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WOMEN WAR SURVIVORS OF SEXUAL VIOLENCE IN LIBERIA: INEQUALITIES IN HEALTH, RESILIENCE AND JUSTICE

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Abstract

This article argues that the human consequences of conflict sexual violence have often been misunderstood. Typically research has conceptualised these effects in terms of an individual manifestation of psychological trauma and physical injuries. The corresponding post-conflict responses have therefore been confined to a medical one. This paper, based on research with women war survivors in Liberia, argues for an alternative understanding and response. First, it views conflict sexual violence and torture as gendered, that is, although both men and women endure these experiences, their responses are different. Second, it believes that beyond the individual's trauma the impact of conflict sexual violence and torture affects whole communities and identity. Third, it recognises a strong desire for justice among survivors whose fulfilment is vital to their recovery. Fourth, it recognises high levels of resilience among women survivors. In the light of these perspectives, the article argues that for post-conflict responses to be effective they must go beyond a purely individualistic and medical conceptualisation of needs. Rather they have to be gendered, culturally sensitive, address justice as well as health needs and build upon the resilience of women war survivors and their communities.

Key Words: Women, war, health, justice, resilience, Liberia.

Introduction and Context

Conflict in Liberia had descended into civil war by 1989 and continued almost constantly until 2003. The war displaced nearly one third of Liberia's population and took the lives of approximately 250,000 people. The 14 years of conflict saw not only the destruction of Liberia's social and economic infrastructure, but high levels of brutality by all factions. These included widespread killings, rape, sexual assault, abduction, torture, forced labour and recruitment of child soldiers. Sexual violence and torture of women and girls were particularly prominent, including gang rape and sexual slavery.

At the intervention of international community a Comprehensive Peace Agreement was reached in 2003 and the United Nations organised the UN Mission to Liberia (UNMIL) to support the peace process, sending 15,000 troops. Presidential elections in November 2005 brought the first ever elected woman head of state in Africa, Hon. Ellen Johnson Sirleaf.

As a result of their experiences of conflict violence and torture the population of Liberia is suffering from a wide range of psychological, alcohol /drug related addiction, surgical problems and for women, urgent gynaecological problems. Yet the dilapidated health system of Liberia struggles to respond to the needs of survivors of sexual violence. There are few health centres or adequately trained and employed health workers.

Another major challenge has been to create an environment secure from crime. Gendered crime, such as rape and domestic violence has escalated since the ending of the war and coerced prostitution, and human trafficking are widespread. By and large Liberia's citizens are not being protected from crime or having crime successfully investigated and prosecuted by the state policing agencies.

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In 2006, the government of Liberia launched a national action plan to prevent and respond to violence against women. It included plans to strengthen the justice system and facilitate health care for survivors of sexual violence. Though Liberia was the first country to launch a plan for the implementation of UN Resolution 1325 (Republic of Liberia, 2008) and though the legal definition of rape was expanded and the age of consent was raised to 18 years, perpetrators are still hardly ever convicted. Part of the problem is the failure to report incidents or to look for medical or professional assistance due to shame, fear of rejection and lack of confidence that the 'system' will protect the rights of women (IRIN, 2009; MSF, 2007; UNIFEM 2004; and for northern Uganda see Liebling-Kalifani, in press). Whilst recognizing that both sexes are exposed to violence during armed conflict, women and girls are subjected to sexualized and gender-based violence that targets their sexuality and status. The extensive physical and psychological outcomes of armed conflict inhibit women's capacity, not only as individuals, but also in their relationship with their families, households and communities, and their roles in production and reproduction.

A World Health Organization (2004) study interviewed 309 war survivors in the community and 103 in Internally Displaced Persons camps. It was found that rape, during the conflict in Liberia was experienced by 77.4% of respondents. Out of the total rape cases, 64.1% were gang raped by multiple perpetrators. In total, 283 respondents (68.7%) described having a women family member who had also been raped during the conflict. Gang rape was described as the most traumatic and humiliating assault experienced by sexual violence survivors. The study described many women they interviewed experiencing multiple rapes by all forces, when they captured a town or a village where the population took refuge. A woman reported:

The soldiers cut my husband's head off after he witnessed powerlessly them raping me. After they cut him into pieces; they put the pieces in the pot and asked me to cook it. After cooking, they forced us to eat. I am not any more the way I was before (WHO, 2004: 20).

Many of the victims were forced to watch the physical and sexual assaults committed to their family members. Some of the victims had also been brutally penetrated with objects such as a stick, barrel of a gun, into the vagina or anus. Abducted women and girls were taken as wives of rebels to provide sexual services and domestic work such as cooking, cleaning and washing. What was also humiliating, in addition to the sexual violence they were subjected to, was the fact that the victims had to beg to engage in sex in order to receive food, water or to protect their families.

In another recent study carried out by Isis-WICCE¹ in collaboration with two other women's networks,² and the Ministry of Gender and Development, Liberia, with women war survivors of the 1989-2003 conflict in Liberia (Isis-WICCE, 2008) it was found that women and girls used their bodies for 'safe passage' at checkpoints. Rape accounted for 73.9% of sexual violence. Women also survived attempted rape (17%), sexual comforting, and defilement (38%) sex in exchange for food (28%), forced incest (5%), abduction with forced sex (8%) and insertion of objects into the vagina (20%). The percentage of women and girls suffered sexual torture was 62.5; this included sexual abuse, gang rape (14%), opening of the stomachs of pregnant women, genital mutilation, early forced marriages, and pregnancies. A woman interviewee from Maryland Country said:

Four soldiers raped me...they threatened me that if I refuse, they will kill men with my children. I accepted because I wanted to save my children and I knew they were serious ... other women were raped, mutilated and then killed ... for me, to survive together with my children ... (Isis-WICCE, 2008: 120).

Both studies concluded that the civil war and the sexual violence and torture carried out, had severe and devastating effects, not only to individual women and girl survivors, but to whole communities.

¹ Isis-WICCE (Isis-Women's International Cross-Cultural Exchange, Isis-WICCE) is a women's non-government organisation that promotes justice and women's human rights, with a particular focus on documenting women's realities in armed conflict and peace situations from a human rights perspective. Its training and research in Africa has focused on northern Uganda and more recently Liberia. (Isis-WICCE 2001a, 2001b, 2002a, 2002b, 2008).

² WIPNET (Women in Peace Building Network) and WANEP (West African Network for Peace Building) are both non-government organisations based in Monrovia, Liberia.

The Isis-WICCE (2008) research found evidence of extensive physical, psychological and sexual torture inflicted upon both women and men during the conflict. Further it was found that violence was gendered. Significantly more men survived physical torture whereas significantly more women and girls survived psychological, sexual torture and sexual violence. However, it is important to note that the issue of sexual violence being perpetrated against men during conflict is an under-researched area (Hettonen et al. 2008) and Johnson et al. (2008) found higher levels of sexual violence in Liberia amongst former combatants; 42.3% in women and 32.6% in men. Lawry (2009) also found that 42% of women combatants and 32% of male combatants in Liberia were survivors of sexual violence. Studies have reported that due to the stigma and shame of their experiences, and the resulting underreporting, these figures are likely to be much higher (Governance and Social Development Resource Centre, 2009; Liebling-Kalifani, in press).

The war also had a serious detrimental effect on the very services that the war survivors needed namely judicial and medical. Although there are a few examples of health initiatives, the capacity of the Liberian government to respond to women survivors of sexual violence is thus extremely limited. There is little to address their physical and psychological health needs; and their need for justice against the perpetrators of the violence.

This paper, drawing on findings of recent research carried out with women war survivors in Liberia, argues that for post-conflict responses to be effective they must go beyond a purely individualistic and medical conceptualisation of needs. Rather they have to be gendered, culturally sensitive, address justice as well as social and health needs and build upon the resilience of women and their communities.

Health Effects of Sexual Violence

As a result of sexual violence and torture during the conflict, women and girls suffered severe reproductive and psychological health problems, as well as surgical complications. Those who had objects forcefully inserted in their vagina frequently acquired traumatic vesicle or rectal vaginal fistulae. The Isis-WICCE (2008) research revealed women and girls were infected with sexually transmitted diseases, HIV/AIDS and left with serious and urgent reproductive health problems. Sixty eight point five percent of women had at least one gynaecological complaint but 50% had no access to health care. Younger women up to the age of 24 years were more likely to get a gynaecological problem due to their increased vulnerability. Common problems reported included abnormal vaginal bleeding (9.5%), abnormal vaginal discharge (31.8%), infertility (22.1%), leaking urine (21.6%) and chronic abdominal pain (37.1%). Other complications included; leaking of faeces due to fistulae, sexually transmitted diseases, perineal tears, genital sores, sexual dysfunction and unwanted pregnancies.

Further, due to their experiences, women survivors were discriminated against, marginalized and sexually assaulted. Many were widowed and became heads of households and these were found to be more vulnerable in terms of poverty, human insecurity and sexual abuse.

As a result of the conflict sexual violence, Liberia is very likely to experience a rapid spread of HIV/AIDS in a very short time unless public awareness is aggressively pursued. The Ministry of Health and Social Welfare together with the United Nations theme group on HIV/AIDS (2003) state:

HIV has the potential to become a national disaster because it affects the most productive, reproductive and vulnerable age groups of people (15-49 years) with more females than males.

Women's experiences of sexual violence during the conflict also affected their psychological health. The Isis-WICCE (2008) research found that a considerable proportion of the population in Liberia suffered war related torture/trauma; 27% lost a spouse; 62.5% of the women reported a personal experience of sexual torture; at least two thirds of the respondents had suffered physical torture and 80% suffered at least one form of psychological torture during the conflict. Sixty nine point one percent of respondents reported that psychological symptoms affected their ability to work; 42.8% of had psychological distress scores suggestive of a mental disorder, 12% had alcoholism, which was twice as high than in men; 14.5% had attempted suicide and 17.9% had experienced homicidal ideation, wanting to kill someone.

The same study found that significantly more men than women used addictive substances to try and 'deal' with their experiences, including cigarettes (15.1%), alcohol (29.2%), marijuana/opium (10.1%), cocaine (9.6%), and sniffing petrol or solvents (10.7%). The research concluded that the entire population is suffering from a wide range of psychological problems and drug/alcohol addiction related to the conflict. Eighty percent suffered at least one form of psychological torture; 42.8% of respondents had significant psychological distress as measured by the Self-Reporting Questionnaire (SRQ-20). Sexual violence and torture of women and girls and the associated stigma and shame exacerbated the serious and long-standing psychological effects. More respondents in Grand Kru (63.5%) and Maryland (61.5%) reported significant psychological distress than Bong and Lofa. The psychological consequences of sexual violence and torture were severe and the stigma experienced further exacerbated the silence, as a man in Monrovia described:

One of the women I have been counselling was raped by 7 to 10 soldiers every night for two weeks... She now feels useless and wanted to commit suicide. She could not tell her husband and the children (Isis-WICCE, 2008: 119).

A recent study by Lawry (2009) of Liberian households found 44% interviewed met the symptom criteria for post traumatic stress disorder, 40% for major depressive disorder and 8% for social dysfunction. However, the same study found levels of post traumatic stress disorder were even higher in former combatants with 74% of women and 81% of men experiencing symptoms. In terms of major depressive disorder, 52% of women combatants and 64% of men combatants were found to meet the symptom criteria.

Post-War Health Services

The majority of women fail to access medical treatment due to a combination of factors including poverty, lack of health care facilities and associated stigma from their experiences and the effects of sexual violence, including HIV/AIDS. Post-war Liberia faces substantial public health challenges and is unable to provide adequate health care (IRIN, 2009; MSF, 2007).

Just two medical clinics run by Medecins Sans Frontieres, MSF, in Monrovia handle 20,000 consultations per month (Derderian et al. 2007). According to Derderian et al. (2007), 77% of all medical care in Liberia is currently provided by international non-government organisations and faith-based organisations. Redemption Hospital is one of Monrovia's main public hospitals, but since its handover to the Ministry of Health in 2006 and there are now major staffing gaps, patients have to purchase their own drugs and fees for services; thus drugs have been re-introduced. As a result, the number of patients has dropped dramatically as the people do not have the means to pay. The situation is far worse in the remote and marginalised areas of the country (IRIN, 2009). And despite an increase in the government's health budget to \$10m, (Ministry of Health and Social Welfare 2007, 2008) it is unlikely that this can be sustained (Derderian et al. 2007).

With respect to war survivors there are large gaps in reproductive and gynaecological health and an absence of knowledge regarding men's health needs. MSF also provides 79% of all the paediatric beds available for survivors of sexual violence. Hence, the majority of health care is for children. The World Health Organization (WHO, 2004) study found that the survivor's mothers (100% of cases) were found to be the most helpful amongst various groups of people approached by women regarding their rape experiences. Survivors also reported women's groups (82.1%) followed by religious leaders (78.3%) helped them to cope with their experiences. Medical assistance was cited by only 31.4% of the respondents. It was concluded that women felt freer to go to religious leaders and women groups because of the need for confidentiality regarding rape. In groups, they also meet others who share the same experience, which makes it easier for them to confide in one another (WHO, 2004).

Analysis of health facilities by the World Health Organization (2004) in Liberia shows that they are willing to receive survivors of sexual violence, but they are not equipped to give them quality care due to the insufficient equipment and supplies, and the lack of health professional training. As for non-government organisations, it was concluded that there is still some confusion in roles.

Under the auspices of Isis-WICCE (2008) research and training for providing psychosocial and medical services to the war survivors, was carried out by the first author and others in south east Liberia during May 2009. Participants attended including health workers, psychosocial counsellors, religious and women leaders, activists, legal personnel, non-government organisations, community and social workers

attended. Both authors have subsequently developed the training manual in terms of the professional standards, human rights approach, psychosocial interventions, psychological support for professionals and the health effects of sexual violence. Following this, health interventions have been carried out in isolated marginalised communities and a Ugandan-Liberian team have screened over 1000 war survivors and operated successfully on 130. The majority of these had reproductive health complications. A number of men were also operated on. Women and male respondents all reported a decrease in stigma and increase in their quality of life due to successful treatment of their physical health problems, although a large majority of respondents had psychological trauma. Due to the lack of trained health workers and poor health infrastructure, Liberia is ill-equipped to deal with these psychological and mental health effects with only one psychiatrist, no clinical psychologists and a handful of counsellors. Unresolved trauma including anger is likely to lead to trans-generational effects, including cycles of violence and conflict (Liebling-Kalifani et al. 2008). In addition to this, there are barely any adequately trained and employed health workers to deal with the overwhelming levels of reproductive and gynaecological health needs of the population.

Survivors' Experiences of Justice

As stated by one of the survivors:

The rebels and fighters killed and raped, but who has come to our aid? They just go free. I saw him – the boy that killed my child. I know who he is and I will never forget him. He had small earrings in his right ear. And nothing happens to him. We are still living with the same people, we see them every day. They see us. There is no justice in Liberia (Smidt, 2004).

A culture of partial justice and impunity for the powerful had long marked by the pre-war system and in fact had been one of the primary catalysts for the civil war. According to one survey (Liberian CJS Report, 2002) 56% of those who had been arrested and forwarded to court believe that the court had not been fair to them, citing reasons such as partiality of judges (41%), interference by government officials (24%), no opportunity for legal representation (18%) and jury manipulation (6%). Thus 59% of these respondents were not satisfied with the outcome of the cases. Overall, 61% of respondents said they had little or no confidence in the courts to render justice.

Despite the end of the conflict, rates of sexual violence in Liberia remain high. The 2006 government action plan to prevent and respond to sexual violence against women called for a strengthening of the justice system, but implementation takes time. Significant changes were made to legislation, which expanded the definition of rape so that now any form of sexual penetration is considered rape under Liberian law. The age of consent has also been raised to 18 years. The new laws have also established harsher punishment for perpetrators and abolished bail for rape cases. Despite these steps, the judicial system has yet to adapt these changes so the new laws have made little difference. Perpetrators are still hardly ever convicted. Rape still tends to be dealt with privately. Most victims never press charges. According to the Association of Female Lawyers of Liberia, there is a conspiracy of silence and denial within the community and within the families involved. The judicial system is an ongoing source of frustration. An MSF (2009) report noted that health workers acknowledge that impunity may affect the way a rape victim deals with trauma after a sexual attack. "If they know the perpetrator and justice is not done, they feel afraid and powerless", said a MSF psychologist, "Justice is also a way of telling the victims that it is not their fault" (MSF, 2009: 30). As most rapes are committed by people known by the victim, impunity also means that they may be at risk of repeated attacks.

During the war, women were subjected to distinct abuse for reasons linked specifically to their gender. Rebel fighters often raped women and killed men on a systematic basis. Women survivors are thankful in terms of whether or not they were raped, or 'disgraced.' More women and girl-children have survived than were killed yet only with tremendous wounds to their bodies and minds, assaults on their dignity, their feelings of self-worth and their future. There seem to be no consequences for the perpetrators of the violence (Smidt, 2009).

Post-War Criminal Justice Services

After the war the criminal justice system was in a wretched condition at every level. According to the International Crisis Group (2006) there are 300 Justices of the Peace, many corrupt and incompetent, charging excessive fees and meting out justice beyond their jurisdiction. 50-75% are illiterate and work in ill-equipped magistrates' courts without being included on the judicial pay roll (hence operating on a "pay yourself" basis). Being unsupervised they have commonly accepted cases beyond their jurisdiction, such as serious cases of violent assault and rape. Further, contrary to the law, some have illegally detained people, in their homes, until relatives have posted bail, or until those found guilty have paid fees or bribes. The magistrates have been little better. The 130 magistrates present in 2006 lacked legal expertise, with only three having law degrees and few having access to legal texts. With many court houses destroyed, magistrates have been forced to conduct judicial business out of their own homes or in premises rented by the government. They often operate without typewriters, stationery, and court officers (such as associate magistrates, county and public prosecutors), defence counsels, and bailiffs. In many instances no records are kept of proceedings. To supplement their low salaries they have implemented *ad hoc* court fees. It took until August 2005 before 20 new circuit court judges were sworn in, but this still has left 5 circuit courts operating scarcely if at all. And even the new appointees have not always attended their courts, preferring to live in Monrovia. The scarcity of prosecutors has also delayed work. The inactivity at the circuit court level has paralysed the rest of the justice system. Where a circuit court has not functioned, it has been left to magistrates to hear a case well beyond their jurisdiction for suspects in rape, murder, and burglary cases to walk free.

Following the war, the Security Council did authorise the United Nations Mission to Liberia (UNMIL) to undertake judicial and security sector reform. It helped reopen the Law School at the University of Liberia; it trained 150 county and city attorneys; and it refurbished and rebuilt thirteen county court structures. Likewise the United Kingdom Department for International Development (DFID) helped refurbish some courts. Donors have also established a Rule of Law Committee to address human rights, legal, judicial and police reform issues. Nevertheless given the continuing high levels of legal illiteracy among the judiciary, the male domination of the service and the restricted forensic and court resources, the judiciary are ill equipped to respond to cases of sexual violence. The war also largely destroyed the security infrastructure and by its end many personnel had either departed or had been compromised in terms of human rights abuses. Liberia's post-war policing consisted of 14 separate state agencies. Many were dysfunctional and non-operational agencies filled with ghost workers or political appointees. Corruption, abuse and inefficiency abounded and impunity prevailed. According to the December 2002 survey mentioned earlier, two thirds thought that police officers were not fair; 67% said police officers were not honest; and over 70% agreed that the police were intimidating, brutal and aggressive; at the same time, 70% thought the police did not provide equal treatment to citizens. Law enforcement officers in general were perceived to be corrupt by about 70%. Additionally, about 64% said they had little or no confidence in the ability of law enforcement officers to prevent crime, while about 65% said they had little or no confidence in law enforcement officer's ability to solve crimes.

When the new administration of Ellen Johnson-Sirleaf took over in 2005 a priority was to create an environment secure from crime, particularly sexual violence. Yet her attempts at security sector reform and rationalisation have moved at snail's pace. Research in 2007 (Baker, 2009) revealed large numbers of the population are fearful every night of burglary; large numbers regularly experience theft; large numbers live where the police are not able or willing to patrol; large numbers endure child abuse, domestic violence, rape and labour exploitation without redress; and large numbers ignore the emergency 911 phone service because of its unreliability. Inevitably there are problems of under-reporting by the public of crime because of lack of access to the police, embarrassment, fear of the police, alternative resolution systems and desire for speedy justice. The under-reporting is particularly evident as regards sexual offences and domestic violence. Women repeatedly mention the continuing issue of domestic violence

To a large extent Liberia's citizens are not being protected from crime or having crime successfully investigated and prosecuted by the state policing agencies. The prevailing explanation for the current failure of policing is that it is the product of under resourced state policing agencies. Three thousand 500 urban-based police officers are not enough to provide crime protection and investigation for a population of 3 million over a countryside that has few tarmac roads. In rural areas the police are a minor player; with active police numbers are as low as 30 for Bomi County, 28 for upper Margibi County, 54 for Bong County. Nor do the police have sufficient resources, whether handcuffs, batons, torches, radios, stationery supplies or vehicles for the officers; and the police stations are often without

electricity, filing cabinets and toilets. The chief of Women and Children's Section in Tubmanburg, interviewed in 2007, said:

[In this room] we have to deal with juveniles and women, but there are no juvenile cells or female cells. We keep them in this room unless someone goes security for them; or we put them in the cell corridor at night. There is no secrecy for sensitive issues in a small crowded space.

There is only one forensic laboratory for the entire country. There are few fingerprint kits. Its chemistry laboratory is empty. The photographic section has one digital camera, but the computer is down. There is no crime scene vehicle to transport the necessary equipment and staff. There are no specialists including, toxicologists, ballistics specialists, fingerprint specialists, forgery experts, and only one pathologist temporarily supplied by the UN. Given the high levels of illiteracy among officers, the high proportion of men in the police and the restricted resources, the police are ill equipped to respond to cases of sexual violence.

Despite important legislative steps in Liberia, perpetrators are still hardly ever convicted under the formal justice system; rape still tends to be considered an act of aggression that should be dealt with privately; and most survivors never seek health care or press charges. A recent review by Amnesty International (2008b) of the Truth and Reconciliation Commission process (TRC) in Liberia found that despite the fact that special initiatives were devised to encourage women to participate in the statement taking process, observers interviewed by Amnesty International described the TRC activities to support women's participation as "fragmented" and only 21 out of the 78 witnesses who appeared to give evidence in January 2008 were women (The Analyst, 2008).

A Re-Conceptualisation of Trauma, Justice and Resilience

Despite the new awareness of criminal justice systems of the importance of tackling sexual violence, the needs of survivors of conflict sexual violence worldwide are poorly understood and services offered to them are rarely viewed and practiced in a gendered or holistic manner (Jewkes, 2007). Previous research in Uganda and Eritrea argues that services tend to be based on a 'medicalisation of distress,' rather than a considered understanding and approach based on war survivor's own views, experiences and needs as well as their strengths and resilience (Almedom and Glandon, 2007; Liebling-Kalifani, in press). Further, although research with war survivors indicates women and girl war survivors have psychological symptoms that can be partly understood within what has been termed a 'complex Post Traumatic Stress Disorder', PTSD, model (Herman, 1992), it is argued that their war trauma is a 'normal' not 'pathological' response to torture, and requires recognition as 'normal' by others (Tal, 1996; Summerfield, 1997; Liebling-Kalifani, in press).

Analysis of the research data from Liberia suggests that the effects of conflict sexual violence and torture should be regarded as gendered, that is, although both men and women endure these experiences, their responses are different. Women war survivors reconstruct their identities by taking on male roles, becoming heads of households, peace building as well as engaging in collective and political activities. Women's ability to voice their experiences, form groups as a political act of resistance, results in a shared identity and a decrease in trauma experienced. In contrast, men largely turn their trauma inwards, using strategies such as alcohol and drug use in an attempt to 'manage' their distress (Isis-WICCE, 2008). Further, it is suggested that women's war trauma is differently constituted than men's due to the effects of sexual violence and torture being understood as a 'destruction of cultural identity' and of the ethnic group. Hence, the effects of these experiences on women are equally valid, and therefore deserving of compensation and facilities for recovery, as has been awarded to male soldiers (Liebling-Kalifani, in press). The gendered differences in the nature of the effects of violence during conflict have been reported in other parts of the world (McDevitt, 2009).

Research also demonstrates that beyond the individual's trauma, the impact of conflict sexual violence and torture affects whole communities and identities. War trauma can therefore be understood as a collective/communal destruction of cultural identity, not an individualistic manifestation of psychological symptoms. The types of sexual violence and atrocities carried out caused destruction of cultural norms and respectability codes important within African communities. The obvious symbolism of torturing women requires little explication. Soldiers not content with ordinary rape violated women in Liberia with foreign objects they had also used to threaten their lives with. When a rape failed to obliterate her, the next rapist used

a more potent weapon to accomplish the same objective. Liberian women as repositories of ethnic and community knowledge, values and practices and bearers of honour for Liberian men, were targeted for sexual dishonour and cultural disruption. War trauma can further be conceptualised as a breakdown of cultural identity, manifested in physical, psychological and social effects that are integrated and inseparable, not split between mind/body and society (Liebling-Kalifani, in press).

It is emphasised however, that although destruction of cultural identity and entitlement to power was in many ways 'successful' from the point of view of the military groups, in the sense that it did erode Liberian women and girl's sense of self, cultural identity and entitlement to power, this was never an uncontested process. Liberian women and girls, who were the objects of attack, also resisted the breakdown of their cultural identity, not only physically and militarily, for example as combatants, but also socially, psychologically and culturally. As Andermahr et al. (1997: 287) suggest, 'theoretically informed accounts by women who have experienced rape and struggled to retain their sense of autonomy are needed'.

What is emerging from recent research is a strong desire for justice among survivors. Despite the gross level of human rights abuses and torture of women and girls during the conflict period, there has been a failure to address the injustices. Though Medecins Sans Frontieres (2009) has started issuing medical-legal certificates for rape survivors who visit health facilities, in practice, few have used them to pursue legal action. High levels of illiteracy amongst the poor make following all the necessary legal steps difficult or they cannot afford the legal process. In 2008, only 4 out of the total 771 victims MSF treated took the accused perpetrators to court. However, as a result of lobbying efforts, this certificate has been adapted as the national medical report, which is recognized throughout the country by Liberian law. Since October 2008, this has been used in all public health facilities that treat survivors of sexual violence. Justice for survivors of sexual violence still looks a long way off and yet its fulfilment is vital to survivor's recovery (Ullman, 1999).

Despite the suffering, endured women have not been merely passive victims. On the contrary, in Liberia women have been active campaigners for peace, presidential elections and have taken up male roles, becoming heads of households. Their role in national liberation struggles, in guerrilla warfare or in the military has varied, but generally international research has viewed them in a supportive and nurturing relation to men even where they have taken most risks (Yuval-Davis, 1985). However, a feminist analysis of women's roles by Anthias and Yuval-Davis (1989), Lovell (2003) and Liebling-Kalifani (2010) for example, enables us to view women's contributions during and since the war as active agents. Hence, it is argued that despite the devastating effects of sexual violence during the war, it is evident that Liberian women have demonstrated resilience (Almedom and Glandon, 2007) resistance and power during and since the conflict period ended.

Building an Alternative Service Response

The Liberian government has sought to re-integrate all ex-combatants into society and to facilitate humanitarian assistance delivery, promote economic growth and to increase women's participation. Unfortunately the research and reports reviewed demonstrate that this programme has failed so far to respond effectively to the needs of former combatants, particularly women and girls and several former soldiers were forced to quit programmes for lack of funding (Amnesty International, 2008a). There are also large gaps in Liberia's mental health policy which does not address mental health or sexual violence.

Lawry (2009) recommends developing programmes with religious and community leaders to aid in mental health counselling. The approach followed by Isis-WICCE (2009) in its training programme in Liberia was to utilise the mutual support of local war survivors and their experience as a way of building on and utilising survivor's resilience, and helping to cascade counselling and support skills to the grassroots level. This approach has value since in a country like Liberia with inadequate resources services need to be informed by survivor's views and expertise. This provides further empowerment, increased ownership of services in conjunction with maximum use of limited resources. Establishing support groups for those sharing similar experiences can also assist survivor's to regain trust and decrease the stigma experienced.

In line with existing research findings as well as key literature and policy documents (e.g. UNFPA, 2006; UNIFEM, 2000), we argue that the health and legal responses to survivors of sexual

violence and torture should be firmly based on a model that recognises their resilience and utilises a gendered and holistic approach to their needs (Amnesty International, 2008a; Buseh, 2008). Further, in order to enhance the quality of care received, services should adhere to ethical and safety recommendations (WHO, 2007) as well as good practice guidance for carrying out this work (Sexual Violence Research Initiative, 2006). Ideally the health sector should be working towards actively screen clients for sexual violence; ensuring same sex interviewers; responding to the immediate health and psychological needs of the woman or girl who has been exposed; instituting protocols for treatment, referral and documentation that guarantee confidentiality; providing sexual violence-related services free of cost; and being prepared to provide forensic evidence and testimony in court when authorized by the individual. However, although these responses are required, the current lack of resources and trained personnel within the Liberian health and legal systems makes it unrealistic without donor support.

The psychosocial sector should be able to provide ongoing psychological assistance. To achieve this goal requires the training and on-going supervision of social workers, psychosocial counsellors, religious leaders and community services workers; the confidential gathering and documenting of survivor data; and facilitating referrals to specialist services. Again this is a large programme that the Liberian government will not be able to install and sustain without outside help. According to a recent World Health Organization (2009) report, survivors of sexual violence commonly experience fear, anxiety, shame, guilt, anger and stigma. As a result, about a third develop post traumatic stress disorder, the risk of depression and anxiety disorders increases three- to four-fold, and a proportion of women commit suicide. The WHO report recommends, besides encouraging the non tolerance of these practices, that the needs of those survivors and afflicted with these conditions be addressed. Education and income-generation projects are also considered important under the umbrella of holistic psychosocial programming within this multi-sectoral model. The aim must be to ensure that the education systems should introduce curricula that cover healthy relationships, and basic human rights; institute codes of conduct for all teachers as well as training on identifying risk signs among children; and provide school-based services for children who have been exposed to sexual violence. There is also a need for income-generating projects that not only promote women's economic self-sufficiency, but also monitor for domestic and sexual violence risks and integrate human rights education into project activities.

The target for the justice sector is that it should be able to provide free or low-cost legal counselling, representation and other court support to women and girls who have been exposed to sexual violence; review and revise laws that reinforce these abuses, monitor court cases and judicial processes. Within the security sector police, military and peacekeeping personnel should be educated about sexual violence; held to zero-tolerance codes of conduct; and be trained on how to sensitively intervene with these cases. Police should have private rooms for meetings with individuals who have been exposed to sexual violence; ensure same sex interviewers; institute protocols for referrals to other sectors; collect standardized and disaggregated data on incidents; and create specialized units to address sexual violence.

To implement a service response that incorporates the features outlined above is clearly beyond the resources of the Liberian state or other post-conflict states now and for the foreseeable future. It is not surprising therefore that despite its widespread nature, and despite the well-documented fact that sexual violence has serious consequences for the physical, sexual, and mental health of women and young girls, their families and communities, in most post-conflict states programming efforts are grossly inadequate when compared to the scope of the problem. The solution may in part be donor support for those states. It may also be found in innovative programmes that mobilize and utilise the resources found in non-state organisations and structures.

Conclusion

The 1989-2003 conflict in Liberia and the sexual violence and torture perpetrated caused devastating effects on individuals and communities. Sexual and gender-based violence caused extensive damage to the psychological, reproductive and gynaecological health of women and girls. Many of the health problems are not treatable by the grossly over-stretched and under-resourced Liberian health care system. Violence against women in Liberia still persists and a 'militarization of intimate relations' is evident following the ending of the war, with high levels of domestic and sexual violence.

The question of who delivers health and justice services and how, from a development point of view, is about the quality and efficacy of the health service provision and policing received by citizens,

regardless of who delivers it. However, ultimately the question is a political and normative one, dependent upon local contexts, institutional capacities, popular demands, leadership, national trajectory and dominant ideology. It requires in-depth and gendered analysis of the post-conflict state and its political terrain, its capabilities, functions, and cultural legacies. Further, it requires health and justice service provision that conceptualises conflict sexual violence as gendered, incorporates a resilience framework for understanding survivor's needs. The most appropriate developmental approach to the delivery of health and justice in post-conflict conditions is one that recognizes the differing nature of states and the presence of multiple providers whose services are layered to meet differing contingencies.

A multi-layered approach that uses non-state agencies appears to be the only solution when the state is deemed unable to provide services in the medium term, even with donor aid. Of course practical difficulties arise concerning the African state's capacity to undertake a steering function of ensuring the quality, efficacy and accountability of all health and justice services. It may not be realistic to imagine it fulfilling four key functions of a network regulator, namely: to license, vet, monitor, and regulate the delivery of services; to ensure that effective justice is equally accessible to all; to protect and preserve civil rights and human rights; and to establish the parameters within which non-state services provided. It may require local partnerships to prove that hybrid and multi-layered governance can provide effective, sustainable and locally accountable health and justice before the state will think in terms of radical changes to its national strategy.

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