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 300 000 inhabitants. Aside one other clinic covered by a local
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.

### 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

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

<table>
<thead>
<tr>
<th>Form of Sexual Violence</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rape</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Sexual exploitation</strong></td>
<td>Any act of sexual intercourse in exchange for money, food or any other benefit</td>
</tr>
</tbody>
</table>

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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.

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

<table>
<thead>
<tr>
<th>Variables</th>
<th>Females n (%)</th>
<th>Males n (%)</th>
<th>Total n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1477 (98)</td>
<td>23 (2)</td>
<td>1500</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–4</td>
<td>136 (9)</td>
<td>2 (9)</td>
<td>138 (9)</td>
</tr>
<tr>
<td>5–12</td>
<td>479 (32)</td>
<td>12 (52)</td>
<td>491 (33)</td>
</tr>
<tr>
<td>13–19</td>
<td>554 (38)</td>
<td>8 (35)</td>
<td>562 (37)</td>
</tr>
<tr>
<td>20–44</td>
<td>291 (20)</td>
<td>0 (0)</td>
<td>291 (19)</td>
</tr>
<tr>
<td>≥45</td>
<td>15 (1)</td>
<td>1 (4)</td>
<td>16 (1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (0.1)</td>
<td>0 (0)</td>
<td>2 (0.1)</td>
</tr>
<tr>
<td>Median, years (IQR)</td>
<td>13 (9-17)</td>
<td>10 (6-16)</td>
<td>13 (9-17)</td>
</tr>
<tr>
<td>Type of sexual aggression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape</td>
<td>1473 (99.7)</td>
<td>23 (100)</td>
<td>1496 (99.7)</td>
</tr>
<tr>
<td>Sexual exploitation</td>
<td>4 (0.3)</td>
<td>0 (0)</td>
<td>4 (0.3)</td>
</tr>
<tr>
<td>Number of aggressors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1143 (77)</td>
<td>17 (74)</td>
<td>1160 (77)</td>
</tr>
<tr>
<td>2–4</td>
<td>239 (16)</td>
<td>4 (17)</td>
<td>243 (16)</td>
</tr>
<tr>
<td>≥5</td>
<td>93 (6)</td>
<td>2 (9)</td>
<td>95 (6)</td>
</tr>
<tr>
<td>Unknown</td>
<td>2 (0.1)</td>
<td>0 (0)</td>
<td>2 (0.1)</td>
</tr>
<tr>
<td>Place of aggression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home*</td>
<td>546 (37)</td>
<td>6 (26)</td>
<td>552 (37)</td>
</tr>
<tr>
<td>Day-to day activity†</td>
<td>806 (53)</td>
<td>16 (70)</td>
<td>822 (53)</td>
</tr>
<tr>
<td>Migratory situation‡</td>
<td>108 (7)</td>
<td>1 (4)</td>
<td>109 (7)</td>
</tr>
<tr>
<td>Other</td>
<td>16 (1)</td>
<td>0 (0)</td>
<td>16 (1)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (0.1)</td>
<td>0 (0)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Type of aggressor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known civilian</td>
<td>1017 (69)</td>
<td>20 (87)</td>
<td>1037 (69)</td>
</tr>
<tr>
<td>Unknown civilian</td>
<td>227 (15)</td>
<td>1 (4)</td>
<td>228 (15)</td>
</tr>
<tr>
<td>Military</td>
<td>141 (10)</td>
<td>2 (9)</td>
<td>143 (10)</td>
</tr>
<tr>
<td>Policeman</td>
<td>8 (0.5)</td>
<td>0 (0)</td>
<td>8 (0.5)</td>
</tr>
<tr>
<td>Institutional member</td>
<td>6 (0.4)</td>
<td>0 (0)</td>
<td>6 (0.4)</td>
</tr>
<tr>
<td>Nuclear family member</td>
<td>42 (3)</td>
<td>0 (0)</td>
<td>42 (3)</td>
</tr>
<tr>
<td>Unknown</td>
<td>36 (2.4)</td>
<td>0 (0)</td>
<td>36 (2.4)</td>
</tr>
<tr>
<td>Armed aggression§</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>268 (18)</td>
<td>4 (17)</td>
<td>272 (18)</td>
</tr>
<tr>
<td>No</td>
<td>1149 (78)</td>
<td>19 (83)</td>
<td>1168 (78)</td>
</tr>
<tr>
<td>Unknown</td>
<td>59 (4)</td>
<td>0 (0)</td>
<td>59 (4)</td>
</tr>
<tr>
<td>Time of presentation (h)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>≤72</td>
<td>607 (41)</td>
<td>12 (52)</td>
<td>619 (41)</td>
</tr>
<tr>
<td>≤120</td>
<td>691 (47)</td>
<td>16 (70)</td>
<td>707 (47)</td>
</tr>
</tbody>
</table>

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.

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...
that the woman was too advanced in her pregnancy or that she requested an abortion did not receive it. Possible reasons maybe –

§Denominator includes all women aged 10 years or older pre-

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| 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 may be that the woman was too advanced in her pregnancy or that she never returned for the operation. |

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.

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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

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References


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