View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by MSF Field Research

Tropical Medicine and International Health doi:10.1111/j.1365-3156.2012.03066.x

VOLUME 17 NO 11 PP 1356–1360 NOVEMBER 2012

Short Communication

Sexual violence in post-conflict Liberia: survivors and their care

K. Tayler-Smith[1], R. Zachariah[1], S. G. Hinderaker[2,3], M. Manzi[1], E. De Plecker[4], P. Van Wolvelaer[4], T. Gil[4], S. Goetghebuer[4], H. Ritter[5], L. Bawo[6] and C. Davis-Worzi[7]

1 *Medecins sans Frontieres, Medical Department, Operational Center Brussels, Luxembourg, Luxembourg*
2 *Centre for International Health, University of Bergen, Bergen, Norway*
3 *International Union against Tuberculosis and Lung Disease, Paris, France*
4 *Medecins sans Frontieres, Operational Center Brussels, Brussels, Belgium*
5 *Medecins sans Frontieres, Monrovia, Liberia*
6 *Ministry of Health and Social Welfare, Monrovia, Liberia*
7 *Ministry of Gender and Development, Monrovia, Liberia*

Abstract Using routine data from three clinics offering care to survivors of sexual violence (SV) in Monrovia, Liberia, we describe the characteristics of SV survivors and the pattern of SV and discuss how the current approach could be better adapted to meet survivors' needs. There were 1500 survivors seeking SV care between January 2008 and December 2009. Most survivors were women (98%) and median age was 13 years (Interquartile range: 9–17 years). Sexual aggression occurred during day-to-day activities in 822 (55%) cases and in the survivor's home in 552 (37%) cases. The perpetrator was a known civilian in 1037 (69%) SV events. Only 619 (41%) survivors sought care within 72 h. The current approach could be improved by: effectively addressing the psychosocial needs of child survivors, reaching male survivors, targeting the perpetrators in awareness and advocacy campaigns and reducing delays in seeking care.

keywords sexual violence, survivors, care, Liberia

Introduction

Sexual violence (SV) is 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work'(WHO 2002).

During 14 years of civil conflict in Liberia, there were unprecedented levels of SV (Liberia Institute of Statistics & Geo-Information Services (LISGIS) 2008; Amnesty International 2004). Despite the war ending in 2003, reports suggest that high rates of SV have continued (Yarney 2008).

Médecins Sans Frontières (MSF) is an international medical humanitarian organisation that provides assistance to populations affected by armed conflict, epidemics, natural or man-made disasters or exclusion from health care. Since 2003, MSF has been offering care to survivors of SV in the capital, Monrovia. The term 'survivor', rather than 'victim', is used to embrace the idea of resilience, empowerment and recovery (Population Council 2008). The package of care for SV is principally designed with adult women in mind, but the reality in Liberia is that SV survivors also include children and some men. Furthermore, a proportion of the perpetrators are minors (<18 years old). This raises the question of how appropriate is the MSF approach to SV in this specific context?

In three SV clinics in Monrovia, Liberia, we describe the characteristics of SV survivors and the pattern of SV, the medical consequences and management, and how the current approach could be adapted to better meet survivors' needs.

Methods

Study setting and population

The study sites were three MSF-supported clinics, dedicated to offering free care to SV survivors in Bushrod Island, an area of Monrovia with about 500 000 inhabitants. Aside one other clinic covered by a local

© 2012 Blackwell Publishing Ltd

non-governmental organisation (NGO), these clinics were the only facilities providing comprehensive SV care in Monrovia. This study included SV survivors (men and women) presenting to the MSF clinics between January 2008 and December 2009.

Package of care offered to SV survivors

Survivors were offered a comprehensive package of care by staff trained in SV care. All survivors were provided with psychological support and, after a thorough medical history and examination, were offered a number of medical interventions. These included the following: wound care for any physical injuries, post-exposure prophylaxis (PEP) for HIV as indicated (providing care was sought within 72 h of the aggression), systematic prophylaxis or treatment for other sexually transmitted infections, emergency contraception (providing care was sought within 120 h), termination of pregnancy through referral to another NGO, and hepatitis B and tetanus vaccinations. For follow-up, those receiving PEP were encouraged to return at intervals of 7, 14, 21, 28 days and three months, and those not receiving PEP, at two weeks and three months. All survivors were offered a medical certificate to be used in court as a legal document as needed.

In addition to the package of care provided for survivors, MSF engaged in extensive SV community awareness raising activities in Monrovia. These activities included leaflet distribution, talks and drama sessions in the health facilities and in the surrounding community (public places, markets places and schools), radio broadcasts and newspaper articles. These activities were targeted at the whole community, with the central message being: if you have been raped, seek care – free of charge – as soon as possible. In addition, drama sessions aimed at preventing sexual exploitation amongst children, emphasised the importance of children refusing money in exchange for sex.

Data collection and analysis

Survivor data were obtained from an electronic Excel database, entered from individual SV master-cards. The different forms of SV reported in this study, as defined in the MSF clinics, are listed in Table 1.

Ethics approval

Ethics approval was received from The Union Ethics Advisory Group and the Liberian Biomedical Ethics Committee. The study also fulfilled the criteria for analysis of routine data by the MSF Ethics Review Board.

Table 1 Definitions of the different forms of sexual violence reported in this study, Monrovia, Liberia

Rape
An act of sexual penetration without the survivor's consent. This includes physically forced or otherwise coerced penetration (even if slight) of the vulva, anus or mouth using a penis, other body parts or an object. In accord with Liberian law, sexual penetration – forced or unforced – involving a minor (person less than 18 years old) is also considered to be rape as minors are not deemed to have the mental capacity to consent to such an act. This means sex between 'underage' adolescents is deemed to be rape
Sexual exploitation
Any act of sexual intercourse in exchange for money, food or any other benefit

Results

Characteristics of SV survivors

Between January 2008 and December 2009, 1585 individuals attended the SV clinics in Monrovia. In 85 (6%) cases, the aggression was either non-sexual in nature or was recorded as 'other' (without a clear definition), and these were excluded. Table 2 shows the characteristics of the remaining 1500 survivors included in the analysis, along with details of the SV. Of these, 1477 (98%) were women. Median age was 13 years [Interquartile range (IQR) 9–17 years] for females and 10 years (IQR, 6–16 years) for males. In 1496 (>99%) cases, rape was the reported aggression. This occurred during day-to-day activities in 822 (55%) cases and in the survivor's home in 552 (37%) cases. In 1160 (77%) cases, the aggression was inflicted by one perpetrator only and by a known civilian in 1037 (69%) cases. Amongst children aged up to 12 years (n-629), the perpetrator was reported by survivors to be a minor in 104 (17%) cases (data not shown; data about the age and sex of these minors unknown).

Amongst all 1500 survivors, less than half (41%) presented within 72 h and only 47% within 120 h of their aggression. In 707 (47%) cases, MSF community awareness campaigns were the main source of information motivating survivors to come to the SV clinic; this was significantly lower amongst male clients, (26%, $P = 0.03$).

Medical consequences and management

Table 3 shows the results of medical examinations of survivors and treatment interventions. Amongst the 1443 (98%) women undergoing a vaginal examination, 9% had vaginal wall lesions, and in 30%, there was suspicion of a pathological discharge. Amongst the 1095 (73%) survivors undergoing a rectal examination, 3% had anal and rectal

© 2012 Blackwell Publishing Ltd

Table 2 Characteristics of survivors, details of the sexual violence in Monrovia, Liberia

Variables	Females *n* (%)	Males *n* (%)	Total *n* (%)
Total	1477 (98)	23 (2)	1500
Age (years)			
0–4	136 (9)	2 (9)	138 (9)
5–12	479 (32)	12 (52)	491 (33)
13–19	554 (38)	8 (35)	562 (37)
20–44	291 (20)	0 (0)	291 (19)
≥45	15 (1)	1 (4)	16 (1)
Unknown	2 (0.1)	0 (0)	2 (0.1)
Median, years (IQR)	13 (9-17)	10 (6-16)	13 (9-17)
Type of sexual aggression			
Rape	1473 (99.7)	23 (100)	1496 (99.7)
Sexual exploitation	4 (0.3)	0 (0)	4 (0.3)
Number of aggressors			
1	1143 (77)	17 (74)	1160 (77)
2–4	239 (16)	4 (17)	243 (16)
≥5	93 (6)	2 (9)	95 (6)
Unknown	2 (0.1)	0 (0)	2 (0.1)
Place of aggression			
Home*	546 (37)	6 (26)	552 (37)
Day-to day activity†	806 (55)	16 (70)	822 (55)
Migratory situation‡	108 (7)	1 (4)	109 (7)
Other	16 (1)	0 (0)	16 (1)
Unknown	1 (0.1)	0 (0)	1 (0.1)
Type of aggressor			
Known civilian	1017 (69)	20 (87)	1037 (69)
Unknown civilian	227 (15)	1 (4)	228 (15)
Military	141 (10)	2 (9)	143 (10)
Policeman	8 (0.5)	0 (0)	8 (0.5)
Institutional member	6 (0.4)	0 (0)	6 (0.4)
Nuclear family member	42 (3)	0 (0)	42 (3)
Unknown	36 (2.4)	0 (0)	36 (2.4)
Armed aggression§			
Yes	268 (18)	4 (17)	272 (18)
No	1149 (78)	19 (83)	1168 (78)
Unknown	59 (4)	0 (0)	59 (4)
Time of presentation (h)			
≤72	607 (41)	12 (52)	619 (41)
≤120	691 (47)	16 (70)	707 (47)

IQR, inter-quartile range.
*Aggression occurred in or around the survivor's home.
†Aggression occurred during any day-to-day activity (e.g. walking to school, whilst at the market, whilst collecting fire wood).
‡Aggression in migratory circumstances (e.g. whilst fleeing a location, at a checkpoint).
§Armed aggression includes aggression using any kind of weapon – e.g. knife, gun, bottle and stick.

wall lesions, with these injuries more frequent in males (10/22, 45%). Amongst survivors presenting within 72 h of their aggression (*n*-619), 482 (78%) received PEP, of whom 278 (58%) completed prophylactic treatment. Of the 81 female survivors who reported becoming pregnant because of the rape, 48 (59%) requested an abortion. This was performed in 39 (81%) cases.

Medical certificates were accepted by 1360 (91%) survivors. In 509 (34%) cases, the survivor (or their caretaker) wanted to press charges against the perpetrator.

Discussion

This is one of few studies to report on the characteristics of survivors seeking care for SV in a post-conflict West African country. The majority of survivors were young adolescents, the perpetrators were often known civilians, and the analysis highlighted gaps in the current approach to dealing with SV in this specific setting.

The strengths of this study are that a relatively large number of individuals were included; the data come from a program setting and likely reflect the operational reality on the ground; and the SV clinic staff are well trained and supervised, so we feel that the clinical data are relatively robust. The study limitations are that no data were available about the prevalence of SV or survivor characteristics in the general population in Liberia, and therefore, we cannot accurately quantify which groups were, or were not, seeking care. No specific data were available on the perpetrators' age and sex; the data did not allow differentiation between different 'types' of rape (for example 'consensual' intercourse between adolescents, which falls under the definition of rape). We could not confirm whether HIV or pregnancy were a consequence of the SV. From these data, we cannot make any inferences about whether those survivors who did not receive certain interventions (such as PEP) should have. Despite these limitations, the study findings raise some important considerations.

Half of the survivors were children aged 13 years or younger and included infants and toddlers. This warrants the need for a stronger focus on psychosocial follow-up and protection of this vulnerable group, including stronger collaboration with child protection organisations.

There seemed to be a disproportionately low number of older girls and women seeking SV care, despite reports suggesting that SV is most prevalent amongst this group (UNMIL 2008). These survivors may avoid seeking care because of fears of stigmatisation, being blamed for what they have suffered and family/community rejection (MSF 2009). Measures to address these issues need to primarily focus on changing cultural and behavioural beliefs and practices, which often goes beyond the scope of MSF. However, to better access these survivors, MSF awareness campaigns could be expanded to try to tackle some of these

© 2012 Blackwell Publishing Ltd

Table 3 Medical consequences and management of survivors of sexual violence seeking care in Monrovia, Liberia

Medical examination	No. examined	*n* (%)
Vaginal wall lesion	1443	131 (9)
Suspicion of a pathological vaginal discharge	1443	430 (30)
Anal or rectal lesions	1095	40 (3)
Males	22	10 (45)
Females	1073	30 (3)
Testing positive for HIV	435*	6 (1)
Pregnant as a result of the aggression	1108†	81 (7)
Medical treatment	**No. eligible**	***n* (%)**
Post-exposure prophylaxis for HIV (PEP)	619‡	482 (78)
Completing PEP	482	
Yes		278 (58)
No		152 (31)
Unknown		52 (11)
STI prophylaxis or treatment	1500	1356 (90)
Emergency Contraception	425§	207 (49)
Women becoming pregnant	81	
Of these, abortion requested	81	48 (59)
Of these, abortion received	48	39¶ (81)

STI, Sexually transmitted infection.
*Amongst those survivors who tested positive for HIV, it is not possible to conclude whether this was a consequence of the sexual aggression they suffered or as a result of an unrelated sexual encounter.
†Denominator includes all women aged 10 years or older.
‡Denominator includes all survivors presenting within 72 h of their aggression.
§Denominator includes all women aged 10 years or older presenting within 120 h of their aggression.
¶No data were available to confirm why nine of 48 women who requested an abortion did not receive it. Possible reasons maybe that the woman was too advanced in her pregnancy or that she never returned for the operation.

factors, as well as emphasising that confidentiality is respected for all survivors who decide to seek care.

Survivors also included men, a population group often not considered in the reported SV literature. Whilst the number and proportion of male survivors seen in our SV clinics was very small, this probably understates the true prevalence of SV amongst men (WHO 2002). For instance, population-based data from a setting that may be comparable – the Democratic Republic of Congo – revealed that 24% of men had endured some form of SV in their lifetime (Johnson *et al.* 2010).Many men may avoid seeking care owing to feelings of guilt, fear and shame (Etienne *et al.* 2002; Jejeebhoy & Bott 2003), compounded by the relative lack of male peer support (WHO 2003); lack of male-friendly SV services (including the absence of male SV staff); and the absence of male representation in awareness campaigns and focus on male SV (MSF 2009). Addressing these issues is needed to ensure better access to this group. A modified counselling approach for male survivors may also be required to address issues around masculinity and sexuality (Population Council 2008).

Most SV occurred in survivors' homes or close communities by known civilians, contrasting with what MSF commonly witnessed when it first began providing SV care in Liberia in 2003. Previously, assault by non-civilians, involving armed threat and gang rape, was common. Now, survivors often live in close proximity to their assailants and repeated assault is a problem. Exploring ways to prevent re-assault is urgently needed (Medecins Sans Frontieres 2009).

Minors were the perpetrators of SV in some cases, drawing attention to the fact that, in addition to tackling the 'symptoms' of SV, much more is needed to address the root 'causes'. Although not ascertainable from the data, anecdotal evidence indicates that 'finger play' (insertion of a finger into someone else's vagina or rectum) is a commonly reported form of 'rape' amongst children, often perpetrated by minors themselves who do not necessarily understand the implications of their actions. Awareness and advocacy campaigns thus need to include the perpetrators (minors and adults).

The definition of rape used in the clinics (in accord with Liberian law) is problematic, as it currently also includes sexual intercourse involving any minor even if the minor 'consents' (including sexual intercourse between 'underage' adolescents). The psychosocial implications of the latter are likely to be quite different from those of forced, non-consensual rape. Thus, differentiating between these two types of events and ensuring that the psychosocial care and follow-up offered is tailored appropriately would seem important.

It is of concern that fewer than half of all survivors presented for care within 72 h of their aggression. For rape involving sexual intercourse, early care is crucial for ensuring the efficacy of PEP and emergency contraception. Delays in care seeking may be due to survivors only becoming aware of available services months/years after their assault, families discovering their child had 'underage sex', and then bringing them to the clinic, or shame, stigma and fear of rejection. A better understanding of such possible factors is needed to guide the response strategy. Finally, distinguishing between rape involving sexual intercourse and not (e.g. finger play), is important to monitor the appropriate uptake of interventions like PEP. This issue has since been addressed in the SV clinics in Monrovia.

© 2012 Blackwell Publishing Ltd

The fact that only one-third of clients considered pressing charges against their perpetrator/s may be due to stigmatisation, shame, fear of retaliation from the perpetrator, fear of not being believed, perceived police corruption, lack of knowledge about the legal process and inadequacies in the judicial system (United Nations Mission in Liberia [UNMIL] 2008). Multidimensional efforts are needed to tackle these issues, with an emphasis on: SV awareness programmes that focus on dispelling common myths about SV and challenging cultural practices which perpetuate SV; protection for survivors; public education on the prosecution process together with provision of support to take this up, and measures to address the large number of shortcoming in the judicial system. In conclusion, this analysis has identified a number of gaps in the current MSF approach to sexual violence in Liberia and has suggested ways to improve it.

Acknowledgements

We are grateful to the Liberian Ministry of Health and Social Welfare for their collaboration and support in implementing the package of care for survivors of SV and we are particularly grateful to the staff in the field for their hard work. A special thanks also goes to Angie Huyskens for her valuable comments and inputs. This research was supported through an operational research course, which was jointly developed and run by the Centre for Operational Research, International Union Against Tuberculosis and Lung Disease, France, and the Operational Research Unit, Medecins sans Frontieres, Brussels-Luxembourg. Additional support for running the course was provided by the Centre for International Health, University of Bergen, Norway.

References

Amnesty International (2004) Liberia: No impunity for rape – A crime against humanity and a war crime. Available at: http://web.amnesty.org/library/index/engafr340172004 (accessed 26 July 2011).

Etienne K, Dalhberg L, Mercy J, Zwi A & Lozano R (2002) *World Report on Violence and Health*. WHO, Geneva. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf (accessed 18 August 2011).

Jejeebhoy S & Bott S (2003) *Non-Consensual Sexual Experiences of Young People: A Review of the Evidence from Developing Countries*. Population Council, New Delhi. Available at: http://www.popcouncil.org/pdfs/wp/seasia/seawp16.pdf (accessed 19 August 2011).

Johnson K, Scott J, Rughita B *et al.* (2010) Association of sexual violence and human rights violations with physical and mental health in territories of the Eastern Democratic Republic of the Congo. *JAMA* **304**, 553–562.

Liberia Institute of Statistics and Geo-Information Services, Ministry of Health and Social Welfare, National AIDS Control Program, and Macro International Inc (2008) *Liberia Demographic and Health Survey 2007*. Liberia Institute of Statistics and Geo-Information Services (LISGIS) and Macro International Inc, Monrovia, Liberia.

Medecins Sans Frontieres (2009) Special Report: Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims. Available at http://www.doctorswithoutborders.org/publications/reports/2009/MSF_Shattered-Lives_Sexual-Violence.pdf (acessed 26 July 2011).

Population Council (2008) *Sexual and Gender Based Violence in Africa: Literature Review*. Population Council, Nairobi, Kenya. Available at: http://www.popcouncil.org/pdfs/AfricaSGBV_LitReview.pdf (accessed 19 August 2011).

United Nations Mission in Liberia [UNMIL] (2008) Research on prevalence and attitudes to rape in Liberia Sept–Oct 2008. Available at: http://www.stoprapenow.org/uploads/advocacyresources/1282163297.pdf (accessed 20 June 2012).

WHO (2002) World Report on Violence and Health. Available at: http://www.who.int/violence_injury_prevention/violence/world_report/en/ (accessed 19 August 2011).

World Health Organization (2003) *Guidelines for Medico-legal Care for Sexual Violence Victims*. WHO, Geneva. Available at: http://whqlibdoc.who.int/publications/2004/924154628X.pdf (accessed 20 August 2011).

Yarney A (2008). Research on prevalence and attitudes to rape in Liberia September to October 2008. United Nations Mission for Liberia. Available at: http://www.stoprapenow.org/uploads/advocacyresources/1282163297.pdf (accessed 12 August 2011).

Corresponding Author **Katie Tayler-Smith,** Medecins sans Frontieres (Brussels Operational center), Medical department (Operational research), Rue Dupré 94, 1090 Brussels, Belgium. E-mail: katie_harries@yahoo.co.uk

© 2012 Blackwell Publishing Ltd