than, I am not myself. I am having nightmares.

Another woman revealed:

> My hands and feet were tied up while five men were raping me. They also use cloth on a stick to wipe my vagina before another got on board. I have since developed bleeding and also I cannot have a child. Who really will take care of me? I want a child…(sobbing)…

Another participant reported:

> I was naked for two weeks waiting them to sex me anytime they wanted. I was riding with them everywhere they went, naked. I have sharp pain during sex. It is as if I have fresh burning wound in my vagina.

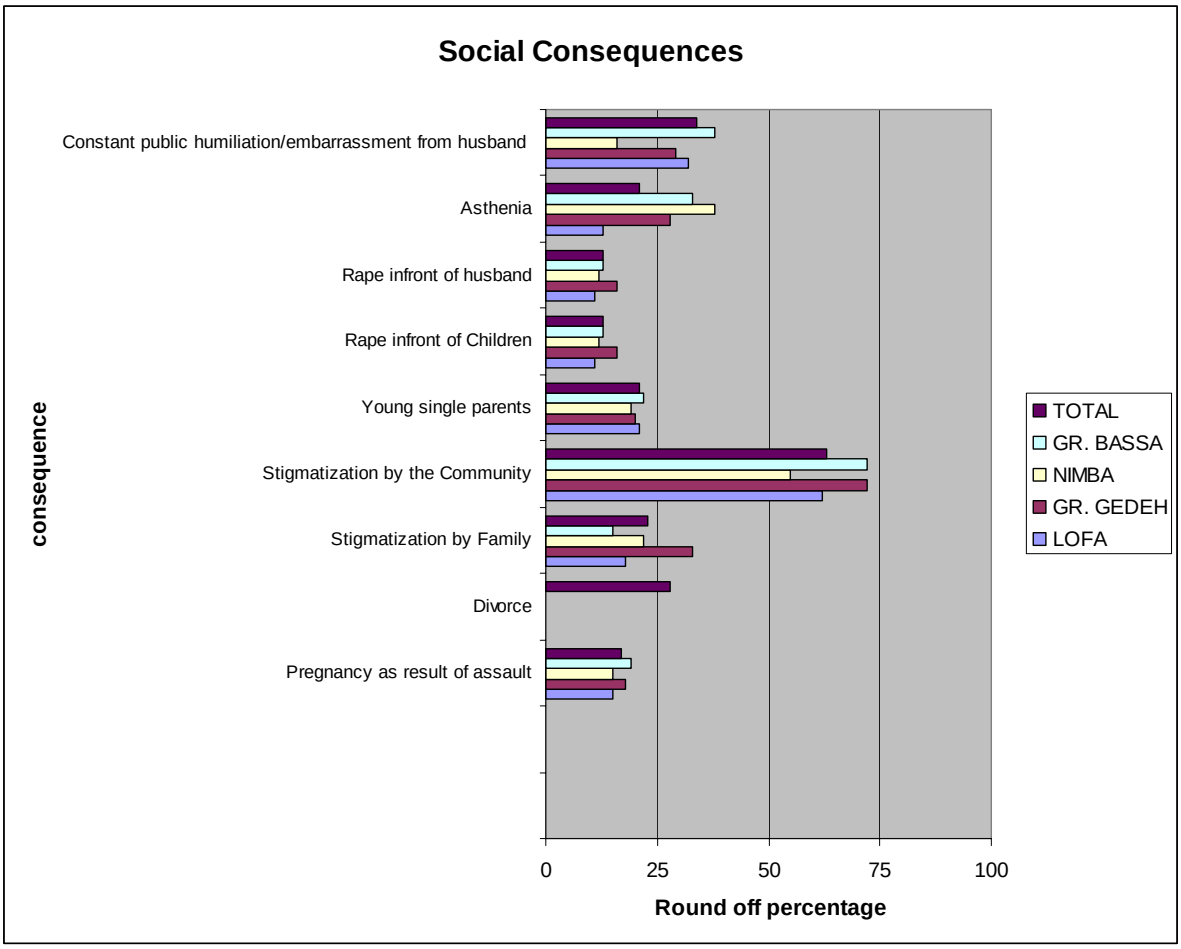
Women and girls who participated in the study reported having witnessed other women and relatives raped and killed at the time of the assault. The reported many cases in which grandmother, daughter and grandchild (daughter) raped or forced to watch each other be physically and sexually assault.

2.c Social Consequences of Sexual Gender-Based Violence

Table 11: Social consequences of sexual gender-based violence

County / SOCIAL CONSEQUENCES OF SGBV	LOFA	GR. GEDEH	NIMBA	GR. BASSA	TOTAL
Pregnancy as result of assault	14.8	18	15.4	18.5	16.8
Divorce					28.3
Stigmatization by Family	18.1	33	22.3	14.9	23.6
Stigmatization by the Community	62.2	71.5	54.9	71.8	62.8
Young single parents	21.4	20.4	18.5	22	20.5
Rape infront of Children	10.8	16.2	11.8	12.5	12.7
Rape infront of husband	10.8	16.2	11.8	12.5	12.7
Asthenia	13.2	28.3	38.1	32.6	20.5
Constant public humiliation/embarrassment from husband	32.1	29.3	15.6	38.1	34.3

* *This table is made of information (percentage) from different tables.*



This table and this figure describe the social consequences of sexual gender-based violence experiencing by the survivors. One person can experience one or more of these problems. The most reported social problem survivors are facing is stigmatization by the community. It is experienced by 62.8% of the respondents. The higher proportions are in Grand Bassa and Grand Gedeh with 71.8% and 71.5% respectively. Nimba represents the lowest percentage with 54.9%.

The second social problem is constant public humiliation and embarrassment from the husbands or intimate partners representing 34.3% of the study sample.

Asthenia and young single parents accounted for 20.5% each. The survivors, who experience asthenia, feel too exhausted to function socially and normally. Young single parents are still children themselves to take care of their children. Some have already three kids at the age of 17 years. One 17 years old girl said:

> I was abducted at the age of 13 years old by a group of rebels. I have three children from three different men. Now I am left alone with the children. I don't have a job or family. I haven't seen my mother since she was abducted, I don't know where she is. My father was killed. With three kids who will really help me?

c. Economic Consequences

According to the Demographic and Health Survey (op.cit), over eighty percent (80%) of the Liberian people depend largely on subsistence farming such as mixed cropping, production of rice, corn, cassava, peppers, beans, bananas, coastal food, bitter boils and etc. These crops are mostly for home consumption and local markets.

During the conflicts, most of the respondents lost all of their possessions. Rural women in Liberia are practically farmers. They are doing agriculture, fishing and petit trading, selling dry goods in front of their houses. During the conflicts, their possessions were either looted or destroyed or burned up by members of fighting forces. Many women sought refuge in the bush in order to avoid violence. In this process, they carried with them what they could from their houses. While on the run, *they would meet the assailants who assaulted them and robbed them of everything.* Now they have to start their lives from the bottom.

One woman said:

> Everything in my house was taken away (mattresses, household materials, money..) and they burnt down my house. They killed my husband and sons. I am left with nothing.

As a result of the conflict, in rural areas, the way of life in terms of economy is most likely based on barter system of transaction. Most of them either exchanged their personal belongings or goods for services/goods among themselves. Thirty four point three percent (34.3) are chronically sick and tired (34.3%) resulting in the survivor not being productive and reproductive. The families become weak physically and economically. This economic vulnerability of the women especially girls will force them to prostitution and sexual exploitation for the granting of goods, services and assistance benefits by any person in possession of money or control of material resources and services such as business man, humanitarian aid workers, teachers, officers at checkpoints, and etc.

3. Outcome of the Pregnancy

3.1. Pregnancy at the time of the incident

An average of eighteen percent (18%) of the respondents were pregnant at the time of the assault. The proportion of pregnant women who were subjected to sexual violence is high in Nimba (23.4%), followed by Grand Gedeh (18%), after came Grand Bassa (16.4%) and finally Lofa registered the lowest rate (13.1%). The outcomes of the pregnancy are summarized in table 13.

TABLE 13: Outcomes of the Pregnancy

County / OUTCOMES OF PREGNANCY	Lofa		Nimba		Gr. Gedeh		Gr. Bassa		Total	
	N	%	N	%	N	%	N	%	N	%
Miscarriage	7	15.5	6	13.0	9	25.0	10	24.4	32	9.0
Still Birth	5	11.1	7	15.2	1	2.8	1	2.4	14	8.3
Delivered Healthy Baby	12	26.7	23	50.0	15	41.7	19	46.3	69	41.0
Criminal abortion	15	33.3	9	19.6	6	16.7	7	7.0	37	21.6
Premature delivery	4	8.8	0	0.0	5	13.9	3	7.3	12	7.1
Refused	2	4.4	1	2.2	0	0.0	1	2.4	4	2.4
	45		**46**		**36**		**41**		**168**	

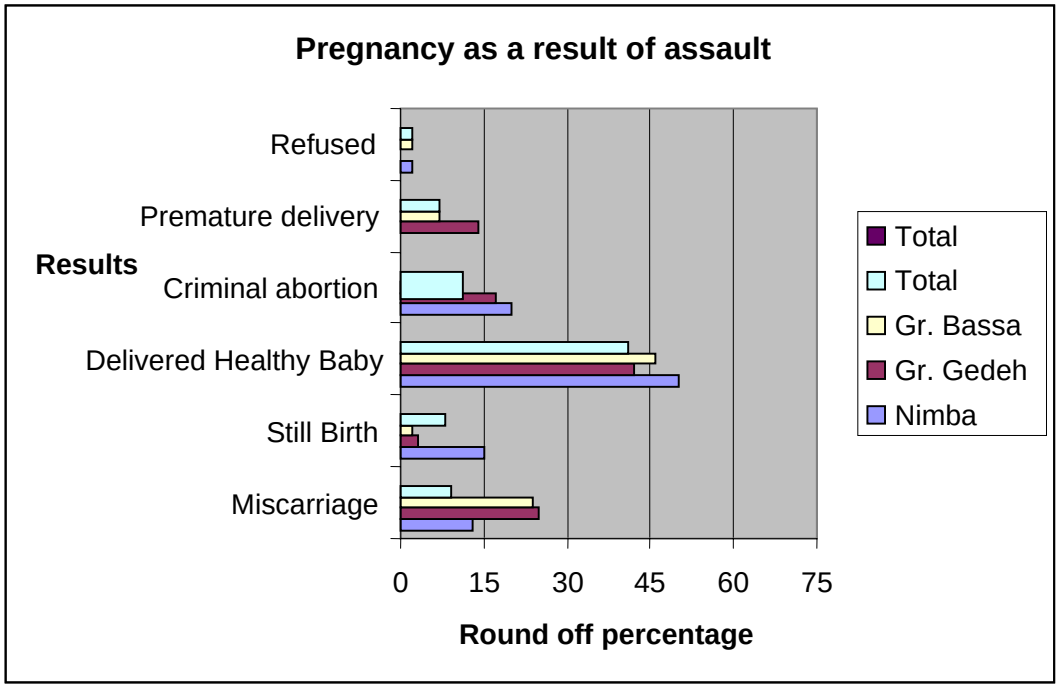


Figure 13: Outcome of the pregnancy at the time of the incident

UNHCR (1995) pointed out that women who were sexually assaulted during pregnancy are physically and psychologically more vulnerable. The risk of having miscarriages, and premature births is high

among pregnant women survivors of sexual violence. On the question of what happened to the pregnancy, the respondents' different answers are summarized in Table 13.

Miscarriage was the most reported pregnancy outcome (41.6%). Nimba registered the highest rate of miscarriage (54.4%); followed by Lofa (39.6%); and Grand Bassa (36.6%). The lowest rate of miscarriage was registered in Grand Gedeh (10.4%). The delivery of healthy babies was reported by 22.1% of women who were pregnant at the time of the assault. Grand Gedeh registered more women who delivered healthy babies (27.1%). In Lofa, 21.2% of women who were pregnant at the time of the assault gave birth to healthy babies while Grand Bassa and Nimba reported 19.5% respectively.

One woman said:

> We were more than 10 pregnant women. The rebels raped all of us. Some of us gave birth in the hours that followed the incident. Some babies died because of lack of medical care. One pregnant lady was shot in the vagina. They asked all of us to laugh other wise we will be killed.

Despite the fact that the babies were healthy at birth, some women (20% of women who gave birth to healthy babies) complained about the illness of the child. They said in these terms:

> "My baby always gets sick, she is not growing well as the other children of her age, and this is because I was raped when pregnant."

The proportions between those who had a spontaneous abortion (12%) and those who had stillbirth (11.7%) are quite similar.
The proportion of pregnant women at the time of the assault who delivered prematurely is 13.5%. More than half of these premature babies died because of lack of appropriate medical care.

3. Pregnancy as result of the assault.

Sixteen point eight (16.8%) of women became pregnant after being raped. There is very little difference between Grand Bassa and Grand Gedeh on the number of women who became pregnant as a result of rape. These proportions are 18.5% for Grand Bassa and 18% for Grand Gedeh. Lofa and Nimba accounted for 14.8% and 15.9% respectively.

The emotional damage to victims/survivors is compounded by the implication that she is pregnant as a result of rape. What to do? How the community will react to my pregnancy since I am not married? How my husband will react to the pregnancy? Should I tell him or keep it, as if it was his baby? And so on. These are all questions (not exclusive) popping up in the minds of the pregnant women because of the humiliating and traumatic circumstances that led to the unwanted pregnancy. The women are facing stigmatization from the husbands or the intimate partners, or from the family. The child she will give birth to will be subjected to stigmatization, and etc.

To the question about what happened to the pregnancy resulting from rape, respondents provided the responses that are summarized in Table…

Table: 3 Distribution of women responses in relation to the pregnancy as a result of the sexual assault.

The majority of respondents who became pregnant as result of sexual assault might have decided to have the baby. Thirty-nine point four (39.4%) delivered healthy babies. It was a difficult choice regardless of the marital status. Many say they did not have any choice than to continue with the pregnancy. As some of them said in these terms:

> "I was praying that I wouldn't become pregnant. But later when I got to know that I was pregnant I wanted to kill myself. After I figure out how to abort. I moved to another county to deliver. There I told everybody that my husband was killed. When I returned to my village I told them that I was married and the husband was killed. Everyone sympathized with me. I am all right now and the child is all right too.

When breaking down the percentage, Lofa got the lowest percentage (26.7%) on the choice to have the baby conceived through rape. Grand Gedeh shows the higher proportion (50%). As for Nimba and Grand Bassa, the proportions are 41.7% and 46.3% respectively.

Twenty-three point six percent (23.6%) of the women, who became pregnant as a result of rape, preferred getting rid of the pregnancy. It is known that a girl or woman who became pregnant through rape is more likely to abort the pregnancy. The abortion was carried out in the bush or at home under no hygienic conditions without anti-biotherapy, using dubious methods associated with the risk of infection, incomplete abortion, bleeding, irreparable damage to the uterus and the reproductive capacity of the girl or the woman. Lofa registered the highest rate of criminal abortion followed by Grand Gedeh (19.6%); Grand Bassa (17.0%) and Nimba registered the lowest abortion rate (16.7%).

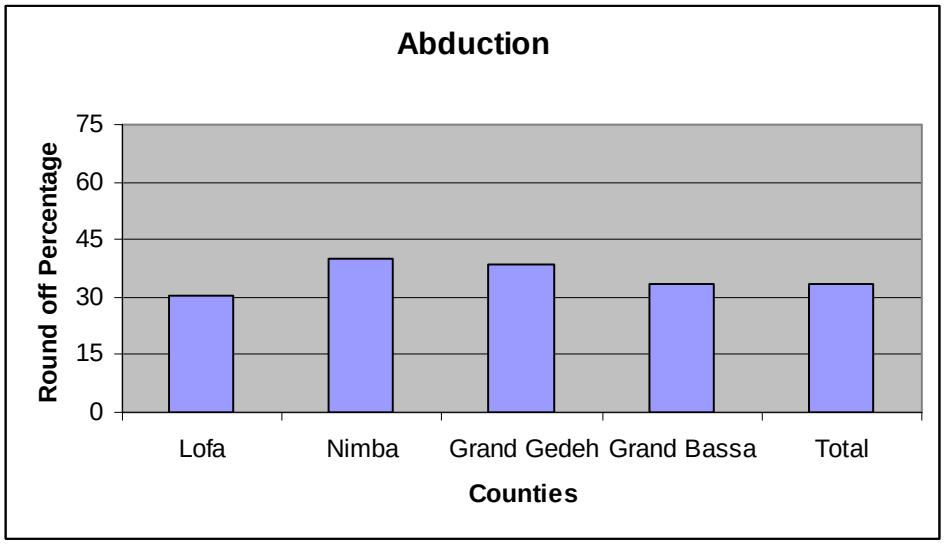
Seventeen point three percent (17.3%) had miscarriage. 10.2% had stillbirth; 7.1% had premature delivery. Two point four percent (2.4%) of the respondents refuse to disclosure the information about the outcome of the pregnancy conceived through rape.

4. Abduction

An average of 33.2% of the respondents had experienced abduction of one day to ten years. The proportions of the number of abducted women and girls are quite similar in three counties (Grand Bassa 32.8%; Nimba 30.9% and Lofa 30.9%) (Grand Gedeh reported higher percentage 38.4%).

Table: Number of abducted women and girls per County

Frequency /County	Expected frequency	Observed frequency	%
Lofa	304	93	30.5
Nimba	304	94	39.9
Grand Gedeh	304	117	38.4
Grand Bassa	304	100	33.2
Total	1216	404	33.2



The abducted women and girls were taken as "wives" for the rebels or soldiers. They were providing sexual services and domestic work during abduction. The following are different reports from women about how they lived during the abduction:

> I was forced to cook for the soldiers and I was often beaten that I had a miscarriage.
>
> …I was naked and would wait for them to sex me anytime they wanted. I was also carrying their ammunition and loads.

I was abducted at the age of eleven and taken as a cook and a wife for the rebels. I was also carrying their ammunition on the front line.

The rebels abducted me for three years. I found other women there in the bush. They were beating us almost every day. We were sex slaves. Every day more than 5 men will rape you. One day they inserted firewood into my vagina as a penis. I always have pain during sex.

The rebels abducted me for sex and work. Four to five men were having sex with me every night. Three months afterwards, one of them decided to keep me as his wife.

2. Health Facility situations

A total of 6 hospitals and 9 health centers participated in the study.

- Lofa County: Voinjama Telewion Hospital, Curran Lutheran Hospital, Konia Health Center, Barzewein Health Center.
- Nimba County: United Methodist Hospital, Equip Community Health Ambassadors Health Center and Tappita Health Center.
- Grand Gedeh County: Martha Tubman Memorial Hospital, Ziah Town Health Center, Zleh Town Health Center and Zais Town Clinic
- Grand Bassa County: Liberian Government Hospital, Stephen A Tolbert Hospital, St. Peter's Catholic Health Center.

2.1 Referral Hospitals

Strengths

- Hospital buildings are in good condition and newly renovated. The renovation of Curran Hospital is on the way.
- Equipment (tables, chairs, beds) in good condition; gradual replacement of equipment
- Good Laboratory material although limited
- Laboratory technician is the head in all hospital laboratories except Curran Lutheran Hospital, which has no Laboratory equipment acceptable for a hospital.
- Accessibility is satisfactory for all the hospital except for Curran Hospital, which is located in the bush at 1KM from the community.
- Monthly drug supply system from partners except Curran Lutheran Hospital, which does not have partner and is facing drug shortage.
- Medical visit, follow up visit and drugs for the patients are free of charge in 5 out of 6 hospitals. The cost of medical visit is L$90.00, follow-up visit L$70.00 and drugs L$200 for Ganta Methodist Hospital.
- Good hand pumps as water supply system
- All hospitals have generators
- An average of 2 doctors per hospital except for Curran Lutheran Hospital, which does not have a Medical Doctor.
- Willingness to receive SGBV survivors

- Government Hospitals have partners who provide drugs, incentives and training.

Weaknesses

- Shortage of health professionals and they are insufficiently trained in clinical and psychological management of SGBV survivors.
- Rape kit for collection of forensic evidence, medical chart with pictograms, written medical protocols including all aspects of clinical examination of SGBV survivors, specific consent forms for SGBV, information pamphlets for post-rape care for survivors, are not available.
- Post exposure prophylactic of HIV transmission (PEP), Hepatitis B vaccine are not available.

2.2 Health Centers

Strengths

- Regular drug system available on a monthly basis;
- All health centers except St. Peter Health Center and Zorzor Clinic have partners who provide drugs, incentives and training.
- A registered Nurse or a Physician Assistant is the head of health centers.
- Willingness to receive SGBV survivors
- Monthly drug supply system
- All have good hand pumps as water supply system.
- Medical visits, follow-up visits and drugs are free of charge.

Weakness

- Health professionals are not trained in clinical management of SGBV survivors
- Problems for patient in critical condition to get to referral hospitals, which are, located in an average distance of 66 km from the health centers.
- Drug supply is not enough to respond to the demand;
- Average shortage of drugs of at least 1week, due mostly to the bad road conditions that constraint drugs delivery to the health centers;
- They do not have supplies for minimum care for SGBV survivors in lower resources settings;
- There is no electricity in the health centers.

Conclusion

Community Assessment and Health Facility needs to respond to specific needs of SGBV survivors in six counties – Bong, Montserrado, Grand Bassa, Lofa, Nimba and Grand Gedeh – reveals that SGBV is still widespread in the communities.
Cases of rape were increasingly high during the war. Yet, rape is still on the increase in the community. Sexual violence impacts the physical and psychosocial well being of the survivor long after the abuses are committed.

The consequences of SGBV continue to disturb the victims and often lead to many health problems. A large percentage of women who experienced SGBV are still suffering from psychological and social disturbances. In most instances, victims of SGBV did not seek medical care because of fear of stigmatisation and rejection by family or community members, lack of health facility and because of the war. In addition, survivors are not going to hospital due to lack of confidentiality and empathy.

Moreover, the health facilities lack the requisite supply to provide quality care to victims. The assessment shows that health professionals are not sufficiently trained to respond to the specific needs of SGBV survivors. Many victims have put this ugly past behind them while some still continue to be bothered by this traumatic experience. Comparatively, there is similarity regarding repetition of the same pattern in this assessment and the previous one.

The general mean percentage of rape for the six counties is 73. %. Regarding NGOs, the coordination mechanisms and collaboration activities are yet to be established in Lofa, Grand Bassa and Grand Gedeh. However, in Nimba County where there is an interagency committee but collaboration activities need to be strengthened.

Recommendations

To: The Liberia Government (Ministries of Health and Gender)

- Take concrete preventive measures to prevent occurrence of sexual gender based violence in the community.
- Strengthen punitive measures against the perpetrators
- Ensure the training of healthcare providers on the clinical and psychological management of SGBV survivors.
- Organize awareness and sensitization campaign in Liberia, (in the15 counties), in order to minimize the stigma associated with rape and clarify SGBV definitions.
- Develop SGBV national plan of action to prevent SGBV and care for the survivors.
- Extend logistical support for equipment supply to the referral hospitals and health centers to provide quality care to SGBV survivors.
- To supply the referral hospitals and health centers with essential drugs.
- Support International and National NGOs to adhere to nationally developed established guidelines and protocols on SGBV.
- Develop or adapt the training modules for the management of SGBV survivors by health care workers at the community level.
- Introduce the clinical management of SGBV survivors in the curricula of formal health education in Liberia

To: U.N and WHO

- Provide logistical support for the training of all stakeholders in the management of SGBV survivors.
- Streamlining surveillance and assessment activities in the Counties.
- Support the NGO to adhere to nationally established guidelines and protocols on SGBV
- Support the local NGOs to mobilize and sensitize SGBV survivors, family and Community to reduce the stigma associated with SGBV.
- Give logistical support for equipment supply to the selected referral hospitals and health centers to provide quality care to SGBV survivors.
- Provide technical support for the development and the implementation of SGBV modules in the formal health education in Liberia

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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	

Team members

Monrovia Interviewers

1. Prof. Marie-Claire Omanyondo
   Principal Investigator
   WHO/SGBV Consultant

2. Mrs. Phyllis N. Kimba
   Director
   Women Health and Development
   Ministry of Health & Social Welfare

3. Ms. Miatta Sheriff
   SGBV – Focal Point
   Ministry of Gender and Development

4. Mrs. Lorpu M. Sherman
   WHD/MOH/SW

5. Mrs. Winifred Newton
   WHD/MOH/SW

6. Mrs. Kao Wortoson
   FHD/MOH/SW

Lofa Interviewers

1. Ms. Mariam Kollie, CM
2. Ms. Bedee Basah
3. Ms. Beatrice Flonie – SGBV focal point
4. Ms. Mayke Sheriff - Midwife
5. Ms. Esther Kollie Gender focal point

Nimba Interviewers

1. Ms. Musu Kardanie – Director of Women Center
2. Ms. Yah Doto – Police-Security

3. Ms. Pinnah Sherriff – Community member
4. Ms. Nanc Yohu - CM
5. Ms. Yah Gbatu - Midwife

Grand Gedeh Interviewers

1. Ms. Garmai M. Harris- Director of Nursing
2. Ms. Clarisa Davids – CM
3. Ms. Angie Kollie – CM
4. Ms. Lillian Barbley – CM
5. Ms. Edith F. Kudah – Gender coordinator

Grand Bassa Interviewers

1. Mrs. Victoria W. Zaway – MOH/SW
2. Ms. Esther G. Walkpolo – CM
3. Ms. Nattie J. Doepe – Gender Coordinator
4. Ms. Charlyne Gborie – Community member
5. Ms. Kula Geddeh – Youth Coordinator

Data Management

1. Mr. D. Levi Hinneh, II - Data Manager

Drivers

1. Mr. Morris Amara

   NU-452

2. Mr. James Massaley
   UN-157