Managing sexual and gender-based violence (SGBV) in Liberia: Exploring the syncretisation of Western and traditional approaches

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ABSTRACT

Background: Sexual and gender based violence (SGBV) is endemic to Liberia. Children are particularly impacted. The health of and justice for those impacted by SGBV are the concern of the government of Liberia (GOL), local and international non-governmental organisations (I/NGOs) as well as local community-based traditional leaders and healers. The state, in close partnership with the international community is in the process of rebuilding its formal health and judicial structures after a devastating 14-year civil war. The traditional Liberian Sande (women) and Poro (men) secret societies are also in the process of reviving traditional culture and traditional medical and judicial practices. Traditional culture and healing played an important role during the civil wars and continue to be deeply rooted in society, especially in the interior. Yet, little research has been undertaken in the extent to which these informal mechanisms cater to SGBV and how and if they interact with Western medical and judicial interventions.

Objective: This study aimed to explore the coherence or contention in the relationship between traditional Liberian and Western approaches to treating SGBV, both medically and through jurisdictive methods. Approaches and techniques undertaken by the international community and the traditional Sande society in managing SGBV were explored. Local perceptions of these two structures were sought as well as any endeavours to syncretise the approaches.

Methods: This qualitative study followed a phenomenological approach. The study was conducted in two sites: Monrovia and one interior county emphasising the geographic disparity. There were five groups of participants: I/NGOs running programmes supporting survivors of SGBV, government SGBV focus persons, religious and traditional community leaders, girls aged 14-18 years who have experienced SGBV, and traditional healers. Key actors including I/NGO officers, government officials, the Liberian police and the Head of the Liberian Traditional Sande Women's Society were interviewed about **programmes** that support SGBV survivors, with a particular focus on children. I/NGO programme implementers, local community groups, local leaders, traditional healers and girl survivors of SGBV were interviewed about the **impact** of the programmes. In-depth semi-structured 30-60 minute interviews, conducted in English were the primary method for data collection. Where possible, a gender balance of participants was sought. Thematic network analysis was used to explore and interpret data. A WHO Ecological Model and Connell's Theory of Gender and Power were used to help analyse the phenomenon.

Findings: The few attempts at syncretisation have proved unsuccessful. Government and the funding targets of international donors play a significant role in what is being prioritised, namely western-based medical treatment and psychosocial support. Externally funded programmes to support survivors of SGBV are largely concentrated in Monrovia and nearby counties. At the community level traditional cultural beliefs – regardless of religion – prevail, especially in the interior. The effectiveness of solely western-based initiatives is questionable, considering the impact traditional culture bears on society. Another point of contention is the issue of female genital cutting (FGC). There are a number of underlying factors (war, cultural gendered roles, customary rituals) and contributing factors (ineffective in/formal systems, family, education) that influence the prevalence and outcome of SGBV cases in Liberia, which equally impact the formal and informal structures.

Despite the understood importance of local context and including traditional voices and methodologies into programming, little of this has been achieved. In reference to SGBV cases, the dual medical and judicial structures operating within Liberia are seemingly being used as antitheses, rather than as complementary mechanisms. This may be a consequence of the various underlying and contributing factors, particularly as a result of the ineffective and corrupt formal systems, the survivor's age and the relationship between the survivor and the perpetrator. The simultaneous operation of customary laws and government laws leads to inconsistencies and contention in a number of areas; in particular, the concept and understanding of biological age and sexual maturity denoting childhood/adulthood is a point of contention. This in turn influences early marriage, child rights, and statutory rape laws.

Conclusion: There are major inconsistencies in law, health care and beliefs throughout the country. Urban and rural Liberians use a combination of formal and informal medical and judicial services to complement each other. Yet, in regard to SGBV cases the perpetrator or the survivor's family often use the informal and formal system to compromise the case, to the detriment of the survivor. Endeavours at syncretising these two co-existing but often contentious approaches and ideologies have had little success. This may be a result of the structure of humanitarian aid and donor funding. Government as well as international donor focus and funding, play a significant role in what is being prioritised, while traditional cultural beliefs strongly prevail, especially in the interior.

Key words: Sex, power, post-conflict development, humanitarian aid, hegemonic development, western healing, traditional healing, Sande Society, children, FGC, poverty.

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MAP OF LIBERIA

(Source: UN October, 2010 in Landis (2012).)

ACRONYMS AND ABBREVIATIONS

ACRWC	African Charter on the Rights and Welfare of the Child
CCF	ChildFund
CEDAW	Committee on the Elimination of Discrimination against Women
DCM	Division of Complementary Medicine (MOHSW)
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GOL	Government of Liberia
GOL/UN JP	Government of Liberia and United Nations GBV Joint Programme
HOW	Head of WACPS
HRT	Human Rights Treaties
IDP	Internally Displaced Person
IJS	Informal Justice Systems
INGO	International Non-Governmental Organisation
IPV	Intimate Partner Violence
IRC	International Rescue Committee
JDJ	James N. David Junior Memorial hospital
LNP	Liberian National Police
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MIA	Ministry of Internal Affairs
MOGD	Ministry of Gender and Development
MOHSW	Ministry of Health and Social Welfare
MOJ	Ministry of Justice
MSF	Medecins Sans Frontieres
NGO	Non-Governmental Organisation
NRC	Norwegian Refugee Council
NSD	Norwegian Social Science Data Services
OCHA	The United Nations Office for the Coordination of Humanitarian Affairs
PM	Project Manager
SAVE	Save the Children
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender-Based Violence
SV	Sexual Violence
TGP	Theory on Gender and Power
TNA	Thematic Network Analysis
TRC	Truth and Reconciliation Commission
UN/MOGD	UN representative at the MOGD on GBV joint programme
UNDP	United Nations Development Program
UNFPA	United Nations Populations Fund
UNHRC	United Nations Human Rights Council
UNICEF	United Nations Children's Fund
UNMIL	United Nations Mission in Liberia
UNSCR	United Nations Security Council Resolution
UNWOMEN	United Nations Development Fund for Women (Formerly UNIFEM)
US	United States of America
WACPS	Women and Children Protection Section
WIPNET	Women in Peace Building Network

LIBERIAN TERMS

Causing: To make trouble

Bush school: secret society schools located in the bush where initiation takes place for boys and girls

Juju: bad medicine (something to carry: *"It change from county to counties and it change from tribe to tribe"* (MOHSW).)

Lappa: colourful fabric generally wrapped around the waist or worn as a dress by women

'o': Often placed at the end of sentences when speaking Liberian English

Palava hut: community meeting hut

Poro: Liberian traditional men's secret society

Sande: Liberian traditional women's secret society

Sitting fees: fee expected by some community members to take part in programmes

The bad thing: rape/ sexual abuse

To born: to give birth

To love: to have sex

Uncle: often not biologically related, but term of respect for community men

Zoe: Name and title of some traditional secret society leaders/ healers/ birth attendants

CHAPTER 1: INTRODUCTION

1.1 Background

Gender based violence defined by the UN (1993:1) Declaration on the *Elimination of Violence Against Women* is,

> *[a]ny act of gender-based violence that results in, or is likely to result in, physical, sexual, or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life.*

Sexual gender-based violence (SGBV) is one type of gender-based violence (GBV)[1]. As the most personal type of offence, rape is often used to frame SGBV. By raising the profile of one brutal form of SGBV, it aims to promote awareness of the situation as a whole. SGBV as a weapon of war was widely used during the brutal 1989 – 2003 Liberian civil conflicts (Liebling-Kalifani et al., 2011). The Liberian government, along with the United Nations (UN) and various international non-governmental organisations (INGOs) have constructed several policies, resolutions, laws and programmes directed at dealing with SGBV in response to the on-going issue. However, ten years later the prevalence of SGBV (i.e. acts of sexual violence (SV)) seemingly continues to be as severe as it was during the war (Tayler-Smith et al., 2012).

The health of and justice for those impacted by SGBV in Liberia are the concern of organisations and individuals ranging from well-funded INGOs to local, community-based healers. However, there is little literature on the mutual acceptance and interaction between these different types of approaches, particularly in the context of a humanitarian setting. INGOs often distance themselves from traditional medicine. As the World Health Organisation (WHO, 2008:1) states, *"traditional medicines and practices can cause harmful, adverse reactions if product or therapy is of poor quality, or it is taken inappropriately with other medicines".* More significantly, the consultants who practice traditional healing often perform other services that are rejected by Western organisations and governments as human rights abuses, like female genital cutting (FGC). As a consequence, very little research on traditional practices and scientific testing on traditional medicinal products has been carried out (WHO, 2008). Similarly, customary laws dictating the outcome of SGBV cases can often rule on gender biases, favouring the perpetrator, at the expense of the survivor. Considering the extent to which this dualistic (formal/informal) system operates and influences each other, the Western shunning of traditional approaches and practices are seemingly problematic in holistically managing SGBV in Liberia.

[1] Participants often used SV, GBV and SGBV as interchangeable terms during fieldwork. However, they made the distinction between GBV, which typically does not include sexual violence and SGBV, which does.

1.2 Problem statement

SGBV continues to be one of the most severe post-conflict issues that both females and males in Liberia face (Liebling-Kalifani et al., 2011, UNFPA et al., 2007). Children make up a significant portion of the individuals affected. The United Nations Office for the Coordination of Humanitarian Affairs (OCHA) (2012) states, *"[d]uring the last civil conflict in Liberia, local media reported on the massive increase of sexual violence, with nearly 50 per cent of the 658 rape survivors aged between 5 and 12 years"*. It is believed that a large proportion of these SGBV survivors utilise both traditional and Western care to complement each other (Utas, 2009). However, some survivors seek no care at all or may prefer traditional practices, which may prove more easily accessible. Contradictory medical and judicial approaches have the potential to harm, confuse and frustrate survivors. The current global nature of aid largely neglects local Liberian tradition and knowledge and does not give it the platform is deserves. Yet, these structures do not exist independently from other social, cultural and legal institutions *or* Western medicine and INGO initiatives. The lack of productive collaboration between the international community and traditional leaders limits and worsens the possibilities for effectively and directly dealing with SGBV.

1.3 Context

Liberia is bordered by Guinea, Cote D'Ivoire and Sierra Leone (page ix). The West African country's history is complex. Its political formation and deep-rooted history of secret societies played a significant role in the brutal 14-year civil wars. The American Colonisation Society sponsored and encouraged freed slaves to return to Africa in **1822** (Sendabo, 2004, Outram, 2013, Peek & Yankah, 2004). The resettled, self-named 'Americo-Liberians' founded the state of Liberia in **1847** on a constitution based on the United States (US) structure (Ibid.). The constitution read, *"We the people of the Republic of Liberia, were originally the inhabitants of the United States of North America"* (Huberich, 1947:2). Citizenship was restricted to the Americo-Liberians. The distinction between the elite and proud American Christians and the 'tribal people' (photo#1) began immediately (Ellis, 1999). Numerous and serious armed conflicts between the two communities ensued up until the **1930s** when the various indigenous tribes were suppressed (Waugh, 2011). Fundamentally, the almost apartheid like situation enslaved the 95% of

Photo #1: Liberian Tribes

Reddy, 2013

indigenous tribes[2] and elevated the 5% of resettled elite (Outram, 2013, Peek & Yankah, 2004). The settlers' motto was *'the love of liberty brought us here'*. Yet, the marginalised and exploited indigenous groups were not granted any of these liberties for almost 60 years. Between **1847** and **1980**, the government comprised only of Americo-Liberians (Ibid.). In **1979**, when the government proposed a significant price rise in rice, a staple food, mass protest occurred (Outram, 2013). The police brutally killed demonstrators in response. After despot President William Tolbert and his cabinet were executed on a central Monrovian beachfront, Samuel Doe became the first indigenous president in **1980** (Outram, 2013, Sawyer, 2005). Hope for inclusion was high. Yet, Doe's administration and oppression of the Liberian people was possibly worse and more public than his predecessor (Sawyer, 2005). The state remained a one-state party for decades and the president enjoyed unrestricted powers. Doe's tyrannical dictatorship culminated in the **1989** civil war, when he was assassinated. Mass killings, sexual violence and migration ensued. Charles Taylor temporarily declared himself president in **1996**, and was elected president in **1997**. Taylor followed in Doe's favouritism of their personal clans, exacerbating the distinction between the two groups and fight for land rights. Opposition to Taylor's presidency resulted in the outbreak of the second civil war beginning in **1999**. Fighting began in the interior, which was significantly impacted and devastated as an outcome (Persson, 2012). Liberian women were absolutely pivotal in ending the war (Tripp, 2013, Reticker & Disney, 2008). Africa's first female head of state, Ellen Sir-Leaf Johnson was elected as president in **2006** (Outram, 2013, Peek & Yankah, 2004).

While there were a number of attributed reasons, the war was essentially the result of dissent between indigenous communities who had been excluded from **power** and the Americo-Liberian's who held the **power**. Due to the course it took, the conflicts transpired into largely tribal ethnic wars (Sawyer, 2005, Villa-Vicencio, 2009). The indigenous tribes and the settlers from the south of the US had deep-rooted beliefs about witchcraft that permeated both cultures. The war absolutely devastated Liberia. Yet, some of the traditional rituals that the indigenous tribes believed in and practised were widely used. Some of these rituals involved the sacrificial murders of children. Vital organs like the heart were consumed. This was often done in combination with rituals that touted abilities to become bulletproof (Waugh, 2011, Outram, 2013). Both Doe and Taylor held these beliefs and participated in some rituals. Waugh (2011:53) notes that the,

[2] There are numerous tribes, communities and **cultures** in Liberia across its fifteen states. This paper will refer to the wider traditional culture in Liberia, which is also found across West Africa.

style of combat…may have had their roots in the practices of the traditional secret societies and cannot simply be explained away as being a consequence of the fighter's intoxication or the desire of the combatants to spread terror among the enemy.

Alliances to the US and west remained strong during the Cold War. The settlers' heritage and links to the US may explain one reason for this (Outram, 2013). Yet, the aid provided by the US to the continent for Cold War strategies provides a more compelling argument. These external actors providing aid helped to keep Doe's regime afloat (Sawyer, 2005). While there are over 11 spoken languages, English is the official language (Sendabo, 2004, Peek & Yankah, 2004). Liberia still uses the US dollar and is commonly known as 'small America' and the Long Star state in reference to the US flag. The US-founded Firestone Tire and Rubber Company, is still one of the biggest companies in Liberia. Statistics about religious denominations significantly vary (page#12) (Sendabo, 2004, Outram, 2013, Peek & Yankah, 2004). Sendabo (2004) notes that the indigenous population makes up 95%, while the Americo-Liberians make up 2.5% of the population. There are 40% who follow indigenous religions, 40% who follow Christianity and 20% who follow Islam (Ibid.). In reality, many people practice a combination of Islam, Christianity and traditional religions.

1.4 Literature overview

Much of the literature referred to in this paper is based on studies in **neighbouring states**. The majority of existing studies have explored the consequences of GBV being neglected as a public health issue (Heise et al., 1994); the trauma of SV (Peterman & Johnson, 2009); the stigmatisation and neglected social benefits (health care) for children born of rape (Mochmann, 2008, Carpenter, 2007, 2010) the HIV consequences of SV (Lalor, 2008); SGBV against refugees, returnees and internally displaced persons post conflict (UNHCR, 2003), GBV legislation in post-conflict Africa (Tripp, 2010) and post-conflict sexual exploitation and its consequences for re-victimisation (Fukui, 2010). While a number of studies exist, only a handful of reports refer to SGBV in relation to a dual system of medical or judicial intervention (Cohen & Green, 2012, GOL/UN JP, 2011, Kruk et al., 2011, Abramowitz, 2010, Sipsma et al., 2013, Abrahams, 2011). Literature on post war cultural norms and **post-conflict** SGBV on women in Liberia, presents a much more limited scope (Liebling-Kalifani et al., 2011). Literature on children and male SGBV is scarcer. Despite the dearth in research on SGBV and dual management systems, there is growing interest in the field. Schia and Carvalho are currently conducting research on 'Peace-building, Gender and Protection in Liberia: A Role for Customary Justice?' (de Carvalho, 2013).

1.5 Aims

This research aims to contribute to knowledge about SGBV in Liberia. In particular, it intends to supply a greater understanding of the **dualistic approaches** in managing SGBV and the attempts at **syncretisation**. By analysing these dualistic health and judicial systems, I intend to substantiate the apparent lack of interaction between the Western and traditional structures and investigate the possibility for synergy between the two. It will shed light on the possibilities but also question the current systems and **accountability of humanitarian aid**. This research focuses particularly on children, defined by the UN (1989) as, *"every human being below the age of eighteen years unless the law applicable to the child, majority is attained earlier".* The impact of legal instruments including, the Convention for the Rights of the Child 1989 (CRC), the African Charter on the Rights and Welfare of the Child (ACRWC), the Children's Law of Liberia 2012, and regulation monitoring the practice of traditional medicine and customary law in Liberia will be examined (WHO, 2001).

1.6 Research question

To what extent do the Western and traditional approaches to managing sexual and gender based violence (SGBV) in Liberia syncretise?

1.7 Objectives

1. To explore the **Western response** in medical and judicial[3] practices dealing with SGBV (focused on children).
2. To explore the local and **traditional response** in medical and judicial practices dealing with SGBV (on children).
3. To explore the **syncretisation** of the Western and traditional approaches dealing with SGBV and **local perceptions** of these systems.

1.8 Terminology

Syncretisation: To attempt to combine different or opposing principles, whether it be beliefs, religions or approaches (HarperCollins, 2014).

Landsby: denotes interior county field location for confidentiality reasons.

Orthodox/formal system: while 'informal' may be value-laden, this study will use it only to denote non-state systems. When referring to 'orthodox', I refer to Western orthodox philosophies, attitudes and doctrines, if not otherwise stated.

Compromising cases: refers to how the outcome of a case (medical/judicial) has been ultimately influenced by an individual. Individuals include perpetrators, perpetrators families,

[3] Initially this study aimed to only explore the Western and traditional medical practices dealing with SGBV in Liberia. However, the judicial structures were later included due to the interconnected nature of the structures.

survivors' families and survivors' themselves. Individuals usually bribe officials or negotiate the formal systems to compromise the intended formal outcome of a fair trial, due process, conviction or formal medical care. Medical staff can change medical forms. Evidence can be destroyed. Proceedings can be ruled in favour of the perpetrator if they are family members of the judge. Survivors can be convinced or threatened not to report sexual abuse.

Victim versus survivor? Bott et al. (2005) (cited in Population Council, 2008) find that levels of service of SV are often swayed by health workers views and attitudes regarding SV and gender roles, reflecting the importance of using single, positive connotative terms. Consistent to this study's choice of term, the Population Council (2008) and Tayler-Smith et al. (2012:1) chose to use the word **'survivor'** over **'victim'**, *"to embrace the idea of resilience, empowerment and recovery"*. WHO recommend health workers use sensitive, reassuring language rather than terms that have the ability to revictimize patients (Population Council, 2008). Alternatively, others prefer using 'victim', as directly quoted by participants (RLP, 2013). Nevertheless, considering where SGBV/gender terms derive (Eurocentric, Truth and Reconciliation Council (TRC) processes, CEDAW, Beijing Declaration) and how they are introduced and used in local contexts is important. This is especially in terms of power and how organisations may use terminology to frame objectives and goals for aid.

Female genital cutting (FGC) versus female genital mutilation (FGM)? The terminology used to describe FGC is political and emotional (Shell-Duncan & Hernlund, 2000, Boyle, 2002, Skaine, 2005, Mottin-Sylla & Palmieri, 2011, Nchogu, 2010). There are a number of different terms including female genital cutting, female genital circumcision (inaccurate/medical), female genital mutilation (political/socially confronting) used to describe the practice. Various terminologies make it confusing and contribute to the misinformation about the practice. I chose to use FGC because it is less value-laden and judgemental, and especially pertinent in this context.

1.9 Thesis structure

This thesis is divided into six chapters. **Chapter 1** introduces the thesis. **Chapter 2** is set out in two parts. The first part consists of a literature review. This aims to conceptualise SGBV in Liberia and present previous research. The second part introduces two theoretical and conceptual frameworks. These will help to analyse findings and also help to frame all three-research objectives. **Chapter 3** clarifies the methods used to produce, analyse and interpret data. **Chapter 4** presents the empirical findings produced during fieldwork, and uses key representative quotes. **Chapter 5** engages in a discussion in line with the empirical results. **Chapter 6** concludes the thesis and provides some recommendations towards syncretisation.

CHAPTER 2: LITERATURE REVIEW

This chapter will discuss the main contributions to the literature in SGBV with particular reference to Liberia. Firstly, a brief overview of major pertinent international and Liberian legislation on women and children's protective statutes will be summarised in a timeline. An overall analysis of literature conceptualising the problem in Liberia will then be outlined. Literature that sheds light on Liberian traditional justice and health systems will be drawn on. Briefly, research on FGC will be explored. General, shared and contrasting conclusions will be identified.

2.1 Global response to SGBV

Widespread sexual and gender-based violence occurs in various developed and developing parts of the world. In recent years, populations in conflict-impacted states including Bosnia, Cambodia, Peru, Somalia, Uganda, Democratic Republic of Congo, Sierra Leone and Liberia have witnessed mass rape and violence (UNHCR, 2003). Consequently, there has been an increased focus on research and management of SGBV in **conflict** environments (Timeline #1). In some cases this has provided the means for survivors to report crimes, allowing better data collection and research (Liebling-Kalifani et al., 2011, de Carvalho & Schia, 2009). Yet, statistics and research remains considerably hampered due to widespread stigma and accessibility.

There have been several initiatives to implement legislation and policy on SGBV. These have been at a global, regional and country level (Timeline #1). The United Nations Security Council's Resolution (UNSCR) 1325 was adopted in 2000 in acknowledgement of the changing nature of conflict (UN, 2000). The resolution recognises that children and women are especially impacted by war. Yet, they have most often been omitted from peace and conflict reconciliation. This is despite their pivotal presence and role in peace building (Liebling-Kalifani et al., 2011, UN, 2000) Liberia implemented a comprehensive five-pillar GBV National Action Plan for Resolution 1325 in 2006 (Liebling-Kalifani et al., 2011, Landis, 2012). In line with this, amendments to Liberia's rape law concerning statutory rape, gang rape and consent have also been legislated. GBV Task Forces, specialised courts and prosecutors responding directly to SGBV, the Women and Children Protection Section (WACPS), a referral pathway for abuse, and various I/NGO and GOL programmes have been established. Nevertheless, SGBV remains a **severe post-conflict challenge** (Tayler-Smith et al., 2012, Landis, 2012, GOL/UN JP, 2011, Abrahams, 2011, MOGD, 2012).

Timeline #1: Global and local response to human rights and SGBV: legislation [4]

1948	•Universal Declaration of Human Rights: *equal rights for men and women.*
1959	•Declaration of the Rights of the Child.
1960	•Convention against Discrimination in Education: *particularly referencing girls and practices that impede educational opportunity.*
1979	•Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).
1981	•African Charter on Human and People's Rights (Banjul Charter) & Protocol: *to promote and protect human rights and basic freedoms in Africa.*
1989	•The Convention on the Rights of the Child.
1990	•**African Charter on the Rights and Welfare of the Child.**
1993	•Vienna Declaration: *draws attention to women's rights and particularly the 'girl child'.* •UN Declaration on violence against Women.
1995	•Beijing Declaration and Plan of Action: *reaffirm women and girls rights, especially referencing violence.*
1997	•Regional WHO Plan for the Acceleration of the Elimination of FGM.
1998	•Joint Declaration WHO/UNFPA/UNICEF for the Elimination of FGM. •Rome Statute: *recognises rape & other sexual abuses, authority of the International Criminal Court.*
1999	•United Nations Resolution A/RES/53/117 on FGM.
2000	•Millennium declaration and millennium development objectives: *MDG 3: promote gender equality and empower women.* •UNSCR 1325 *(followed by resolution 1820 (2008) and resolution 1888 (2009) protection of "women and girls" during and after armed conflict.*
2003	•**Maputo Protocol**: *The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa.*
2006	•**Liberia's Rape Amendment Act:** *Amendments to the penal code including requirement of in-camera hearings, amendments to gang rape and the definition of consent and penetration, statutory rape laws included, no clause on marital rape but abortion permitted if rape results in pregnancy.*
2012	•**Children's Law of Liberia.**
2013	•UNSCR 2106: *preventing sexual violence in conflict setting – first time legislation includes **men and boys** as vital source to prevention.* •**Liberia's domestic violence law in session.**

[4] De Carvalho, B & Schia, N (2009); Horvath (2007); Library of Congress (2014); Kouyate, M. (2009).

2.2 Conceptualising SGBV in Liberia: underlying causes and contributing factors

Findings consistently report that the most vulnerable group impacted by SGBV in Liberia is young adolescent girls' and women (Tayler-Smith et al., 2012, MOGD, 2012). A report by United Nations Mission in Liberia (UNMIL, 2008b) Legal and Judicial System Support Division, found that the majority of rapes occurred to individuals between the ages of **10-19**. 46% of rape reported to the Liberian National Police (LNP) in 2007 occurred to under 18-year olds (GOL/UN JP, 2011). A recent study by Tayler-Smith et al. (2012) found that in three Medecins Sans Frontieres (MSF) clinics in Bushrod Island, Monrovia, consisting 1500 survivors, *"half of the survivors were children aged 13 years or younger and included infants and toddlers"*. Participants in a government of Liberia and United Nations Joint GBV programme (GOL/UN JP, 2011) study outlined that this young cohort were targeted for several reasons. Firstly, **on-going** child SGBV occurred due to **economic issues** and poverty. Street selling, on behalf of parents made children vulnerable. Pressure to sell all goods before returning home exposed children to perpetrators who easily convinced them to trade sex on the purchase of their goods. The **weak judicial system, impunity, some religious factors concerning dress code, and the breakdown of traditional structures** due to the war were also held liable (Tayler-Smith et al., 2012). Other participants blamed the lack of basic education. This was particularly in reference to constitutional rights combined with traditional values that disadvantaged women. Girls' were pinpointed here, as they often had to forgo formal education for traditional *bush school* (MOGD, 2011). As the report states, *"according to respondents, traditional beliefs and practices are the main reasons for the perceived increase in sexual violence against children"* (GOL/UN JP, 2011:46). Beliefs included that a girl was ready to have sex after menarche, initiation, and a ritual involving the attainment of power, specifying the need to have sex with a virgin (Ibid.).

Wartime sexual crime was often rationalised as a result of displacement, lack of protective community and war strategy (Liebling-Kalifani et al., 2011, Tayler-Smith et al., 2012). In contrast, statistics reveal that sexual abuse is now most commonly committed in survivors homes and communities by **family members or acquaintances** (Liebling-Kalifani et al., 2011, Tayler-Smith et al., 2012, GOL/UN JP, 2011, Stark et al., 2013, Landis, 2012, de Carvalho & Schia, 2011). 1037 of the 1500 individuals surveyed (69%) in the Bushrod Island area revealed that they **knew the offender** (Tayler-Smith et al., 2012). Stark et al. (2013) maintains that programming needs to be more focused on this fact. Moreover, **compromising** the outcome of cases in favour of the perpetrator and access to both in/formal healthcare and in/formal judicial routes is widespread. Family members, perpetrators and officials exploit survivors through bribery and corruption in inefficient formal services, due to poverty, power and relationships to

perpetrators (de Carvalho & Schia, 2009, GOL/UN JP, 2011, Stark et al., 2013). One report recorded that a mere one-third out of 1500 survivors considered initiating legal proceedings (Tayler-Smith et al., 2012, UNMIL, 2008a). If survivors managed to access police stations, it is a common requirement to provide financial contributions towards the investigation due to limited police resources (de Carvalho & Schia, 2009). Exploitation also occurs in medical facilities. One study found that medical staff in Grand Gedeh altered survivors' medical forms on receiving bribes (GOL/UN JP, 2011). There is a strong correlation between women's empowerment and the utilisation of healthcare (Sipsma et al., 2013). While the overall significant improvement to the health system is required for utilisation, Sipsma et al. (2013) argue that exploring Liberia's stark gender imbalance needs to be prioritised.

Statistics in reporting rape and domestic abuse cases have increased. Regardless, **underreporting** and failing to pursue (formal) post rape care is a worldwide trend (McIlwaine, 2008, Utas, 2009). Stigma and embarrassment play a key role in whether survivors pursue care in Liberia and most other African states (Tayler-Smith et al., 2012, de Carvalho & Schia, 2009, 2011, Stark et al., 2013, MOGD, 2012, UNMIL, 2008b). Fear of retaliation by the perpetrator, impeded marriage possibilities, blame and shame, likelihood of divorce, and disbelief pose barriers to reporting (Liebling-Kalifani et al., 2011, Tayler-Smith et al., 2012, MOGD, 2012, UNMIL, 2008b). Survivors may simply be unaware of available formal services and thus pursue informal more secretive traditional providers (Tayler-Smith et al., 2012). Tayler-Smith et al. (2012) found that only 619 out of 1500 (41%) survivors pursued post incident care within the recommended 72 hours. **Accessing** pertinent resources is commonly cited as a problem as it is practically and financially unfeasible, especially for rural communities. Reports suggest that the majority of I/NGOs, healthcare and police facilities are located in Monrovia or the county capital (Liebling-Kalifani et al., 2011, de Carvalho & Schia, 2009). In a 2008 – 2009 study, there were only four clinics offering comprehensive SV support, three of which were operated by MSF (Tayler-Smith et al., 2012).

The Women and Children Protection Section (WACPS) were established in 2005, under the Liberian National Police (LNP) (Landis, 2012, de Carvalho & Schia, 2009). The objective was to institute an office in each of the fifteen states, in, or adjacent to the county LNP office. These offices would decentralise, engage and manage the protection of women and children. The initiative was managed through the United Nations Development Programme (UNDP), with USD 1.6 million funding granted through the Norwegian government. This was in direct response to the growing issue of SGBV and the need for a separate space, with trained staff to deal with such incidents (Ibid.). Although a considerable achievement, WACPS is plagued

with numerous inefficiencies at a local and regional level (de Carvalho & Schia, 2009). On a two-tier scale, the majority of these police stations simply lack the resources to deal with regular crime, let alone SGBV crimes. Resources like transportation, staff and training were absent. On-going operational costs like fuel to run vehicles and generator run electricity to power computers were not being met. de Carvalho & Schia (2009) argue that the resources provided for WACPS, including new police structures and procedures largely failed to acknowledge existing techniques, nor if these resources would/could actually be used. The staff training model and distribution, as well as implemented systems like in-camera trial hearings have been generally unsuccessful (UNICEF, 2005, de Carvalho & Schia, 2009, GOL/UN JP, 2011).

2.3 Traditional response to SGBV

2.3.1 Sande and Poro secret societies

While there have been anthropologic writings on Liberian traditional secret societies, there is very little recent literature. In order to provide a more cohesive understanding some key authors writing on and around Liberia will be used to explore this complex phenomenon in relation to SGBV (Ellis, 1999, Sawyer, 2005, Waugh, 2011, Pajibo, 2008, Adamu, 2013, Utas, 2009). Secret societies, similar in nature have been present in the West African rainforest belt (northern Liberia, Cote D'Ivoire, Sierra Leone, Guinea) long before Islam and Christianity (Waugh, 2011, Sawyer, 2005, MOGD, 2011). Waugh (2011:48) states, Poro Societies *"have never existed"* in the south and east of Liberia, although communities, albeit less inclusive have used similar resolution and reconciliation techniques (Pajibo, 2008). Liberia's 16 ethnic tribes are divided into two linguistic groups, the Mende and the Kwa (Ibid.). Focus will be on the Mende who operate the Sande women's association, located in western, northern and central Liberia (MOGD, 2011).

There are two main secret societies in Liberia, the Poro (male) and Sande (female). These groups are considered 'traditional society' and very influential. Secrecy is paramount (MOGD, 2011). The threat of abduction and being sacrificed acts as a powerful deterrent for members (Waugh, 2011). The societies consist of a hierarchical, largely-hereditary structure comprising several sub-groups (Ibid., Ellis, 1999). Waugh (2011:48) notes the secret societies beliefs *"focus on the relationship between humans and the land and natural world".* While these natural powers dictate their lives, the leaders are responsible to *"connect, interpret and convey that natural spirituality from its sources to the people who inhabit the land"* (Ibid.). Membership requires youths to undergo a process of initiation carried out in *bush schools. Sande School* sees *"girls into womanhood, confers fertility, instils notions of morality and*

maintains an interest in the well-being of its members throughout their lives" (MOGD, 2011:3). Schools may last between several weeks and several months. It involves being taught discipline, practical skills, and undergoing tattoos, body cuttings and circumcision (Ellis, 1999, Waugh, 2011, Abrahams, 2011). Waugh (2011:49) notes that symbolically, Poro initiation is a *"process [that] involves youths being eaten by wild spirits and re-emerging as adults, according to the…practitioners"*. Traditional leaders (Zoes), several layers of chiefs and a variety of healing practitioners (Zoes, herbalists) are fundamental to this process. They are responsible for resolving disputes (Waugh, 2011) and treating (medically, psychosocially) abuse survivors (Abrahams, 2011). Beoku-Betts (2005) notes that accounts regarding the traditional Sande *bush school* have largely been one-sided and negative. Yet, one MOGD (2011:14) report found that the *"practice of Sande contributed negatively to the efforts to prevent SGBV"*. Moreover, post-war *"the girls' training is* ***more symbolic than utilitarian****…the emphasis is not on learning new skills so much as on looking at it as a course of* ***income*** *for practitioners"* (Ibid.: 15).

Manzini's (1997) local account of Zimbabwean culture points out that when two cultures or religions join (syncretise), rarely does one completely displace the existing belief system. Waugh (2011:51) notes that an estimated 75% of Liberian's *"follow local religions as their primary faith, alongside 15% of the population who are Christians and roughly 10% who are Muslims"*. Belonging to a religion or traditional society is not mutually exclusive. Liberians do not see it as contradictory. Rather, religion and traditional society have in many ways become assimilated, with traditional beliefs still having a strong predominance. However, in Liberia a strict rule in following Islam means that one cannot be part of or follow a secret society (Ibid.)

2.3.2 Traditional justice systems

According to a joint department, UNDP, UNICEF and UNWomen report (UN, 2012:7) titled, *Informal Justice Systems (IJS): charting a course for human rights-based engagement,* "*over 80% of disputes [are] resolved through informal justice mechanisms in some countries"*. Accordingly, IJS and traditional systems play a vital role in the rule of law in some communities. The report recommends that integration of traditional systems into broader development initiatives is necessary in ensuring justice for all. It also emphasises that accessibility, affordability and cultural sensitivity obstacles can be met through IJS. The study highlights the difficulty in defining IJS but broadly defines it as, *"encompassing the resolution of disputes and the regulation of conduct by adjudication or the assistance of a neutral third party that is not a part of the judiciary as established by law…"* (UN, 2012:8).

"*Most Liberians still rely on traditional justice"* (Flomoku & Reeves, 2012:44) particularly in rural communities (GOL/UN JP, 2011, Abrahams, 2011). Pre-settler justice mechanisms included primarily three techniques; the *palava hut* process (public hearing, managed by Zoes and elders), sharing the *kola nut*, and *sassywood* (trial by ordeal) (Pajibo, 2008). Rape cases are judged in the largely non-punitive *palava hut* style (Ibid.) or merely between the survivor, the perpetrator and the families (Abrahams, 2011). Basic procedure involves the case being reported to the elders/Zoes, the two parties coming together at the *Palava hut* or other bush location, the survivor's statement being taken, evidence gathering (sometimes), confession by the offender, final decision by the chief/Zoes and harmonisation between the two parties if desired. Punishment often involves fines of **cash** but also food goods such as cattle or palm oil (Pajibo, 2008, GOL/UN JP, 2011, Abrahams, 2011, Sendabo, 2004). The village women sometimes gather outside the perpetrators house to arrest them (Abrahams, 2011). At times, perpetrators are made to marry the survivor. Both the survivor and the perpetrator undergo a cleansing ritual performed by the Zoes (Pajibo, 2008, Abrahams, 2011).

Liberian traditional justice structures were drastically weakened during the war. Various local and international key actors have spent large amounts of resources in rebuilding the **formal** systems. Yet, corruption plays a key role and reforms have been slow to trickle down to the communities (Flomoku & Reeves, 2012). Though a hierarchical system involving the informal system that reflects pre-war structures exists, there are several clashes between the existing formal and informal structures (Ibid.,de Carvalho & Schia, 2009, de Carvalho & Schia, 2011). These have considerably hindered the capacity for local chiefs and elders to resolve local disputes. One clash refers to some of the traditional methods utilised to determine guilt through harmful practices, which elicits responsibility. Resolving SGBV cases in connection with statutory rape laws is a further point of contention (Pajibo, 2008).

The Carter Centre has been a key actor working with the Ministry of Justice (MOJ), Ministry of Internal Affairs (MIA) and traditional leaders on strengthening and integrating the two judicial systems. They have developed effective guidelines to work with elders and chiefs where there is a clash in law. Sawyer (2005:59-60) states that, *"Poro has been the foundation pan-ethnic social institution embracing the collective social and historical experiences of most Mel-and Mande speaking groups in Liberia, Sierra Leone, and Guinea"*. Ultimately, its foundational legitimacy over a large group provides access to considerable resources and thus power. He and Ellis (1999) argue that rather than being a warring faction; the hierarchical Poro Society incorporates a peace complex and has provided a sense of stability. It has acted as an important *"force for ending violence and managing and resolving interethnic conflicts"* where

state-based techniques were futile (Sawyer, 2005:59-60). Contrastingly, Pajibo (2008) criticises the effect of a dual judicial system suggesting a call for a single formal system. He warns of the possible violent repercussions if these two systems become engrained in separately catering to the rural community and the urban elite. Pajibo (2008:24) maintains that historically, all Liberians have not been afforded equal access to justice, which should be *"underpinned by constitutionality, the rule of law and due diligence"*. de Carvalho & Schia (2009, 2011) and Tayler-Smith et al. (2012) on the other hand criticise the international community for **not understanding** the traditional customary system. They argue that is it necessary that the traditional system firstly be mapped and then examined on how it interacts with the formal structure. In doing so common and deceptive knowledge of cultural practices will decrease.

2.3.3 Traditional healing systems

The World Health Organisation (WHO, 2001:1-2) defines traditional medicine as, *"a diversity of health practices, approaches, knowledge, and beliefs incorporating plant, animal, and/or mineral-based medicines; spiritual therapies; manual techniques; and exercises, applied singly or in combination to maintain well-being, as well as to treat, diagnose, or prevent illness"*. Techniques and knowledge are often orally conveyed through generations with some families specialising in treatment. Corresponding to the aforementioned IJS report specifying 80% (page#12), a frequently cited WHO (2008) statistic states, *"in some Asian and African countries, **80%** of the population depend on traditional medicine for primary health care"*. However, the origin of this statistic is unclear and the WHO factsheet has been removed from the website (accessed 27.10.13). AfricaCheck eventually sourced the reference to a 1983 document that provided no supporting evidence or data to the figure (Wilkinson, 2013). Various documents including WHO and UN reports reference some form of this statistic, though it may be highly exaggerated and unsubstantiated.

Despite this ubiquitous but inaccurate statistic, a recent study of 1434 Liberians by Kruk et al. (2011:3) found that *"the median respondent used **formal** health care 3 times in the year preceding the survey and used **informal** health care 10 times during that same time period"*. The study also found that rather than Liberian's using one form of healing over the other, orthodox and traditional medicine was used to **complement each** other; though, the frequency of informal healthcare increased with lower income and literacy. A Sierra Leonean study found that a significant number (83% of the sample collection) of SGBV survivors violated during or after the war used traditional medicine as an initial source of healthcare (Utas, 2009). This high prevalence of traditional healing makes its use in relation to SGBV in post-conflict settings

particularly relevant, especially in the West African rainforest belt. Despite this dependence on traditional care, particularly for rural communities very little in-depth research or scientific testing on traditional medicinal products or practices and SGBV has been carried out (WHO, 2008). The *Study on Traditional Trauma Healing Mechanisms in Communities in Liberia* was only recently commissioned by UNWomen (Abrahams, 2011). Perhaps, the international community distances themselves from traditional medicine because, as WHO (2008:1) states, *"traditional medicines and practices can cause harmful, adverse reactions if product or therapy is of poor quality, or it is taken inappropriately with other medicines"*. Perhaps it is a funding, political or harmful practice (FGC) issue.

According to WHO (2001) Liberia's traditional medicine and practices are regulated through legislative documents. Health practitioners are regulated through a registry in a number of local and national committees. Authorization is administered through local officials. There is traditional medicine training available for health employees. Abrahams (2011) report, specifically focusing on SGBV and traditional trauma healing sheds light on customary methods, which have not previously been formally recorded. The research was conducted over five counties, with similar results. She is careful however to point out the results should not be considered universal in Liberia. The healing process for SGBV cases involves the combined healing of both the survivor and the perpetrator as previously pointed out (Pajibo, 2008, Abrahams, 2011). The Zoe women and traditional birth attendants determine the extent of the physical and psychosocial damage. Medicine is then administered and may take between a few weeks to several months. The survivor is bathed with a mixture of herbs prepared by the Zoe which may include, *"cassava leaves, palava sauce or kpeto, potato leaves and water to cleanse her of rape…and to ensure that she will be able to bear children in future*" (Abrahams, 2011:27). The perpetrator is also bathed in a mixture of herbs as an act of punishment and to reinstate the law. The perpetrator may also be publicly whipped (Ibid.).

Abrahams (2011) found that stigma and social isolation was dealt with through collective female solidarity. As one participant from Grand Cape Mount noted,

> *When someone is raped, we go to the Zoe house. We get Traditional women who will go to look at the woman to see if they raped her. They will put you in the tub with country medicines and treat you for infection. The traditional women will call everybody in the town and break word and make law so nobody can provoke the woman* (Abrahams, 2011:27).

It is also common to seek advice or what the West would consider psychosocial care from older relatives (Sendabo, 2004). The female Zoes and elders are responsible for counselling and for mobilizing the community women to donate food, clothing or cash and involve

survivors in community activities. Utas's (2009) research interviews found that traditional healers secretively treated SGBV survivors in Sierra Leone due to legal restrictions. Participants noted that this secrecy was beneficial to the survivors in terms of evading social stigma, often unavoidable when dealing with police and hospitals. How communities define concepts like mental illness has implications for syncretisation. Mental illness in Sierra Leone and Nigeria is considered something *"outside"* the body, associated with evil spirits and sin, contradicting the orthodox Western concept and thus treatment (Utas, 2009, Adamu, 2013).

GOL/UN JP (2011) participants made the distinction between child rape and rape against women who dressed in a certain way. Child sexual abuse is harshly frowned upon in traditional culture (GOL/UN JP, 2011, Abrahams, 2011). Despite this widespread disapproval, it has bore little influence on the increase of child abuse cases (Abrahams, 2011). Participants provided several reasons for this. These included perpetrators being 'big men' (men with authority, money, power) which strongly discouraged reporting and/or acknowledging the abuse (Abrahams, 2011), drugs and alcohol, the prolonged war and impunity to commit crimes, and the breakdown of traditional structures and values (GOL/UN JP, 2011). The rise in perpetrators targeting very young children (under two years, as young as nine months) was accredited to witchcraft rituals (Abrahams, 2011). Some individuals strongly believe that the combination of virgin blood and magic can grant them great power and wealth, *"the younger the victim, the purer the blood and, therefore, the more potent the medicine"* (Abrahams, 2011:32). Participants noted that child abuse cases were immediately reported to the police and the community assisted in capturing the offender. It was common for perpetrators to flee to bordering countries. Elders were also known to expel the perpetrator from the community (Ibid.). The child's family would determine the type of healthcare and justice pursued. A combination of hospital, police or Zoe care would be pursued in no particular order. This is similar in Sierra Leone (Utas, 2009). If traditional routes were taken the community women and elders would decide if the child could return or would need relocating (Abrahams, 2011).

The dichotomy between modern and traditional medicine and practitioners' remains strong, despite increased interest in traditional forms. Adamu (2013) criticises WHO and the promise to provided health for all by 2000. WHO has yet to achieve this goal, nor do they have the capacity to do so. Failing to seriously consider traditional healers' as an important source to accomplish this goal would be foolish. As Adamu (2013) argues, the majority of traditional medicine in Nigeria "*still remains unofficial, crude and sometimes, a harmful part of healthcare system in Nigeria".* Other countries like China and India have had long histories of effective complementary health systems, especially with rural populations. This is important

especially if Western medicine remains *"heavily bureaucratised and elitist-oriented,"* costly and inaccessible to the world's majority (Adamu, 2013:3). People will continue using what they know. While traditional medicine may be more accessible, affordable and culturally sensitive there are several disadvantages, which emphasises the need for regulation. The sector is shrouded in secrecy and while it is inherited, people also inherit the errors of their predecessors (Adamu, 2013). It is also relatively easy to scam individuals due to low education. As there is no formal tested accreditation needed, dosages are a significant problem in Nigeria. Practitioners also often use unsterilized instruments and poorly store medication, emphasising the need for training of traditional healers and birth attendants (Ibid.) Coulter et al. (2008) and Adamu (2013) all note that traditional healers are beneficial in psychosocial care as they have ample time to speak to their patients, though training is needed so patients are not more traumatised. Traditional healers in Sierra Leone have had the capacity and reach to care for sexually abused women (Utas, 2009), which would seemingly be the same in Liberia.

2.3.4 Female genital cutting (FGC)

FGC is a sensitive and highly political issue that has garnered much attention in recent years. WHO (2014b) found that the majority of cases occur in 29 different African countries, but extends to some parts of Asia, the Middle East and some migrant communities in Western countries (Boyle, 2002, Skaine, 2005). Forms of the practice were also practiced in the US and Europe up until the 1950s (Ibid.). There have been several international laws and regulations written on banning or ending FGC (Timeline #1). Liberia has no specific legislation banning the practice (Rahman & Toubia, 2000). Skaine (2005:7) provides one broad definition, *"FGM is the collective name given to several different traditional practices that involve cutting of female genitals".* The practice involves several different techniques of cutting, but has been divided into four classification types by WHO (Skaine, 2005, WHO, 2014b). The procedure is often accompanied with an array of serious long-term harmful physical and emotional impacts (Waugh, 2011:49, Skaine, 2005). FGC frequently results in severe infections, bleeding and reproductive complications (Boyle, 2002, Skaine, 2005, Nchogu, 2010). It is also a painful experience, as anaesthetic is never used. The spread of HIV/AIDS is a further concern due to unsterilized equipment and untrained practitioners (Skaine, 2005, Mottin-Sylla & Palmieri, 2011). In Liberia, only three ethnic groups do not perform the practice according to Rahman & Toubia (2000). Traditional leaders (Zoes) performed type two FGC as part of the initiation process for new members in Liberian secret societies (Ibid.). It is thus seemingly tied up into cultural and traditional social norms. The practice is highly criticized and widely rejected by governments and Western organizations as a human rights abuse and *mutilation*.

Yet, the implications for banning FGC have repercussions like in Kenya, where it is thought to be widely practiced in secret (Nchogu, 2010). In urban areas in some African countries, health professionals have been used in order to practice it safely (Skaine, 2005). However, WHO has condemned this medicalization (Ibid.). This contention leaves little room for effective dialogue and education. It also fails to reflect on how the practice may be considered a protection technique and attacking it would not be the most effective way to reduce it. A Kenyan study on human sexuality notes that the girls undergoing FGC perceive it in the same way, stating *"women who undergo the circumcision describe the rites surrounding the practice as a time of joy, gift giving, and festivity"* (Nchogu, 2010:13). The study found that out of 386 participants 53.5% (205) agreed on the practice while 46.5% (178) disagreed. However, it is important to note that individuals are socialised to accept or believe in practices depending on their environments and social culture. Alternatively, a Liberian MOGD (2011:10) report found that interviewed girls' *"did not understand the value of the practice and were traumatised".* The largely successful Tostan Model, initiated in Senegal, uses local language, culture in education and the community needs, through a **community participatory approach**. Most Tostan staff are community graduates from the Tostan programme (Gillespie & Melching, 2010).

Critically, most of the aforementioned literature has referred to neighbouring countries, highlighting the gap in literature in Liberia. Despite its international significance and the amount of aid directed towards tackling the widespread problem, SGBV and in particular traditional healing and justice mechanisms used to manage it are poorly documented. Understandably, the fundamental challenge of exploring *secret* societies is self-evident. The difficulty in gathering data on SGBV and traditional healing in Liberia, particularly in rural places, is a common problem that has hindered more extensive work in this area (Liebling-Kalifani et al., 2011). However, the need to engage in Liberian cultural beliefs and secret societies in obvious. Particularly so, as in recent years the aid industry has mainstreamed the idea and importance of partnership and local context. This poses the question of how we are actually implementing and 'doing aid' related to SGBV if we have little knowledge of the local systems and cultures that are managing it. It also raises several logistical issues regarding humanitarian emergency aid and implementation in conflict settings. This research therefore aims to fill the gap in the existing literature, which may provide a basis for more informed research in SGBV, the dual system of healing and the possibilities for syncretisation.

THEORETICAL AND CONCEPTUAL FRAMEWORKS

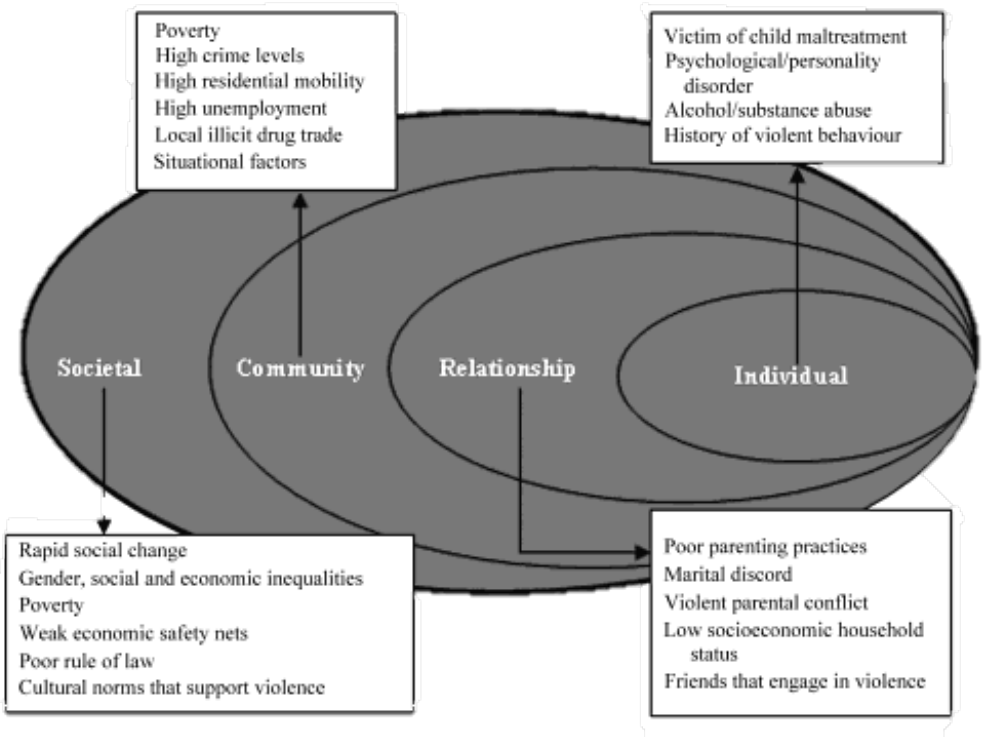
The concept of context is not new. Place and space can significantly influence health variation due to social relations and access to resources (Cummings, 2011). Though, Cummings (2011) argues the need for a greater understanding on the bearing individual geographies have on health in order to provide more effective and 'contextually sensitive' policy and response. This chapter will use two key analytical frameworks to help explore and understand the management and syncretisation of sexual and gender-based violence in Liberia. These are an Ecological Framework and Gender and Power theory. In particular, relations across place and space within individual environments will be highlighted to showcase protective and risk factors of SGBV. This is because the subtle messages and norms of **cultures within individual environments** are pervasive, complex and highly influential (Swidler, 1986, Williams, 1989, Durkheim & Giddens, 1972, Bicchieri & Chavez, 2010, Rimal & Real, 2003). Culture and the social norms that dictate individual environments have the ability to enable and constrain behaviour on the perception of in/appropriateness (Kelly et al., 2011, Berkowitz, 2010). This establishes expectation and shapes interaction. Each of the aforementioned theories will illustrate the **interplay of the internal and external determinants** that have an impact on SGBV. These determinants include historical, social, political (war) and economic influences. Accordingly, important actors and their practices that are essential in framing the discussion will be highlighted. Thus, generalisations can be made on a broadened understanding of knowledge yet confined and limited by the variables and challenges of the Liberian phenomena. Moreover, an eclectic range of theoretical tools will be used to support the discussion chapter and will include theories of resilience and agency.

2.4 The Ecological Model

Human ecology evolves from *"the assumptions that humans are a part of the total life system and cannot be considered apart from all other living species in nature and the environments that surround them"* (Andrews et al., 1980:32). An ecological model assumes that each component that makes up the whole **ecosystem** is **interdependent** (Bubolz & Sontag, 1993). Each part bears a **relative influence** on the other individual parts and thus the whole system. The World Health Organisation's Ecological Framework (Figure #1) draws attention to the dynamic interplay of **four** separate but overlapping environments, namely the **individual, relationship, community and societal** (Kelly et al., 2011). These relationships and levels all have a bearing of influence and probability on an individual becoming a 'victim' or perpetrator of violence (WHO, 2014a) The **first level** (individual) recognises the **personal history** of an individual. As Figure #1 below outlines, these may include a history of child maltreatment and

violent behaviour. The **second level** involves **personal relationships** with family, spouses and friends. The **third level** includes individuals' physical environments and how relationships exist within them, particularly on the **community** platform. Violence levels can rise when individuals are faced with forms of deprivation or individual pressure such as unemployment and social disintegration (Kelly et al., 2011, WHO, 2014a). The **forth level** explicitly deals with influences on the **societal** level such as poverty, and in Liberia, the legacy of civil war, which most likely encouraged a culture of violence (Ibid.).

Figure #1. WHO MODEL



(WHO, 2014a) Ecological Model for understanding violence with examples of risk factors.

An Ecological Model (WHO, 2014a) provides a structure to explore how various underlying and contributing determinants interact at different levels and influence SGBV. It also helps to explore how and where the actors managing SGBV fit into and interact in the Liberian context. Points of contention and also avenues for collaboration are thus highlighted. This model provides a holistic structure to explore two important components in this thesis. The first is the **ecosystem** that manages SGBV in Liberia. This helps to look at the multidimensional interactions and relationships between the four different levels and actors in society. It demonstrates where the I/NGOs, the government, the traditional society and the individual fit into the problem and solution. The second component helps to understand the **individual** and the underlying factors and individual vulnerability to violence. The framework is constructed on evidence that several determinants and multiple environments govern an individual's level

of risk to violence (WHO, 2014a). It looks at an individual's personal history and context influencing their behaviour. While environments do not directly determine human behaviour, they do facilitate, limit or obstruct certain behaviours. This influence is guided on two different structures including **legislation and social norms**. Although the ecological model explicitly highlights **risk factors** it can also highlight **protective factors** (page#99). Importantly, these factors shift depending on the individual perception. For example, a traditional healer or INGO could simultaneously be perceived as a risk or protective factor, depending on one's beliefs. This therefore illustrates the importance of collaboration among the actors navigating within the ecosystems managing SGBV in the post-conflict state. The ecological framework helps to frame all three-research objectives.

2.5 Gender and Power Theory

Gender is diversely defined across and within multiple disciplines. According to UNESCO (2003:1),

> *Gender refers to the roles and responsibilities of men and women that are created in our families, our societies and our cultures. The concept of gender also includes the expectations held about the characteristics, aptitudes and likely behaviours of both women and men (femininity and masculinity).*

Moghadam (1998:136) describes gender as an *"asymmetrical social relationship between women and men based on perceived sex differences, and an ideology regarding their roles"*. Mainstream ideas surrounding sex-gender distinctions have typically considered sex as biologically natural and gender as a societal construct. As a result of sex equating to a natural foundation it has governed ideas of gender because gender is considered in relation to sex (Levinson, 1999). Therefore, there exists predetermined ideas' relating to gender even before birth. Butler (1990), like Foucault, challenges this essentialism and naturalisation of biological binary sex and concepts of gender (Levinson, 1999). Foucault discusses that our focus on sexuality in the public sphere, as related to social identity, is in an 'invention' of the 17-18th century. Similarly, Butler (1990) considers the body as gendered where both sex and gender are social constructions. She argues that the social mechanisms that have helped to establish gender have similarly determined sex norms based on historical and Western misunderstandings of the body. This has been developed through philosophical myth. Subsequently this myth has enforced an ethnocentric Western cultural imperialism, disseminated and cemented as Universalist through colonisation and globalisation (Nagl-Docekal, 2004). Foucault suggests sex differentiation is a tool that is able to regulate and restrain sexuality and therefore a population (Levinson, 1999).

Connell's (1987) tripartite Theory on Gender and Power (TGP) helps to structure and explore the complex issue of SGBV at multiple **overlapping** levels. By exploring the internal (Liberian) components of the problem, the external (international) influence becomes clearer. This provides an analytical basis to comprehend how the individual and social levels interact. The theory explores three defining but intersecting structures. They highlight the historically entrenched power dynamics and sexual inequality between women and men. These include, the **sexual division of labour**, the **sexual division of power**, and the **structure of cathexis**, otherwise defined as the structure of social norms and affective (emotional) attachment. These structures operate on two different levels, namely the societal and the institutional. The theory has been used in numerous studies, including studies exploring the disparities in women's health, HIV risk and violence against women (Wingood & DiClemente, 2000).

The ***sexual division of labour*** defines the economic disparity between men and women in production relations and thus economic consequences (Connell, 1987). As with many cultures, women traditionally remained at home providing child/home care. This perception and trend prevails to a large degree especially in rural Liberia. This structure divides women and men into gender explicit employment. For women this often means informal lower paying or unpaid jobs. The inescapable financial dependence on men has a strong bearing on women's health and empowerment. The ***sexual division of power*** highlights male power and dominance over women in relationships and society. Historically, gender roles have been defined as a derivative of social norms pertaining to men. In other words, women's roles have largely been defined as a subset of norms for males. This division of power begins at the societal level in gender roles, tradition and culture, and is supported at the institutional level through the exploitation of authority and power. The ***structure of cathexis*** discusses the affective (emotional) component of relationships and considers the sexual desire and emotional commitment in relationships between women and men. It emphasises the social norms around gender roles and expectations, particularly drawing attention to expectations within marriage. Women are supposed to be subservient in power and sexual behaviour to men in Liberian traditional society. This raises questions about empowerment and agency. These are two strong concepts advocated for by the international community, which to a certain extent emerged from participatory perspectives.

These three structures (power, production, emotion) operate on the institutional and the societal levels, impacting women's health/SGBV (Connell, 1987). The societal level plays the most important role. Here, ideas and norms are entrenched in historical, economic, social and political forms that are structured on preconceived gendered characteristics, and thus pre-

assigned power. While society adapts and shifts over time these norms and structures essentially remain unchanged for an extended period of time. Alternatively, on the institutional level, changes like the passing of rape laws happen more quickly, but also take some time to fulfil (Tripp, 2013), emphasising the push for a comprehensive intervention (Berkowitz, 2010). These power imbalances across the three different structures and two different levels, incorporating work and school environments, family, religious and state institutions are sustained and influenced by each other. As Connell (1987) highlights, they impact the daily lives of women. However, these imbalances also influence heterosexual men as well as other individuals who identify under other sexual identities. Connell's (1987) TGP is used to shed light on the implicit power relations implicated in the concept of gender and thus Liberian relations and sexual expectation. It demonstrates the struggle that women and men face between traditional and conservative gender roles and 'new' 'empowered' roles advocated for by the international community.

Farrell's 1993 *The Myth of Male Power: Why Men are the Disposable Sex*, questions the definition of power or *"control over one's life"* (Farrell, 2012:5). Rather than believing that women are systematically disadvantaged, Farrell posits that it is in fact men who have less control over their lives. Gender issues have most often been focused on female suppression and disadvantage. The author argues that the socialisation process of certain (gendered) jobs and roles are more detrimental to men. He provides an example of conventional military culture and the male-only drafting process. He suggests that if females or a certain race as a group were asked to 'voluntarily' defend their nations with prospective death, society would consider it extreme sexism or racism. Yet, society and men are socialised to consider it as 'glory' and an obligation. Farrell (2012:22) argues, *"women's strength is their façade of weakness. Men's weakness is their façade of strength"*. He maintains this has implications for psychosocial health for all concerned. The author makes a valid point on questions about recognized agency and in what society teaches **both** girls and boys about their roles and expectations, and thus sense of obligation. Women's issues and gendered identities have been rightly spotlighted because of the centuries of open and furtive discrimination they face. Yet, men's health and issues have not garnered the attention they deserve. This is perhaps because dominant conventional societies have not allowed dominant male gendered socialisations to be openly questioned. There are increasing attempts at shifting this focus, to where gender does not denote 'women' (i.e. Women in Development (WID) to Gender and Development (GAD).) However, there seemingly needs to a greater shift as men's health and socialisation are universally as important as women's. In Liberia, men are a fundamental part in preventing and addressing SGBV, which is not merely a *'women issue'*.

CHAPTER 3: METHODOLOGY

3.1 Research design

Qualitative and quantitative methods

In recent years the use and validation of qualitative methods has considerably developed in the social sciences. Qualitative methods often prove to be a more effective approach of concentrating on individual experiences, meanings, attitudes and behaviours (Ellsberg & Heise, 2005, Green & Thorogood, 2009). Exploring children's experiences of SGBV and access to health and judicial provisions, traditional, Western or otherwise, proves a far more complex task than merely counting the number of SGBV cases that have occurred among the cohort. This is pertinent in Liberia where statistics and data are significantly constrained by limitations of reporting and data collection. There are several benefits of combining qualitative and quantitative methods (Bryman, 2006). While this study is qualitative, it uses some quantitative data from secondary sources. Including data on the actual numbers of **reported** cases highlights several wider structural issues, including inaccessibility to report crimes. An interdisciplinary approach where methodological strengths and theoretical cross-disciplinary approaches from health, political science, gender and development studies was used.

Phenomenology

This qualitative research followed a phenomenological approach. Green & Thorogood (2009:14) describe a phenomenological approach as one, which argues that, *"to understand the 'essence' of phenomena, one [has] to understand how the 'life-world' was directly experienced"*. In order to achieve this understanding, Kvale (1996) explains the importance of transcribing the direct and precise description of the phenomena prior to, and as a separate exercise to the analysis. This intends to reach objectivity through conscious examination of the phenomenon. While a phenomenological approach aims to explore lived experiences through the subject's own perspective, according to Kvale (1996), it also aims to understand pre-reflective meanings to highlight the unseen or un-reflected. This is the understanding that humans are reflexive beings and do not merely understand objects and the world through a passive manner. Rather, we are able to consciously act and think about objects and actions within our environments (Green & Thorogood, 2009). Thus, on description of the account, an *investigation of essence* ensues, which then attempts to explore and analyse the phenomenon for a common rationale. According to Kvale (1996:54) this type of *phenomenological reduction* is used in order to *"[suspend] judgement as to the existence or nonexistence of the content of an experience"*. Applying 'bracketing' to the scientific foreknowledge or rationality to the experience allows for an unbiased description of the essence. While Kvale (1996) points

out that this does not definitively remove biased assumptions, it does allow the researcher to critically explore their own presumptions in a further attempt at impartiality. A phenomenological approach was best used in this study because it refers to subjective experiences. It also relates empirical observations and findings of the SGBV phenomenon in Liberia to each other in order to explore the presence of syncretisation.

3.2 Study area

Data collection was conducted in two sites, Monrovia, (Montserrado County) (1 month), and an interior location (1.5 months), located approximately 385km out of Monrovia (Table #1). The interior location will forthwith be known as "Landsby" in respect to participant confidentiality. The ability to spend two full months in Landsby was hindered due to logistical support and illness. Initial research was conducted in Monrovia for several reasons. The capital provided an avenue to understand the context and ecosystem that dealt with SGBV as a whole. Obtaining the official stance on the issue from key actors was also afforded. Moreover, it presented greater access to people and resources including I/NGO and central government head offices, judicial systems, health facilities and documentation. Due to this centralisation, the promotion and awareness around S/GBV issues were consequently higher in the capital. This impacted the use and access to health support and information about it. While beneficial, this concentration distorts the information about the rest of the county. Moreover, researchers suggested that the majority of research was being carried out in the capital (Utas, 2012). Thus, participants were becoming over exposed to the same repeatedly asked questions. Participants therefore had little interest in speaking to more researchers based on past experiences. Consequently, the need for research to be conducted outside of the hub of Montserrado was highlighted.

Initially, the selection of interior location was based on a Norwegian Refugee Council (NRC) GBV field location, to access logistical support and survivors. However, after some time in Liberia I chose not to restrict my field location to NRC operations. Instead, my decision was significantly supported by information I had learned about Landsby while in Monrovia. This included particular incidents and the prevalence of SGBV, the severe impacts of war the area suffered, the traditional background of the area and other local insights. In addition, the government of Liberia (GOL) and UN GBV joint programme commissioned the *Study on Traditional Trauma Healing Mechanisms in Communities in Liberia* in 2011 (Abrahams, 2011). Initially this study included the Landsby field location. The site was abandoned due to heavy rains and inaccessible roads. The ability to contribute to this data additionally contributed to my choice of location.

Table #1: Time plan

	May 2013	June 2013	July 2013	Aug 2013-May 2014
Place	Monrovia	Landsby	Landsby	Bergen
Participants	INGO offices Government offices SGBV focus persons Girls who have survived SGBV Head Zoe	Regional I/NGO offices Regional government staff Community leaders Girls who have survived SGBV Traditional healers		
Methods	In-depth interviews Observation Participation in trainings Document analysis	In-depth interviews *Informal focus group* Observation		Analysis of data and writing thesis

3.3 Participants

In line with a phenomenological approach I purposefully chose participants who provided me with in-depth information about the issue of SGBV concerning children in Liberia. The intention was to include *five* groups of participants: I/NGOs running programmes supporting survivors of SGBV, government SGBV focus persons, community leaders, girls who have experienced SGBV, and traditional healers. There were numerous other participants who provided other important background information. (Table #6: appendices)

I/NGOs running programmes

The Norwegian Refugee Council (NRC), the International Rescue Committee (IRC), Save the Children (Save) and ChildFund (CCF) participated in the study as four major INGOs providing support to SGBV survivors, particularly in regards to children. In addition, the NRC provided access to observe support programmes for survivors of SGBV and community awareness programmes in Monrovia. All the I/NGOs providing support to SGBV survivors in Landsby participated. (Table #2).

Table #2. INGOs interviewed in Monrovia and Landsby

Monrovia			Landsby[5]		
CCF: ChildFund	Female	Local	INGO1	Female	Local
IRC: International Rescue Committee	Female	Local	Local NGO1	Female	Local
NRC: Norwegian Refugee Council	Male	Local	Local NGO2	Female	Local
Save: Save the Children	Male	Local	Local NGO3	Male	Local

Government SGBV focus persons

A number of pertinent GOL and UN focus persons that directly worked within the system catering for SGBV survivors were invited to participate in the study (Table #3). Monrovia contacts were initially made through the NRC and thereafter through snowballing methods. Contacts in Landsby were made through the regional Ministry of Gender and Development

[5] Landsby I/NGO names are being withheld to protect the identity of participants and survivors.

(MOGD) office. The MOGD Coordinator provided an overall perspective on SGBV in Liberia. The Head of WACPS (HOW) participated and offered the official police perspective on the issue. The head of WACPS in Landsby partook to shed light on the ground level perception. This was done in order to understand how the system at the ground level was operating, with the resources made available to regional office; especially those located far distances from the capital. A formal interview with the Landsby County Gender Coordinator was scheduled but did not take place due to logistical and time constraints. However, several informal conversations were had.

Table #3. Government SGBV focus persons interviewed in Monrovia and Landsby

Monrovia			Landsby		
UN/MOGD GBV Joint Programme: Coordinator	Female	Expat	LNP: regional WACPs	Male	Local
MOGD (GOL) GBV Unit: Coordinator	Female	Local	Regional hospital:	Male	Local
LNP: Liberian National Police: Head of WACPS (HOW)	Female	Local	SGBV focus person		
MOHSW: Director for Psychosocial Support	Male	Local			
MOHSW: Div. Complementary Medicine (DCM)	Male	Local			
Ministry of Justice (MOJ)	Male	Local			

Community leaders

The Head of the Women's Traditional Council of Liberia (Sande Society) provided valuable insights into the female secret society. Contact was made through the NRC and MOGD Montserrado Gender Coordinator. *Five* political and religious community leaders in Landsby participated in the study (Table#4). Communication was directed through the regional MOGD office. Wherever possible respected women leaders were included.

Table #4. Community leaders interviewed in Monrovia and Landsby

Monrovia	Landsby	
Head of the Women's Traditional Council:	Christian Leader: Head of the Minstrels Council of Churches	Male
Sande Society (female secret society)	Muslim Leader: Chairman of Muslim Committee	Male
	Traditional Head of General Chiefs	Male
	Traditional Chairlady[6]	Female
	Youth Group Leaders: Chairman and member	Male

SGBV survivors

Eight girl survivors were interviewed; *four* in Landsby and *four* in Monrovia. In Landsby, *one* girl survivor, aged 13 years (12 years when the assault occurred) was recruited through NGO2. *Three* girl survivors, aged 15, 15 and 19 years (18 years when the assault occurred) were

[6] Each county had a traditional chairman and chairlady who was part of the traditional council.

recruited through INGO1. *Three* other interviews were twice rescheduled due to participants' time commitments such as market day and working on the farm. The guardians of the girls then cancelled all three interviews at the very last minute, despite the girls' willingness (Table #5). Gaining access to survivors was difficult and hindered due to several reasons. These included logistics and the locations of survivors', confidentiality, exam periods, graduation periods, Liberian Independence Day, school holidays, transport to rural areas and logistical and time constraints after the rescheduling. On return to Monrovia, *four* girl survivors, two aged 14 years and two aged 15 years were recruited through a GOL operated, but externally funded safe home.

Table #5. Girl survivors of SGBV interviewed in Monrovia and Landsby

Landsby	Age	Monrovia	Age	Cancelled interviews
SV1 x 1 (INGO1)	15	SV5 x 1 (safe home)	15	x 1 cancelled (by parent) Landsby
SV2 x 1 (INGO1)	15	SV6 x 1 (safe home)	14	x 1 cancelled (by parent) Landsby
SV3 x 1 (INGO1)	19	SV7 x 1 (safe home)	15	x 1 cancelled (by parent) Landsby
SV4 x 1 (NGO2)	13	SV8 x 1 (safe home)	14	
x 8 (informal focus group)				

Traditional healers

I intended to interview *two* or *three* traditional practitioners including healers, herbalists or country doctors in Landsby. Due to their time constraints, the secrecy behind their practices and the stigma associated with SGBV, no practitioners in Landsby participated in this research, despite several efforts. Instead, traditional leaders who were also traditional healers (Zoes) were consulted on healing matters. *One* informal conversation with a Monrovian based traditional healer occurred.

3.4 Data procedures

3.4.1 Data collection

A document review of both qualitative and quantitative research reports was undertaken to help determine the magnitude and context of the issue. This included an analysis of current international, UN and Liberian policies and law relating to SGBV and child rights. Documents obtained from the four participating aforementioned INGOs, were used to analyse their aim, SGBV programmes, processes, and care packages including medical, psychosocial and practical help. Locating, organising and integrating data from a broad range of primary and secondary sources were required in order to carry this out. Careful consideration was taken when analysing the sources of reported data/figures. Fieldwork was carried out to determine

and map local perceptions of both traditional healing and Western based/governmental medical and judicial provisions provided for SGBV survivors. Fieldwork facilitated exploring what traditional healing practices catering to SGBV survivors actually consisted of. The ability to observe, interact and research I/NGO programmes on a first-hand basis was invaluable.

Research instruments

Gatekeepers

The NRC acted as the primary contact in Monrovia. The NRC provided generous support in obtaining contacts for other I/NGOs and government offices in Monrovia. Thereafter, snowballing methods were used. This method was used to contact the Gender Coordinator in Landsby. The Gender Coordinator and local MOGD office staff in Landsby acted as gatekeepers and provided valuable leads and key contacts. Through their assistance I was able to contact local NGOs, community leaders, and local community groups. My primary gatekeeper at the MOGD office in Landsby was female, local and the same age as myself. Her position in the MOGD, local community and ability to initiate contact with NGOs and pertinent government offices was extremely helpful. In addition, she was able to explain some general societal factors including culture, tradition and ritual, as well as modern culture. However, as she came from one particular tribe, a lot of her knowledge about different traditional practices was limited to that tribe. This was the case for the majority of young people I spoke to. On some occasions cold calling or directly visiting ministry and INGO offices was used to contact participants, as alternative contact methods proved inadequate.

One INGO and *one* local NGO who operated a local safe home, acted as the primary gatekeepers who identified key participants for the survivor interviews. The gatekeepers were informed about the inclusion and exclusion criteria. **Inclusion criteria** included that participants be female, who *had* experienced SGBV and were aged between 15-18 years. This age group was initially sought, as permission to interview them would likely have been easier to obtain compared to younger survivors. They may also have had a better comprehension of the issue, greater knowledge of traditional healers and practices. They may have been more articulate. These age parameters were lowered on learning the extent to which younger individuals were impacted by SGBV. The need for participants who *had* experienced an I/NGO/government support programme was highlighted. Equally, the needed for some participants who had *not* experienced an I/NGO/government support programme but visited a traditional practitioner was emphasised. However, survivors who had sought any type of care were included due to the difficulty in accessing survivors and the time constraints of the research. In-depth semi-structured interviews were conducted with all the survivors.

Focus group

There are advantages like shifting power imbalances and disadvantages like not attaining in-depth data to using focus groups (Green & Thorogood, 2009). *One* focus group with the *eight* interviewed girl survivors, prior to in-depth interviews was planned. This proved unachievable. Informal conversations with *eight* girls aged 12-16 years, who had *not* experienced SGBV occurred. They were participants in a Landsby INGO1 awareness programme for girls living in communities of particularly high incidences of SGBV. Data produced from these conversations are used as background knowledge (Table #5). A focus group with the five participating community leaders was unfeasible, largely in reference and consideration to their time constraints and time taken for initial contact. In-depth semi structured interviews were carried out to understand their perceptions and recommendations on SGBV in the community.

Interviews

Interviews played an essential part in data production. SGBV survivors use levels of reflection and therefore active strategies to cope with their experiences (Ellsberg & Heise, 2005). Thus, participants were asked about *their* experiences and *their* understanding of SGBV as well as the health support (programmes/facilities) accessible and available to survivors. A phenomenological approach furthermore focuses on the power structures in what people say and do (Green & Thorogood, 2009). Speech and body language can create unwanted inferences and enact dominant roles. For instance, as an interviewer and researcher, using the term 'victim' versus 'survivor' to describe SGBV survivors instantly implied a power structure and perhaps imparted an unwanted role and revictimisation of the individual. The importance of fieldwork and being physically present to observe, interview and reflect on the understanding of participants' experiences and environments was thus highlighted. By being present, it additionally aimed to reduce the physical and lived 'distance' between the researcher and the participant and therefore the knowledge gained and produced (Chacko, 2004, Milner, 2007).

In-depth semi-structured 30-60 minute interviews, conducted in Liberian English were the primary method for producing data, on attaining saturation. With permission from the interviewees a digital recorder was used. Interviews with I/NGOs, pertinent government staff and traditional leaders were conducted in their offices or in the regional MOGD office. In particular, questions about the incorporation of local knowledge, culture and beliefs about gender and SGBV were highlighted, along with the institutional features of global aid and the impact and influence that can come with it (i.e. ignoring traditional methods because of structural adjustment policies/donor preferences) (#3 appendices). Survivors were given the option to choose where their interviews would be conducted. All four interviews conducted in

Monrovia were carried out in the safe home manager's office. I provided the option of an unused 'safe' space at an INGO's office in Landsby. Two participants chose this option. Another participant chose their private room located in a local NGO office while the fourth chose the location of a different local NGO office. Participants were offered the choice to have an adult of their choice present in the interview. The survivor interview guide (#3 appendices) and questions was discussed with an INGO worker who was previously a nurse and directly worked with SGBV survivors. The opportunity to run a pilot test with survivors was not available, nor the opportunity to run repeat interviews due to time constraints, and the sensitive nature of the study. Moreover, due to the difficulty in accessing survivors, the chance to return and discuss the transcripts for comment or correction did not transpire (Tong et al., 2007).

Participant observation

Participant observation played an essential role in observing and understanding daily life during the three months spent in Liberia (Kapborg & Bertero, 2001). Daily gender relations, cultural and traditional practices, the use in health facilities and the roles and expectations of children, women and men were observed. Participating in and observing I/NGO trainings, hospital and judicial procedures and the perceived community perspective of these systems provided a hands-on ground level understanding of the complex ecosystem. Being present allowed me in some cases to build relationships and rapport with people in the community, I/NGO staff and governmental staff (Kapborg & Bertero, 2001). This also helped people relate to me (page#39). Building these connections supported leads in finding information about traditional healing and SGBV. However, in some cases this was merely a superficial connection as being 'accepted' into the world of the secret societies in a short three-month period would be impossible. Yet, this access, observation and participation of living in the community contributed to the research. While participant observation is regarded as an ethnographic tool, I was restricted in some regard (Watson & Till, 2010). I did not seek to observe secretive traditional healing practices regarding SGBV but observed daily interaction. A number of interviews that were not used directly, but acted as background knowledge can be found on Table #6 in the appendices.

Recording

A digital recorder was used to record the interviews when the participant agreed. This allowed me to be fully attentive to the interviewee. Recording allowed me to pay attention to non-verbal signs, social cues and body language that informants displayed when being asked, or while answering a question. This was especially important for the survivors. This gave me indications on whether to ask questions in another way or reduce the pace of the interview (Kapborg & Bertero, 2001). The ability to verify information at a later stage if necessary was

also provided. Misquoting participants was significantly reduced. The ability to re-listen to dialogue during transcription proved highly beneficial in recalling information and deciphering Liberian English. When consent to use a recorder was not granted on one occasion, an agreement to use what I had written was settled. There are several negatives to using recorders. One of these includes participants being self-aware and preoccupied with the device. Thus, once consent was given, the recorder was turned on and placed out of sight.

Translators

The subjectivity, positionality and concerns regarding the use of a translator were anticipated prior to fieldwork. While various ethnic languages are spoken, English is the official language and is used as a medium to communicate among the different tribes. Thus, no translators were necessary. This included the interviews with traditional leaders. Despite English being the common medium, '*Liberian English'* is spoken. At times this was difficult to decipher as words are often shortened. On such occasions, participants were politely asked to repeat themselves. The use of the recorder was useful in this regard. Prior to fieldwork departure I purposefully watched Liberian movies in order to become familiar with the speech. Socialising with local Liberian I/NGO staff as well as neighbours and friends in the community, helped familiarise the language, sayings and ways of speaking. This proved helpful in interviews, especially in Landsby. I was not completely understood by only one traditional leader in Landsby due to my accent. On this occasion, to avoid any misunderstanding, the aforementioned female regional MOGD gatekeeper helped to directly repeat the questions in Liberian English. As Aase (2007) points out, researchers interpret interpretations of how and what people remember of past events during interviews. Therefore, having only one layer between interpretations (participant-researcher) compared to three layers of interpretation (participant-translator-researcher) may improve validity.

3.4.2 Data management

The majority of interviews were recorded. These interviews were transferred from the recorder onto my password protected personal laptop. A backup copy was saved onto a memory stick. When interviews were transcribed they were deleted on both the laptop and memory stick. Informal conversations and interviews where recording was not permitted were manually transcribed. All transcribed documents were participant indistinguishable and document password protected. The laptop and memory stick were kept in separate safe places at all times. Consent forms were bound, kept in a safe locked location in the field location as well as in a locked locker in the Department of Geography, University of Bergen during the analysis and writing stage. The consent forms do not correlate to any of the transcribed documents in terms of names or individual participant identifiable features.

3.4.3 Data analysis

Qualitative data analysis is an iterative process. There are several tools that can be used to effectively organise and simplify sets of qualitative data in order to interpret it. One of these tools includes Attride-Stirling's (2001) thematic network analysis (TNA). Attride-Stirling (2001:386) argues that thematic analyses are more effectively presented as **thematic networks**, *"web-like illustration (networks) that summarise the main themes constituting a piece of text"*. She outlines thematic analysis as a step-by-step process that provides methodical analyses, which aim to uncover significant themes on varying levels. Thematic networks on the other hand, *"aim to facilitate the structuring and depiction of these themes…and aim to explore the understanding of an issue or the signification of an idea, rather than to reconcile conflicting definitions of a problem"* (Attride-Stirling, 2001:387). Attride-Stirling (2001) critically argues that there is an apparent need to disclose the methods and analysis process in qualitative research. This is achieved by being transparent in the methods of analysis from recording to organising data (MacKian, 2010). By doing this, it improves existing techniques. Examining the data in this way will also allow the researcher to explore both **apparent** and **concealed** patterns within texts (Attride-Stirling, 2001). A TNA requires disclosing each step of the process and thus provides greater validity to the qualitative research. Interpreting the data this way is beneficial as active reflection on the process is required. I used a TNA, which involves three general stages of processing text; condensing, exploring, integration of exploration (Attride-Stirling, 2001). However, as each stage requires a certain level of abstract interpretation, which is difficult to decipher between, there are six steps to achieving the three stages outlined below (Attride-Stirling, 2001:391). Triangulation of data using several perspectives was also used to in the data analysis process to help analyse **latent** and **manifest** content.

Analysis stage A: reduction or breakdown of text

Step 1: Coding material

The first step required that I finish transcribing interviews, organise, read and re-familiarise myself with all the data as a whole. On reading the information a second time, I began making notes in the margins of interesting or repeated information. After reading two transcripts in each of the sets of data, I began formulating a coding framework based on a hybrid of both inductive (data based) and deductive (theory based) data (Attride-Stirling, 2001, Graneheim, 2003). A list of these codes was made, with brief explanations on different coloured post-it notes to help identify categories and patterns within the text. The information was placed into a separate document and the process was reflected on. This was an iterative developing process, where new codes were created, changed, combined, split, renamed and refined. This coding

framework was then used to code the rest of the textual data. Coding in qualitative research has often been criticised for attempting to resemble or create semi-quantitative data, thus removing data diversity. However, by methodically explaining the process and definitions of coding and analysis, while linking the codes to the raw data, this seeks to avoid the loss of individual characteristics that qualitative research can offer.

Step 2: Identifying basic themes

Basic themes were extracted through the coding process in order to reduce the data. Codes that bore the same characteristics or patterns were synthesised where possible and basic themes were created. These basic themes were then refined to reduce repetition and highlight a single concept over a number of data sections. This was particularly handy in the underlying causes and contributing factors section, in being able to triangulate data from various data sets.

Step 3: Construct thematic networks

The process within the extraction of text involved three main themes, basic, organising and global themes (Coding Table: #5 appendices). This process aimed to summarise the fundamental concepts or essence of the issue through stages of analysis, which reduced and refined data into manageable explanatory information. ***Basic themes*** are the basic fundamental themes highlighted in the text. Basic themes were arranged on post-it notes and compiled into different clusters. This was based on links between the themes and how they related to each other. ***Organising themes*** comprise of grouped basic themes, which condense more abstract ideas. Basic themes were arranged and labelled into organising themes constructed on a higher order system, which was based on what the information revealed. ***Global themes*** act as the top-most themes that attempt to summarise the key metaphors throughout the whole text. Global themes were deduced from the three research objectives as well as the organising themes. These were illustrated by a single word or sentence, like 'education'. On the creation of these thematic networks, basic themes were re-evaluated in order to confirm that the description reflected the raw data.

Analysis stage B: exploration of text

Step 4: Describe and explore thematic networks

A description of each network was then summarised. Simplifying and breaking up the data assisted in rationalising and then building up the information to form one set of data. Subsequently, the data could then be analysed through the interpretation of themes and concepts within the text (Attride-Stirling, 2001:391). A TNA is not used to analyse data, but rather to break it down and condense it into manageable themes. In order to analyse and explore these themes other qualitative techniques were thus employed. **Content analysis** was

primarily used for this purpose. This categorised ideas into themes based on the three outlined research questions. Further themes were created for information that was unsuitable and was misplaced under these data sets. Links, relationships, contradictions, similarities and differences within and between the three sets of data were explored. I also used phenomenological techniques, including focusing on my own experience and positionality in the field.

Step 5: Summarise thematic networks

The networks were then summarised. This aimed to clearly highlight the patterns and relationships evident through the analysis. Representative quotations were used in order to substantiate the basic themes in the empirical chapter.

Analysis Stage C: integration of exploration

Step 6: Interpret patterns

As a result of the TNA process, a discussion of findings was written through the use of the TNA summaries in the empirical chapter. These aimed to answer the research questions, while relating the findings in the research to other literature.

3.5 Validity and reliability

Validity and reliability can be defined as the process of *"finding plausible and credible outcome explanations,"* (Morse et al., 2002:14, Gregory et al., 2009) where rigour and transparency act as key agents throughout the *entire* process of a study (Attride-Stirling, 2001, Graneheim, 2003). According to Gregory et al. (2009:457) methodology comprises *"the principles and assumptions underlying the choice of techniques for constructing and analysing data,"* which provide interpretations and conclusions. However, the validity and reliability of qualitative research and methodology has been widely criticised since the 1980s. This criticism has largely come from quantitative researchers who question the transparency and credibility of qualitative methodology/data. For instance, Baxter & Eyles (1997) question the level of transparency in qualitative interviews and argue that there are two appealing dangers. Firstly, in needing to identify common themes, there is a risk of profiling participants and creating stereotypes across transcripts, instead of researching inconsistencies between individual transcripts. Secondly, there is a strong appeal to excavate selective quotes that can strengthen or validate a researcher's preconceived conclusions or interpretations.

According to Morse et al. (2002:13), this sort of criticism has resulted in a transfer, from qualitative researchers' *"ensuring rigour"* throughout a study's process, to the reader ensuring rigorous critique. Several authors have argued that qualitative researchers should reclaim

rigorous techniques throughout their studies and not merely at the end where reliability and validity can be missed (Morse et al., 2002). There are numerous strategies and sets of standards to effectively analyse and validate interpretations of qualitative data (Guion et al., 2002, Tracy, 2010). While Baxter & Eyles (1997) propose one standard for both quantitative and qualitative research where rigour plays a central role, I chose to use a TNA (Gregory et al., 2009). Using a TNA required several specific steps that provided a clear understanding of each step and how interpretations (text analysis) and conclusions were made. It also clearly illustrates why and how methodology was chosen and performed. This provides a means to contest the study's conclusions and improve credibility (Gregory et al., 2009).

During the research I aimed to improve validity and reliability through several techniques. These included providing safe environments for interviews to occur and choosing qualitative methods most conducive to the participants' needs. This aimed to reduce power imbalances. I used the same interview guides and conducted all the interviews myself. As aforementioned, the ability to use a digital recorder helped to validate information by reducing misquoting and recalling information. In spending three months in Liberia, it provided a much clearer understanding of the situation, compared to only being there for a few weeks. This also afforded the opportunity to become aware and better understand things that only a person living, working and interacting with a community would learn. Building rapport and relationships with the people I interacted with was a goal. However, this was difficult in a short three-month period. Building rapport with the survivors was impossible due to the difficulty and time it took to gain access to them. However, the friendliness and welcoming nature of most Liberians made this process easier, even if at first it was superficial. In analysing, consciously reflecting and accepting the role of the researcher, and how the influences that my experiences, relationships, perceptions and understandings may have influenced data, I aimed to improve validity. Consciously reflecting on the positionality of others involved in the research, in addition aimed to improve validity and dialogue. Using methods of triangulation, and sourcing information from a range of different sources also aimed to improve validity and reliability.

3.6 Generalizability and transferability

According to Green & Thorogood (2009:224) *"generalizability refers to the extent to which findings from a study apply to a wider population or to different contexts"*. Similarly, transferability refers to, *"to what extent are these findings transferable to other settings?"* (Ibid., 2009:226). Can the findings be applied to other contexts, settings or countries? The validity and generalizability of sampling methods in qualitative research has been widely

criticised, particularly by quantitative based academics. In quantitative studies random sampling provides the means to extrapolate data and therefore represent findings to a wider population (Ibid). However, several authors argue that qualitative sampling differs in what it aims to present. Green & Thorogood (2009:225) state that rather than presenting *"'typical' accounts,"* qualitative research aims to *"provide 'thick' descriptions, or to address particularities"*. Nevertheless, the subject of generalizability should still be addressed in qualitative research. Findings can be validated when the generalizability and theoretical significance of a study is questioned, when reflecting on other populations or contexts. Green & Thorogood (2009:225) argue that it is not the aim to imitate quantitative methods but rather *"thinking through what kind of relationships the study findings have to other populations and settings, and unpacking exactly what inferences can be drawn from the data analysis"*. In other words, to what extent can the findings from one study be extrapolated to other cases? As Gobo (2004:406) suggests, *"there are two kinds of generalizations: a generalization about a specific group or population (which aims at estimating the distribution in a population) and a generalization about the nature of a process"*.

Transferability concepts need to be considered in terms of context specific information versus concepts that can be generalised. For example, Liberians had specific beliefs and practices about how to treat and heal SGBV survivors. While these specific beliefs cannot be generalised, the idea that there are specific beliefs and practices related to SGBV where traditional medicine is present, can be generalised to other cases and countries (Green & Thorogood, 2009). Moreover, I compared my findings to existing literature on SGBV, both in Liberia and elsewhere in and out of Africa. This comparison either affirmed or contradicted existing literature, thus contributing to the generalizability of my findings.

Sensitizing concepts

Green & Thorogood (2009) discuss three ways of generalising and transferring qualitative data (sensitizing concepts, conceptual generalizability, transferability). SGBV is somewhat widely researched in Liberia. Yet, it is confined to certain areas. Rarely does it include traditional healing and judicial systems. Such studies may highlight where generalizability is less apparent to other cases or wider populations. However, generalizability becomes useful in qualitative research by seeing the study as 'sensitizing concepts' to readers. For SGBV in Liberia, this means **sensitizing ideas** about traditional practices and medicine, the fact that there are alternative ways of thinking about healing, what it involves and that it is widely used. This as a consequence impacts and influences SGBV and how it should be managed.

Conceptual generalizability

According to Green & Thorogood (2009:225), theoretically, it can also provide other ways of **thinking about concepts**, in that *"the most appropriate way of thinking about generalizability in qualitative work is in terms of conceptual generalizability"*. Shifting the way I/NGOs and government health workers perceive or deal with traditional rituals, laws and healing mechanisms, potentially provides avenues for productive collaboration between the two. At the same time, in shifting the way Liberians think about Western medicine could have the same effect. The understanding about what is expected of a person or what can heal or make a person healthy (medically and psychosocially) differ from place to place but can be used to relate to other similar cases. In other words, generalizability in this case is not, 'to what extent can findings be extrapolated to a whole population', but rather, 'how can these data help understand other cases where traditional healing meets Western styled healing'.

3.7 Role of the researcher

My positionality in relation to other cultures is significant as it distinguishes a relationship and thus framework on which society is built, developed and cooperates. According to Milner (2007:388), positionalities which are closely considered may illustrate one's *"own and other's racialized and cultural systems on coming to know, knowing and experiencing the world,"* and thus highlighting *"dangers seen, unseen and unforeseen"*. Intricately linked positionalities such as race, gender, nationality, ethnicity, education, and sex are implicitly constructed through *"unequal power relations"* (Chacko, 2004:52). It is therefore important to acknowledge how these often-overlooked identities grow over time and influence the fluidity of positionality. This makes it difficult yet essential to define in order to create a 'comfortable' environment for fieldwork to occur. A level of reflection is provided and thus aids validity.

Nationality and ethnicity are two very different things to many people, especially 'third culture kids'. Growing up and experiencing life in South Africa may have been beneficial to carrying out fieldwork in Africa, and knowing the 'African way'. Yet, having this sense of association could also have been highly detrimental (Mompati & Prinsen, 2003). The way one perceives oneself is different than the way others may perceive you. Accordingly, you may be seen as an outsider imposing Western concepts. While there are many generalizable factors, Africa is an enormous continent with numerous different cultures and structures. My ethnicity in Liberia may also have proved disadvantageous and advantageous. In Monrovia, there is a noteworthy presence of Indian business people that have been present for some time. Thus, this association of ethnicity may have been highly dependent on the perception and interaction local Liberians' had with these local Indian business people, whether those were good or bad.

As a consequence of ethnicity and diversely influenced sense of nationalities I believe that to some extent I did have a clearer understanding of diverse African culture, tradition and belonging. Having the flexibility and ability to identify as being classed as 'ethnic' may have in some aspects helped to overcome some ethnic difference. I shared a common nationhood and identity of poverty, racism and apartheid (Ganga & Scott, 2006).

Albeit this *sense* of understanding or belonging, my positionality as well as central ideas about identity, politics and nationality have consistently been challenged (Mompati & Prinsen, 2003). During fieldwork, on two occasions I was told by ethnic Africans that, *"South Africa is not Africa"*. Moreover, on numerous occasions children called me *"white"* or *"white woman"*. After some clarification with older Liberian locals, it was explained that I was not being called *"white"* because I was of European decent, but rather because I was not indigenously African and did not have African hair. Alternatively however, when I was often seen at the local market place buying food, people often commented that they never saw foreigners shop there and asked where I was from. Being seen eating Liberian food in local eating-places where foreigners or expats would not chose to visit, I was often told (*participant observation*) *"Eh! You're different"* or *"oh I know, you're like us, you eat everything"*. I also noticed after some time that because of this, I was becoming privy to information I may not have otherwise. The implications of being considered either an 'insider' or 'outsider' for various reasons altered my access to people and information they were willing to reveal (Mullings, 1999). As a consequence this impacted the data I produced. This was also emphasised when locals saw me walking in the community to meetings or around Landsby stating, *"I see, you walk all over the town all day"*. Alternatively, when I was seen driving in an INGO vehicle, locals definitely had a different perception of me. However, reflecting on the various perceptions of what children and adults' thought about my identity brought up further questions about, identity, education, ethnicity and (white/Western) privilege that I may have been associated with and that may have all influenced the research. This challenge to what I perceived as my own identity proves advantageous, as having a false sense of identity could be dangerous in terms of assumptions and assuming a sense of acceptance in a community (Hopkins, 2007). Similarly, preconceived completely positive notions can also hinder research and access to people, space and place.

Although **gender** equality in Liberia has made some progress, women are still largely constrained by patriarchal tradition. Consequently because of cultural restrictions, I as a female was obstructed from traditional male practices and information. However, my positionality and association with the NRC assisted accessing prominent figures within society. Female traditional healers/leaders perform certain practices and convey messages that influence roles

within society and thus SGBV. Although my gender ideals have been influenced directly by partially patriarchal influenced African and Indian tradition, they often largely conform to 'empowered' Western/New Zealand influenced gender definitions. Thus, it was important to acknowledge that in all probability my perceptions of gender equity may have differed to traditional gender concepts and impacted research outcomes. It was therefore important to reflect on this and be open to understand new ideas and ways thinking and not merely be constrained by my way of thinking. Alternatively, being female and sharing this commonality with the majority of the participants I interacted with often proved advantageous (bracketing).

In many traditional African societies, respect and being aware of boundaries between young and old is distinct and important. Knowing your 'place' is essential even in contemporary society. In Liberia, this is a common point of dispute between the older and younger generation, specifically in regards to child rights and responsibility. My young **age** did not impede access to prominent people within society. Most people I met were friendly and willing to talk to me. However, the information I was privy to may have been determined by age appropriateness, without me being aware of it. Alternatively, speaking to girls closer to my age proved beneficial. We were on some levels able to relate better to each other. Additionally, being an unmarried single young female may have proved inappropriate in some traditional rural communities. Although various people assumed I was married, this was not a problem even in Landsby. As experienced on several occasions such as in Tanzania, although not racially African, people have considered me as a 'daughter' due to age and treated me accordingly. The Head Zoe did refer to my age as *'just a baby'*. Although this was not the case, only a very few locals were surprised at my age. This may be a result of 'modern' culture in Liberia and especially Monrovia and the fact that many young women are in university.

Significantly, my positionality and ideas about identities have been influenced and shaped by my **education**. This has no doubt influenced my perspectives and understanding of people and the world. Conducting research prior to fieldwork about Liberian cultural and traditional circumstances was essential, in showing appropriate respect in another culture's environment. I was aware that I might not have been welcome in a community or space regardless of the position I regarded myself to identify with. Acknowledging that my positionality is complex and comprises multi-dimensional aspects, which can all be perceived differently was also necessary. As Chacko (2004:52) states, *"negotiating these identities…is challenging,"* but important in fieldwork and a development environment which acknowledges and deals with power imbalances. Recognising the differences between these cultures and concepts was the first step towards building a trusting relationship and being able to work collaboratively with a

culture that was different from my own. Refraining from judging traditional ideas and practices (like FGC) that are dissimilar to my own was extremely important in this case (*bracketing)*. Trying to understand and be open to the explanations behind certain practices was equally important. Considering my positionality as neutral or objective would similarly have been destructive. Alternatively, completely ignoring the knowledge I had/ve yet to learn, my reflexivity and positionality of space, time and interpretation would prove equally as harmful. Being regarded as a student was beneficial on numerous instances. People were seemingly unthreatened by my presence and felt more open to discussion. I had no bearing on the positions of their employment. On several occasions I was invited to local Liberian homes for meals, which I learned was extremely unusual for expats. When travelling to other counties I was well 'taken care of' by the local staff, and invited to visit their families. The rapport and friendships I built with local Liberians, regardless of their positions, immensely impacted my overall perception and understanding of the country as well as the local knowledge I learnt.

Diprose et al. (2013) state that in geographic research reflexivity, as aforementioned is commonplace. It is encouraged due to the nature and process of the research between participant and researcher. Yet, little has been discussed about unwanted and unexpected sexual experiences and how this influences and shapes the research process. Effectively, their encounters influenced the performance of their gendered sexuality, while challenged their understanding of "*what it means to be 'good researchers'"* (Ibid.: 292). Two such incidents occurred during fieldwork. One involved the Landsby male **hospital SGBV focus** person. Due to the participant's time constraints the first interview was rescheduled for after his shift at 5pm in his office. Throughout the interview, the participant continued to inappropriately touch my arm and leg. He made several suggestive comments directed at me when responding to questions about rape, including, *"if somebody is wearing short pants [touching my leg] it can be enticing, we are human, people have ways of doing things"*. I directly asked him to stop, moved my chair back and continued with the interview. On reflection, the conversation, location (empty hospital) and interaction made me uncomfortable, yet I chose to continue. I felt that I had rushed through the process as a response. The interview also made me question the manner in which this individual as the key SGBV hospital focus person treated SGBV survivors. Post-interview, I questioned the gatekeeper about his manner. She thought he was drunk. Another incident involved an indirect participant, who was a local, older Landsby male. We had a cordial relationship with little interaction. As my time in Landsby progressed he incessantly called my personal phone throughout the day and night and would come to the location of my residence. He also asked me to be his girlfriend. Again I was direct about the inappropriateness of the interaction and asked him to stop, which he eventually obliged. While

he was not a direct participant, he did hold a relatively important position for the INGO1 in Landsby, who also at times acted as a gatekeeper, and where I spent some time at. My demeanour towards him had definitely changed during the process, which ultimately may have stopped me from travelling to some bush locations when he was present.

3.8 Ethical considerations

Due to the sensitive nature of the research topic, ethical deliberation and confidentiality was prioritised. Chacko (2004) posits that ethical practice is contingent on time and context. Thus, having a fixed set of criteria for ethical practice would be unfeasible. A more practical method would be to consider the factors and formal frameworks pertaining to each individual study. Frameworks may include, *legal frameworks, disciplinary codes of practice, local cultural norms of ethical conduct* and *ethical reviews* (Green & Thorogood, 2009).

National level and NSD consent

Before departing for fieldwork an application to the Norwegian Social Science Data Services (NSD) who provide services on privacy and research ethics was submitted (#1 appendices). Approval was deemed unnecessary, as participants would not be identifiable through any collected data. Contact was made with the Norwegian Refugee Council (NRC) eight months prior to fieldwork, to gain support from their GBV programme and to act as a gatekeeper.

Regional and local level

Permission to talk to the Head Zoe of the Sande Society was granted by the Ministry of Internal Affairs (MIA). Permission from the Head Zoe was given to speak to other council members in Landsby. The MIA additionally gave approval to conduct research in Landsby. Once at the site, the MOGD contact acted as gatekeeper. With her help, appropriate procedures were followed which included meeting the County Superintendent and the County Attorney.

Informed consent

No exception was taken in regards to the physical and emotional safety of the participating children. Acute attention to the consent process was given. According to Green & Thorogood (2009:68) *"informed consent is the principle that individuals should not be coerced or persuaded, or induced, into research 'against their will"*. Voluntary participation was emphasised. Following a full explanation of the study, its purpose, content and intention, all participants' were asked to sign informed consent forms. My role and identity as the researcher were explained before each interview. Emphasising that I was not working for any I/NGO or GOL organisation was made clear to avoid biased answers. Participants' ability to ask any questions about the study or myself was stressed throughout the interview process. Participants were assured confidentiality and anonymity. Full anonymity could not be promised for

individuals in prominent positions and was thus highlighted during the consent process. In only one case consent was given verbally due to illiteracy. In the case of children (under 18 years), a guardian was asked to sign the consent form, while the child an assent form. WHO (2013) assent/consent templates were used as a basis for this study's consent forms (#2 appendices).

Confidentiality

Confidentiality was of high importance within this study, especially working with children and the nature of the research. Powell (2011) summarises Alderson's three ethical frameworks on doing research *with* children, which I aimed to use throughout fieldwork. Derived primarily through medical ethics, they include, a *principles, best outcomes* and *rights* framework. These respectively emphasise *"respect, justice and doing no harm…reducing harms and costs and promoting benefits…involving children's provision, protection, promotion and participation rights"* (Powell, 2011:8-9). Participants' privacy was of utmost concern and identities are undistinguishable in the research. They will not be identified in any other published articles. This also includes refraining from relaying confidential information about participants in informal conversations or to any other party (Powell, 2011). I ensured that individual perspectives, names or identities were not shared with any I/NGOs or GOL members. In addition, participants' identities providing information about traditional healing practices, that may or may not be illegal was kept confidential. As aforementioned, the choice to rename the interior county to Landsby was in concern for participant confidentiality.

Ethics in interviews

I aimed to conduct interviews in 'safe spaces', which included I/NGO offices and a safe home. 'Safe spaces' were private locations where confidentiality would not be compromised. Participants were provided with a space or given the opportunity to choose their own location. The spaces offered provided participants' with access to staff who were familiar with the participants' experiences and could then provide emotional or physical support during or post interview (Green & Thorogood, 2009). Clear guidelines were outlined to participants' prior to consent, especially to children. These included the ability to pause or stop the conversation if required and refrain from answering sensitive questions. Some survivors invoked this ability. Nevertheless, particular care was taken while forming interview questions. Questions were aimed to reflect the concerns of children of SGBV, opposed to merely meeting my own research interests (Green & Thorogood, 2009). Any photographs taken of participating individuals were done so with consent. Lastly, on one occasion I was told very specifically that I was being given information but what was I giving back in return? I was clear about reiterating what the research was about and that it was part of my master's thesis. I also added that I was striving to contribute to existing literature and research conducted by GOL.

CHAPTER 4: EMPIRICAL FINDINGS

In the following chapter I will present my empirical findings. Findings are based on the knowledge produced through the conducted individual interviews and observation. Chapter 4 begins with a **short overview and timeline** of how the joint international and Liberian SGBV response and prevention action plan is structured. The chapter is then structured into **four sections**.

The **first section** includes **two parts** comprising the **underlying causes** and the **contributing factors** that influence SGBV. This is necessary to begin with, as it sheds light on survivors' agency and the barriers in choosing a health care provider and means to justice. This is essential in answering the research questions as it reflects the influence these barriers impose on the global and local response. It also aims to shed light on **research objective three** and local perceptions.

The **second section** aims to answer the **first research objective**. This involves the **global response** to SGBV and is primarily illustrated through two tables. The first table #6 explores the initiatives of the four participating INGOs and how they feature in the government's national action GBV plan. The second table #8 indicates the participating government ministries and their responsibilities. GOL response is placed here due to the overall nature of their programmes, which are aligned to the international community and UN agenda response.

The **third section** outlines findings that aim to answer the **second research objective** about the **local and traditional response** dealing with SGBV survivors. This section includes table #10, which explores the response of three local NGOs, and one locally based INGO field site in Landsby. It discusses the traditional community's response to dealing with SGBV.

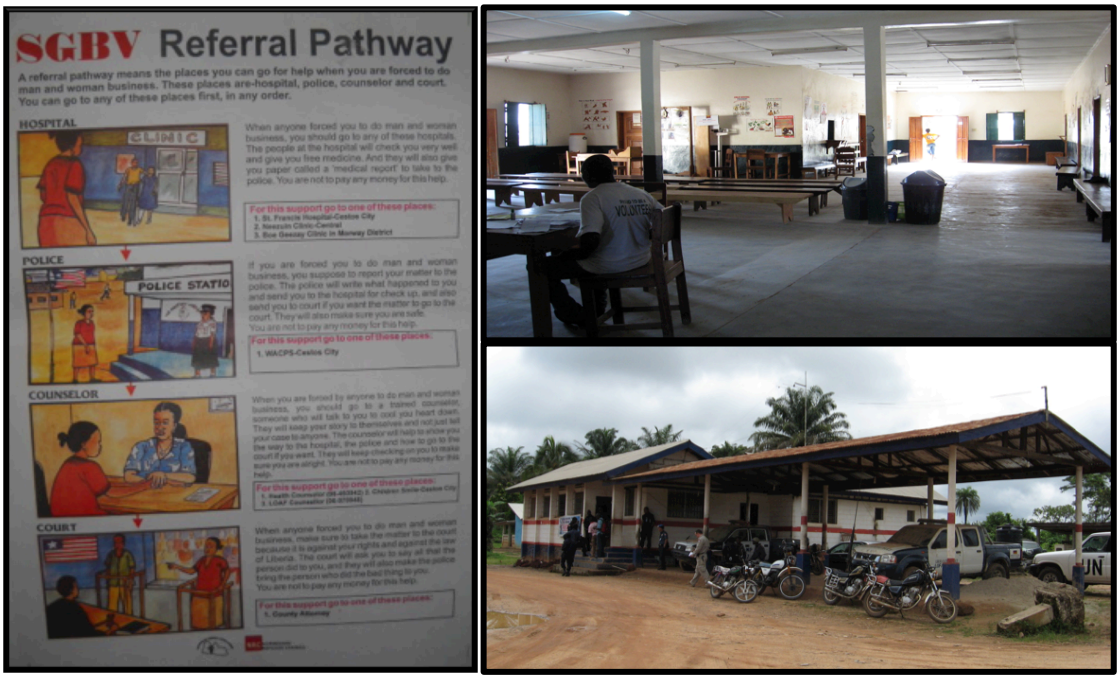
The fourth and final section considers the **third research objective**, in light of the experiences of the interviewed **SGBV survivors** (survivor tables: #4 appendices).

Note: in vivo quotations are used. Large amounts of data were collected during fieldwork. It has been relevantly selected in order to answer the research questions. Not all results are directly attributed to participants. Results include participant observation and informal conversations with community members and girls'. Table #6 on background information can be found in the appendices. A pullout summary page of abbreviations and participants' gender can also be found on the last page of the appendices to keep in mind for gender analysis in reference to pertinent quotes (Table #7).

4.1 Overview and timeline of the S/GBV system in Liberia

The United Nations/Ministry of Gender and Development Joint Programme on gender-based violence (UN/MOGD JP) has two phases. The first phase was between 2008-2011 and directly **responded** to SGBV. It aimed to implement multi sector structures and systems to address SGBV. The second phase was between 2011-2013. It aimed to **improve** the implemented systems established to respond to SGBV and also increase **prevention** awareness. The Liberian GBV National Action Plan established in 2006, under the United Nations Security Council 1325 consists of five pillars. Each pillar is connected to a government ministry and UN agency (Timeline #2). Each pillar is also supplemented by I/NGO implementing partners. It is strongly recommended that all agencies support and follow the Referral Pathway system (photo #2). The Referral Pathway was a mechanism developed by the MOGD and its various partners, particularly the NRC. It is a basic guide that should be ideally followed within 72 hours of sexual assault. The recommendation involves seeking **formal** hospital or clinic medical care (photo #3), contacting the police (photo #4), seeing a counsellor and attending court.

The SGBV situation in Liberia is fragmented and complex. Challenges for actors and survivors cross several different avenues that make negotiating and navigating the problem a fundamental part of the system. To understand the local and global response that caters to survivors it is necessary to first understand the current status of SGBV in Liberia and the traditional cultural context which influences it. Data produced through interviews with GOL, INGOs, NGOs, local community members and SGBV survivors' in the capital and Landsby will be used.



Clockwise from left. Photo #2 SGBV Referral Pathway; Photo #3 Landsby outpatient clinic; Photo #4 Landsby Police Station, *Reddy, 2013*

Timeline # 2: SGBV overview of response and prevention strategy

The following timeline of events includes pertinent historical Liberian dates that have influenced SGBV. It also shows the actions taken by GOL that directly respond to the problem.

1847	•Liberian Constitution drawn up.
1989	•Civil war begins. SGBV rampant.
2003	•Civil war ends.
2005	•First democratic election since conflict began. Ellen Johnson Sirleaf elected, first female African president. •**WACPS**: Women and Children Protection Section established under LNP. Specifically manages cases involving women and children. WACPS units established throughout counties.
2006	•**Rape Amendment Act**: raised legal age of consent to 18yrs, expanded the definition of rape, included gang rape as a first-degree offense, strengthened penalties for perpetrators, stipulated that cases be heard 'in-camera'. •**GBV Action Plan**: 'National Action Plan for the Prevention and Management of Gender Based Violence in Liberia: comprehensive five pillar framework adopted. Pillars: (psychosocial (WHO & MOHSW), health (UNFPA & MOHSW), legal/ justice (UNDP & MOJ), protection (UNMIL & MOJ), coordination (MOGD). Two phases: response: 2006-2010; prevention: 2011-2015. •**GBV Interagency Taskfoce**: established to oversee implementation of action plan. To share information and come up with strategies on prevention. •**GBV Unit**: established under MOGD to coordinate action plan. •**GBV County Coordinators:** established to decentralise MOGD activities.
2008	•**UN/MOGD Joint Programme on SGBV**: established to 'support the operationalization of the National GBV Plan of Action'. •**Criminal "E" Court**: established to specifically manage rape cases in court. (Monrovia only)
2009	•**SGBV Crimes Unit**: established under MoJ, prosecutors dedicated to handling SGBV crimes. •**Standard Operating Procedures** (SOPs): procedures of response and prevention for all SGBV focus persons to follow. •**Referral pathway**: outlines the ideal procedure survivors should follow within 72hours of sexual assault.

Reddy, 2013. Data sourced through interviews with WACPs, MOGD and INGOs.

4.2 Underlying causes and contributing factors to SGBV

Underlying causes of SGBV[7]

4.2.1 The war years: the break down of society and the creation of new social norms

Landsby participants reflected on how the war had particularly and severely impacted the very traditional and agriculturally thriving area (NGO3; Youth Group). Formal and informal traditional physical and social structures that helped to construct and manage society were severely damaged. These norms included customary laws and traditions surrounding accepted behaviours of gender roles, sex, power and sexual violence, and the mechanisms that managed them. Traditional medicine on the other hand played a key role in both healing and harming individuals during the conflict. Often, it was the only source of available and accessible care. Several participants and community members stated, due to the (tribal) nature of the conflict, some traditional practices and rituals were extensively used as tools of protection, initiation or scare tactic. This reforming of certain parts of traditional culture and ritual combined with a high intensity context involving drugs and alcohol had a direct effect on SGBV. SGBV, including rape was widespread. It was both a random act, used as a weapon of war and power tactic against women[8] and their communities[9]. Children were relentlessly exposed to these new standards and also intricately involved in the process. They witnessed, experienced, and committed sex crimes as child soldiers (MOGD; IRC). As the female Head Zoe stated,

> *Oh, it affect too bad. Affect the women, it affect the culture…the boys too with the rebels…small boys[10] will come and say you my wife, they will lay you there and have something with you…eh, that's not the culture, rebels do it. Most of them learn it during the war. So it's one of the effects of war on culture. Because during the war, some of these small boys, see how the bigger men were raping so their mind were affected.*

Essentially SGBV seems to be endemic in Liberia. Some participants strongly refuted the presence of SGBV pre-war and perceived it as a direct consequence of the conflict. Others argued SGBV was present pre-conflict but perhaps hidden because of social stigma and norms, resulting in the lack of reporting (MOHSW; IRC; CCF; MOHSW; MOGD; NGO3). Pre-war, if SGBV occurred, perpetrators were often people in positions of power, like the Chief's son, ensuring no punishment or reporting. As MOHSW emphasised, *"it [SGBV] was happening before but it was not seen as a major crime".* One participant felt that the war increased the occurrence of SGBV and specifically subjected small children to the act (IRC).

[7] For the purpose of this study, an underlying cause will be defined as a condition that helped to produce an effect. In its most basic form, although impossible in this context, eliminating the cause ***will*** eliminate the effect (i.e. SGBV).
[8] Many men were also sexually violated during the conflict.
[9] Unquestionably women are also perpetrators of SGBV. However the percentage is very low. The thesis reflects the views of the interviewed individuals, who when talking about perpetrators are always referring to men if not otherwise stated.
[10] Many girls were also child soldiers during the war, some of who may have committed acts of sexual violence as part of initiation.

4.2.2 Culture and custom in a nutshell: the implications for gender roles and SGBV

Liberian traditional culture and gender roles are intricately woven. Evidently, the conflict and destruction/creation of new social norms influenced traditional culture and gender roles. Yet, it is equally pertinent to look at pre-conflict traditional culture and explore the established traditional systems that dealt with SGBV. Traditional structures continue to have a bearing on the perceived gender roles and thus how women and children are treated, which influence the incidence of SGBV. This consequently effects engagement and collaboration between the formal and informal systems.

The secret societies, culture and religion[11]

Custom dictates that the Sande '*holds the bush'* for three years, while the Poro occupy it for four. The Sande (female) and Poro (male) Societies are seemingly very restricted from each other. Exclusively, females or males, with minimal collaboration, run each society. Correspondingly, the *bush schools* where initiation occurs is strictly segregated and operated by either female or male teachers (Zoes). Children are taught a variety of tasks and behaviours but most notably the role, responsibilities and expectation of women/wife and men/husband (Head Zoe; NGO1; INGO1; Traditional Chairlady). As the Head Zoe explained,

> *Traditional culture is not bad; we train the people in the school. We learn the people to do when it come to respect, to respect your husband, if you married to man, how to honour your husband...We learn you how to cook. We learn the people the culture practice for you to look for money…If you raise money, you don't go in the street, say I beg you for money this and that, their future will not be good.*

The Landsby Traditional Chairlady, who emphasised the importance of showing respect especially to elders, provided similar accounts. Landsby was cited as a particularly traditional county and also the traditional home of the Sande Head Zoe[12]. Participants noted that *bush school* cost a considerable fee for parents, and children had limited agency in deciding if they attended (INGO1; Landsby Youth Group), *"the parents take them there"* (NGO3). However, participants distinguished between small children who were simply taken to the bush and older children who had the ability to say 'no' (NGO3). A false sense of choice was emphasised here as older children were still forcefully pressured by parents and communities into joining, *"they [parents] will tell you and say 'we're going to neglect you if you refuse the school…"* (NGO3). The Landsby Youth Group argued that SGBV was tied to tradition and thus *bush school*. They often referred to the problem as a female issue, "*95% forced to go…some parents set up kids,*

[11] Evidently, there are different cultures and tribes in Liberia. For the purpose of this thesis, a generalized form of traditional culture will be discussed.

[12] As a woman, I was not given access to the Poro Society. The following information derives from the Head Zoe of the traditional Sande Society, with secondary information from other participants, some of who have experienced the bush schools.

'go over there' and people who running the school grab her". They also stated that initiation was very common despite the new law and that fistulas was a big problem as a result of FGC.

There was strong debate about the age girls attended *bush school*. Generally, participants cited pre-puberty (12-15years) as the benchmark. The Head Zoe joined at age 15. The Landsby Traditional Chairlady stated that *"some will be big women, but we can't carry small".* Yet, some participants stated babies (10 months – 1 year) were taken to the school (INGO1; NGO3). In defence, the Head Zoe said, "*Government law says under 18 is a child. We agree to it. First we were doing it force, but now now [sic], the child be 18 years".* The Landsby Chairlady reiterated similar sentiments, *"if you don't want it, no go, no force. We can't force…"* Although the Head Zoe did not mention FGC, several other participants stressed that this was the primary purpose for Sande School, and thus the age contention. Evidently, the Sande School is also a place where FGC occurs and is a very important part of the initiation process. NGO3 stated that the belief behind performing circumcision was to reduce girls' **sexual drive** so that, *"…cut off the clitoris…what cause the stimulant or the sensation…they will **not** have more desire for men. That is the main idea behind taking them there…they forget about the complication part".* Some Sande Societies performed traditional markings cut into the body, after which the girls were given new names and considered women ready for marriage (Head Zoe; CCF; NGO1). *"When a person gives their daughter to the traditional school…she comes out and she's handed over to her husband…when that person marries…she becomes an adult…maybe 15 years old"* (CCF). However, according to the INGO1 participant this was slowly changing. Once girls returned from *bush school* the majority now resumed government school. Boys underwent a similar experience in the Poro *bush school* (NGO3). While male initiation also involved circumcision and traditional markings, according to NGO3, males did not require going into the bush to be circumcised, whereas girls did.

The syncretisation of religion and its interaction with traditional culture plays an interesting role in Liberian society. Observation revealed that although practising individuals were not aware, religion and traditional culture have in many ways fused in both practice and belief. Individuals would attend church on Sunday but simultaneously see traditional healers and believe in witchcraft. There was little contention between the Christian and Muslim groups in Landsby according to NGO3. However, incidents of fighting and other anecdotes refuted this. Nevertheless, NGO3 stated that conflict was rather between the two religious groups and the traditional society. More specifically between the Muslim group who opposed traditional ideas and showed little tolerance towards the traditional community (NGO3). In reference to SGBV, the Church Council took a strong stance on abstinence before marriage and *"preached greatly*

against SGBV…[because it] promot[ed] evil…going against word of god, STI, pregnancy…attempt criminal abortion". Similarly, the Muslim Chairman stated that the religion and *"Muslims in general [do] not allow fornication,"* before marriage.

Customary rituals: implications for SGBV

I heard a number of accounts by expats and locals about certain harmful customary rituals that involved the rape or murder of children. The 'bad medicine', 'juju' or just 'medicine' that involved sexual violence was performed as part of the ritual by individuals who desired power, materialistic objects, promotions, wealth or relationships (NGO2; WACPS HOW; MOHSW). NGO3 believed that child rape was primarily answerable to ritual purposes. As a traditional county, such practices and beliefs were common in Landsby (NGO2; NGO3). Men went to a Zoe (witch doctor) who requested they brought them several items (DCM). Included in this list was the blood of a virgin and as aforementioned possibly due to associations of purity. As WACPS HOW stated, *"some of them…they want to have power and then they believe that having sexual intercourse with babies, children they're going to get certain powers".*

Societal roles: the status of children, women and men

Orthodox traditional gender roles have somewhat merged into the wider Liberian community. Traditionally, women were seen as mothers, wives and home carers while men were responsible for decision-making and providing for the family. Males had the final say and women were subservient to them. Children were required to help their parents with chores. It is important to differentiate the distinctions between the urban and rural areas, especially when discussing gender and societal roles where traditional roles continue to be strong (CCF).

Children had relatively the same overall status in traditional, religious and contemporary societies. Children's safety and freedom was the concern of everyone. Parents greatest concern was providing them with food and clothing and then schooling (IRC; NRC; Church). In general, children were considered 'helpers' in the home (NRC; SV3) or in some cases, a 'labour force' (NGO1) and 'breadwinners' (NGO3). All participants commented on the importance of obeying and respecting parents but also the respect that children were expected to show to **anyone** older then themselves, *"not just biological parents"* (Church), affording easier access to perpetrators. Although boys were still being prioritised in being sent to school, this was slowly shifting (NRC; NGO1). The NRC participant pointed out that it all *"boil[ed] down to the culture"* and the fact that the boys would remain in the family. Alternatively, girls would marry and leave with her husband, highlighting that it was economically unviable to educate them (NRC; NGO1). The male Youth Group participants differentiated between boys who still had few responsibilities and girls who had "*lots of work…[they do] everything".*

While traditional people now understood that all children had rights, they were still considered children and should respect their elders (CCF). The CCF participant emphasised that "*the welfare of their children is paramount,*" despite the fact "*they may not send their daughters to school."* SV5 stated children must, *"...respect your guardians, like in the schools, your parents, your country and your education, you have to respect it most. And respect god"*.

While some expectations of children in an African context may be considered child abuse, perception plays an important role. The Church Councilman explained that he would purposely make is son carry a load he knew was too heavy for him because it would make him strong. Whereas he said I ['the West'] would see it as child abuse, but that was just how things were done in Africa. He commented on how because of children's rights, *"even teachers can't chastise or beat…children [are] being told not to take violence"*. The Muslim Chairman remarked on how children were *"well protected"* before the children's law because of certain dress codes and customs like abstinence. He also stated that children should have a sense that their parents would protect them. Yet, only SV2 felt that she had an adult she was free to talk to if anything bad happened. SV5 felt she could not talk freely with any adult, stating, *"Eh, I don't go to them o. If I got a problem, I keep it to myself, I don't go to them"*. The local Save participant reflected on what he thought Liberians common perceptions about child rights involved, *"well, from the perspective of an ordinary Liberian, when you talk about child rights…they will say…Western idea, changing their culture"*. He felt that this belief was stronger in the interior. The Christian, Muslim and Landsby Traditional leaders blamed 'other ideologies' for *"spoiling their children"*. Guardians felt that I/NGOs and schoolteachers were teaching children they had **rights but no responsibilities** (NGO2; INGO1). While communities began accepting children's rights, conflict arose when children refused to help with household chores, claiming that it was their right, causing great disrespect.

Women's traditional roles involved staying home, caring for the house, her husband and especially her children to ensure they did not disgrace the family, according to all the participants. SV5 stated that women have *"to have respect for your husband, your husband family and your country"*. NGO2 stated that, *"In our African setting, in our culture, the woman stay home…To do EVERYTHING [sic] domestic work…the women work more here than the men…up till now"*. According to the male NRC participant, *"women [have] lower status in the society"* and some traditional practices negatively impacted them. They are constrained to passive roles, especially in decision-making (IRC; INGO1; SV3) where *"they are asked to stay in the back seats"* (NRC). This partly stems from the traditional gender roles and laws as the Head Zoe emphasised, *"the rural laws, first the women were slaves for the*

men. The women, the husband treating like animal". The Landsby Traditional Chairlady reiterated this sentiment. She also added that Landsby was particularly harsh on women. According to the NRC participant, traditional gender roles restricted women from education and saw them simply as child bearers. Men continue to use this gap in power, status and education as an opportunity to *"suppress women. Because they were not economically empowered to even buy clothes or food for themselves so the men was almost like using them as remote control"* (NRC). As NGO3 stated, *"some men will say 'this is the LAST [sic] time a women will ever be president for Liberia. It was a mistake and it not going to happen".* One Landsby male community member stated, *"they should enjoy it now, because they won't have it again".* Another strongly expressed his approval for equal rights but was adamant that there should still be a 60/40-power division. A surprising number of GOL and community women echoed this response and reflected on how women were taking advantage of the benefits while they could, *"when Ma Ellen in power we enjoy ourselves…When she leaves we know we are going to be slaves again"* (Community woman). NGO1 (male) asked for a supplementary interview in order to further discuss the strong influence customary laws surrounding inheritance, which impact women's statuses and rights. After the death of a husband, it was very unusual for women to inherit anything. This practice largely continues despite a new law stating otherwise, particularly in the interior. It was also easy for other male relatives (uncles, grandfathers, older men) to exploit a woman and her children and distribute the inheritance among themselves.

Men act as the head of the family according to all the participants. Men fed and sustained the family and were responsible for finding employment and making money. Men were the **decision makers** (NRC) and because power had always been invested in them, according to NGO3 "*a typical Liberian man will NOT like to hear about the gender equality issue".* The Head Zoe reinforced this idea by expressing that the Poro society was far more powerful than the Sande society,

> *Yeah, if you're a woman you can't talk to the men about it, you can't even ask them about it. The men and the women are different. Yeah we work together but in the culture of anything, different, different. They own different. They own powerful more than us.*

The young woman (+-25 years) seated next to her during the interview expressed her opinion while referencing Christianity, which may reflect a generalised view,

> *…the men. You know all the time, god made men more powerful. Yeah, because even in the bible it is said that the men should be the head and the women follow so it's the same with the culture. Yes, the culture respect men, women are* ***submissive*** *to men*.

The Muslim Chairman however stated that the man should love his wife and women and men should *"work as a team".* Alternatively, SV5 stated that men should *"Have your respect for*

your country, your environment, your women people, your people children and yourself…" SV3 commented on how her 'uncle' *"can help the woman, the wife…in the house"*. Yet, as INGO1 reiterated what one Imam told her about an INGO programme he was involved with,

> *anything they [I/NGOs/government] tell me, I agree, because if I can beat my own wife and them tell me why did you beat your wife, what am I going to say? So anything they tell me this time I'm going to agree.*

Numbers: age vs. sexual maturity and the bride price

Sexual maturity, defined by developed breasts (IRC, SAVE) or the act of giving birth (NGO3) played a key role in the informal definition of age. Participants provided various and conflicting ages on how traditional culture determined the distinction between childhood and adulthood, which was marked by attending *bush school* and initiation. The DCM (male) participant, an active member of the traditional community stated, *"ah, somebody **21, 22,** that not small girl, big woman. She can decide for herself…a child, like sometime in Liberia sometime **12**"*. NGO2 stated **13** and above. INGO1 explained adulthood was considered **16** years but was downplayed due to the international community presence. When asked about the children at the safe home SV6 replied, *"Some of them BIG"*, which denoted 15. She stated that big denoted **15**. Comparatively, the Church Councilman stated that children were regarded as adults, *"only when they begin to live on their own, when can manage yourself"* and when they can financially contribute to the family. Alternatively, the Muslim Chairman stated that by religious law, children are adults at **16** but that the government law said **18**. The Youth Group noted **18** and up but that traditionally *"once under the roof of parents, [you are] still a child"*.

The 'bride price' was a common concern. It was tied up into the age debate, particularly in the interior where it proved challenging for I/NGOs and GOL to infiltrate and create awareness (MOHSW; WACPS HQ; UN/MOGD; INGO1). Differentiation was made between the two major religions and the incidence of paying a dowry. MOHSW explained that Muslim men often 'paid for a girl' around eight or nine years old and thus expected to have sexual relations with her whenever **he** was ready. INGO1 also gave an example of the Mendi tribe who *"tell the parents I want your daughter for sex"*. One participant believed underage marriage had somewhat curtailed (CCF). Others believed that it was still common, particularly in the rural areas and despite many awareness campaigns (NGO2, IRC). As the Save participant noted,

> *They do not look at the child from the age perspective. They look at the child from the physical growth and appearance…from different activities that they're involved in…For example if a 16 years old is like huge, **big [breasts]**, they no longer see that person as a child.*

4.2.3 Perpetrators: conditions that allow perpetrators to access children

According to several participants and statistics, perpetrators were mostly men and boys. Participants rarely mentioned female offenders. The male Landsby Youth Group participant argued that, *"even women can do it [SGBV] but call it seduction"*. A trend brought to my attention during fieldwork, included women asking INGO drivers and expats for rides across town. They would then claim to have been raped. Once they received compensation they would change their story. This practice performed by a few women and girls provided a platform for many men to blame the majority of rape on some individuals' actions, rather than on the actions of the perpetrator.

Every participant reflected on how in the majority of SGBV cases perpetrators and survivors were **"acquaintances"**. Five survivors knew the perpetrators, three survivors did not answer. According to statistics, family members made up about 70 – 75% of offenders and this was on the increase (MOHSW, JDJ, INGO1). Family members included stepfathers, grandfathers, uncles, brothers and cousins. 'Uncles' made up a large proportion of this figure. Yet, in this context, 'uncle' did not always denote biological relative, but rather a term of respect to community men (NGO2; IRC). NGOs in Monrovia and Landsby commented on how it was "*very seldom"* that a stranger sexually assaulted a survivor, especially a child (INGO1, IRC). These strangers (25-30%) were people survivors knew, like the 'uncles', neighbours, peers, ministers and schoolteachers (MOHSW; NGO1; NGO2; NGO3). During fieldwork, several GBV actors in Monrovia emphasised a concern of the rising trend involving bike riders committing SGBV crimes. It involved known bike riders offering children transportation, and then proceeding to sexually violate them. A small portion of offenders were, *"just pervert…and people who did not respect women dignity"* (MOHSW). While schoolteachers made up a significant proportion of perpetrators within this group, both international and national NGO workers committed SGBV (NGO1; NGO3). Though foreign workers had the advantage of leaving and thus less likely to be condemned (NGO1).

There were several reasons attributed to why SGBV was committed. These included *"wickedness"* (IRC, INGO1, NGO2), ritual/medicine purposes (IRC; MOGD; NGO2), power dynamics (Save, Landsby hospital), drunkenness, alcohol and drugs (SV3; Landsby WACPS; JDJ; Youth Group; DCM). The two Youth Group males strongly argued that girls were *"setting them up"* by accusing men of rape because of bad relationships (page#104). The (male) DCM participant believed girls' *'ask for it'* by the way they dressed and behaved. He strongly stated men could not help themselves with the combination of this dress and alcohol. As he explained,

> *Now see how the Liberian girls dress. You see eh? Girls, girls, you see how they dress. [Claps hands]. They are ASKING [sic] for it...SO, what do you think can be done to* ***change women's mind*** *about this thing, especially in Liberia. Before the war, Liberia was a GOOD place…NOW, they use their appearance to attract mate, then play in the street…(DCM).*

The (male) Landsby **hospital SGBV focus person** also faulted girls' dress code. Comparatively, the (female) IRC participant argued that dress was not a causal factor and the war had exposed the culture to sexual violence. She explained that pre-conflict, especially in the villages, girls often only wore *lappas* with no blouses *"and men were not tempted".* NGO2 (female) also felt that using dress code as an excuse, especially in regard to children (13yrs below) and babies was completely unwarranted. In Landsby girls continued to be faulted if they were assaulted, *"they blame them they say, 'you know, you tempted the man, these days girls love men, they love to go around men, so the man did it to you, why are you, why are you trying to spoil his name?"* (INGO1). While Landsby participants felt that the prevalence of SV was far worse in their county compared to others, impunity and power imbalances were a massive problem throughout Liberia.

As the MOGD highlighted, children aged from 10 months to 13/14 years made up 60% of rape cases in Liberia. While relationship status between survivor and perpetrator played a defining role in accessing children, it also considerably influenced post assault care. Many families would prefer to settle the matter between themselves as it was seen as a *"family issue" or "family business"* (MOHSW; INGO1; Youth Group). This generally involved the exchange of money, which averted formal judicial and most often medical channels. Paying survivors families was necessary for perpetrators who committed the act for ritual purposes. If exposed, *he* would not achieve his desired outcome (DCM). Thus, similar findings that were discussed in the literature section about compromising cases were revealed, said to be widespread and a concern for all actors (IRC, CCF, SAVE, NRC, DCM, NGO2; Youth Group).

Contributing factors towards SGBV[13]

4.2.4 Education and sex for grades

Liberia's education system was the concern of every participant. In late August 2013, all 25,000 students writing the University of Liberia entrance exam failed. This raised serious questions and mainstreamed the debate about the quality of education students and student teachers were receiving. Participants provided several explanations as to the poor quality of

[13] A contributing factor will be defined as a condition that exacerbates the effect. In its most basic form, eliminating the contributing factor will ***not*** eliminate the effect (i.e. SGBV).

education that saw 10th grade students writing letters at the level of 2nd graders (CCF). Post-conflict, the number of unqualified teachers was high (Save). **Unfavourable learning conditions** established by inadequate teachers, who did not or could not motivate students was a leading concern (Landsby Youth Group). As cited by SV2, *"Some are good, are good to us and some very bad. Because they help us, and some teachers come, they put the writing on the board and they go outside, they don't read it…the time it come, they give test"*. Many participants maintained that students were simply too lazy and did not study. One female expat teacher living in Liberia for a year explained while grading her 11th grade students' papers and being frustrated about how poorly they had done, *"They just don't care. I hold extra study sessions but they never show up and then at the end of the year they come begging for help"*. When questioned whether this was because of the inability to study as a consequence of other responsibilities like work, she responded that, *"mostly they just don't care. As much as Liberians say education is important to them, it's not really"*. However, all the survivors stated the importance of school to them. SV5, *"I want to be a well-educated person to rule our country",* SV6, *"I love to learn. It good for your future",* SV8, *"Our government [should] run after education and people who love education"*. All the survivors were attending school except SV3 who could no longer afford it and SV4 who had recently given birth. Four out of eight survivors commented on being well taken care of involved being sent to school. The Church Councilman blamed the trauma mothers endured during the conflict, which had enduring impacts on their children's lives. Though he also strongly criticised parents for not setting good examples. The participant emphasised that it was common for five-six-year-olds to purchase cigarettes and alcohol for their parents and also watch them consume them. This scenario was frequently observed. Young children under 10 would be out late at night hanging around local bars, restaurants and clubs, either alone, waiting for their guardians or working as the children of the owner (photo #5). It was therefore difficult to discipline school children because most lived in single parent homes, and teachers were relied on to discipline them. The participant added that sex for grades was *"very common…these days children don't take learning as a challenge*" (Church). Save and CCF emphasised the common trend that qualified teachers were

Photo #5: 9pm, children outside a local Landsby bar

Reddy, 2013

unwilling to relocate to the rural areas due to the lack of resources. Moreover, there was a disproportionate male to female teacher ratio (CCF).

"Sex for grades" bore a high pervasiveness in children's lives, especially in Monrovia. There are two sides to this issue. The first involved the practice where students exchanged sex for a passing or improved grade.[14] The second involved girls desire to attend school, but will be discussed later (page#67; 101). SV1 and SV2 stated that their teachers were 'fine'. SV1 stated however, *"my school too many girls are getting pregnant"*. Yet, this was not by the teachers, but by boyfriends. Her stepfather, who was also her schoolteacher, raped SV4. Bribing teachers was *"plenty"* especially in Monrovia (SV5, SV6, SV7). *"Bribing teachers. YES...Lots of bribing"* (SV5). *"Yes. It happen in our school…That the same 12th graders…If they fail the subject they goes to the teacher and pay money, just give them grades"* (SV7). *"Oooooh [sic], all that USED to happened…Teacher will follow behind student, but since that law came, they pass it to the school…"* (SV3). In reference to sex for grades, SV5 stated that, *"They can do it!"* She mentioned that *"the teachers started the bribing,"* but because of the new laws about 'loving', teachers could no longer do it (SV5; SV3). The Youth Group participant strongly argued that it was the girls who were offering it, not the teachers. He was adamant that *"women don't put in time to study…rather put money for grades or offer body"*. He felt that women were academically weak and that boys were in *"hell"* because they had to pay if they could not study, due to other burdens preventing them from studying. Notably, **transactional sex** was widely practiced in universities (WACPS HOW; Church Council). Sex for employment was also pervasive and occurred in government and I/NGO offices (Church; INGO1; SV3; Background).

4.2.5 Ineffective formal systems: in pursuit of health care and justice[15]

The health system: the structure

SGBV survivors were required to go to specifically trained and equipped referral hospitals for treatment. There were three government-run referral hospitals and one referral clinic in Monrovia. These included James N. Davis Junior Memorial hospital (JDJ), Redemption Hospital, Star of Sea Hospital and Duport Road Clinic. The county hospitals generally acted as the referral hospital in the interior. Like Landsby hospital, they rarely had a specific S/GBV unit or area to treat survivors. GOL contracted out the management of some health care facilities, particularly those in the interior to several pivotal partners, including the United Presbyterian Medical Unit, and NGOs like Equip and Save the Children (MOGD).

[14] Labour like house and garden work can also sometimes be exchanged.
[15] During fieldwork I did not receive one coherent answer about the structure of the formal and informal systems.

The procedure

The formal procedures for treating SGBV survivors were based on Westernised systems and policy, largely **established by Western partners** who operated the hospitals post-conflict. At JDJ, the male doctor usually performed the medical exam. The hospital's SGBV unit carried out initial and post psychosocial care. They received 207 cases between January – April 2013. About 60 of these involved 0-18years. 18-25 year olds mainly sought medical care for domestic violence. They rarely received male cases. The Landsby hospital was open 24hours, with 12hour shifts. They had 4 physician assistants (male) and 1 nurse (female). All patients were required to pass through the emergency room where the on-duty practitioner (often male) saw them (Landsby hospital). Initial psychosocial care was performed by the hospital. If accessible, other partners like the MOGD or I/NGOs continued treatment. Survivors were ideally supposed to have four follow-up check-ups up to one year, after which if their psychosocial score had not dropped to zero it was *"sometimes"* extended (JDJ). The facilities were required to provide medical certificates as evidence for court.

The challenges at the government level

Funding proved a central challenge to the entire health system. Post-conflict, the majority of health facilities were funded and operated by INGOs like MSF who *"were providing medical, salary, incentives [and] powers"* to JDJ hospital. Now that the government managed most facilities, staff complained about the insufficiency and lack of resources. JDJ dealt with constant shortages of important drugs for SGBV survivors, like the hepatitis vaccine. Staff from Redemption Hospital complained about the shortage of medical staff and staffs' inability or fear to use basic medical equipment like incubators. Comparatively, the Landsby hospital participant stated that funding was not a problem for them and they had enough resources. Contradictorily, he felt the hospital did not have the capacity in staff or transport to educate people about SGBV in the community. The Landsby MOGD office faced several logistical issues like holding meetings and sending reports (INGO1). The office did not have a computer as it was stolen twice. Monthly reports were sent to Monrovia through the UNMIL office. Moreover, there were concerns about the oversight of the MOGD employing a well-known local manager of a local NGO to simultaneously operate the MOGD safe home. Seemingly, the capacity and ability of the manger to effectively operate both institutions was significantly compromised, and raised issues about confidentiality. One participant felt that raising this concern was a problem as people feel like *"you want to put others out of job"* (INGO1).

The MOHSW faced challenges with some partners ineffectively managing sites to the point of collapse. They were also unable to match **wage rates** and incentives provided by INGOs.

Hospital staff emphasised how low incentives significantly impacted job motivation, and thus aimed to seek alternative employment (JDJ; MOGD; Redemption). Furthermore, training, hiring and maintaining staff was difficult for GOL as staff often moved to other programmes or counties for family or better paying jobs (MOGD; MOHSW). GOL distributed two psychosocial counsellors to Redemption Hospital in early March 2013. Yet, the counsellors were deemed unnecessary. Hospital staff felt that rather than additional staff, GOL needed to support the already present employees, perhaps with increased wages or training (MOHSW). During fieldwork, there were several radio and newspaper articles discussing the inappropriate health care services that patients were receiving from medical staff. Like the numerous unqualified teachers, the UN/MOGD raised major concerns about dealing with unqualified psychosocial counsellors. Evidently, community members and some healthcare workers stigmatised and associated counselling with mental health issues and something that only *'crazy'* people needed. Another challenge the ministry faced was distributing rape kits.[16] While United Nations Populations Fund (UNFPA) was responsible for ordering the kits, the MOHSW was responsible for distribution. Although they believed they were doing a *"better job",* on-going problematic logistical issues including shortages, excesses and kits failing to arrive constantly occurred.

The challenges on the ground

In more remote areas, individuals only really saw country doctors (NGO3). Yet, as one Landsby woman aged 25 noted, *"young people want to go to the hospital"*. If people were educated about SGBV, some would make the effort to seek formal medical care (NGO2), but ultimately it was still a choice (CCF) based on preference and swayed by awareness. The lack of access to services like transport crucially impacted whether, and where a survivor's family would seek medical care (CCF; NRC; JDJ; NGO1; NGO2; NGO3; Youth Group). Psychosocial follow-up check-ups were seldom achieved and considered a key challenge. In both locations, survivors lacked the capacity to return to hospitals due to poverty. Nor did the hospitals have the means in transport and staff to pursue the survivor (Ibid.). All the participants explained that if **anyone** wanted to compromise a SGBV case they would not seek formal medical care but rather use traditional methods. Alternatively, a few would choose to go to the hospital but then compromise the case thereafter by relocating the survivor, destroying the evidence or failing to appear in court (INGO1; Landsby hospital; NGO2).

INGO1 was trying to address a number of logistical issues with the Landsby hospital. Firstly, staff complained about the detail and size of the SGBV medical forms they were required to

[16] Sexual assault evidence collection kits commonly known as 'rape kits' are kits that help medical staff treat survivors. They include a number of items, which help to preserve evidence for the use of investigation into the rape case.

complete. Secondly, the SGBV focus person (physician assistant) was male. This proved uncomfortable for survivors. Although women were trained in SGBV, they tended to steer away from it. The INGO1 participant credited this to the fact some of the women lacked confidence, while others felt it was too much work. The majority of female staff were in the obstetrics ward. They did not want to be in the emergency room because according to the participant, *"they prefer being in a place where at some point, there is time to sit and rest"*. While survivors may have preferred being examined by female staff, the INGO1 participant noted that the female employees were not patient with the survivors, whereas the male employees were. The women staff felt embarrassed to treat the survivors, and often said, *"heeey [sic] I beg you o, that a embarrassment, they shouldn't be embarrassing us o"* (INGO1). Thus, the women constantly made the male staff perform sexual assault examinations. Some women took issue with signing medical forms, due to the possibility of having to attend court proceedings and needing to interpret and defend their findings. Being held responsible by community members for testifying against their children was a further barrier. While INGO1 encouraged women to take part in the training and stand for positions within the unit, they were often told to stop being bothersome. The Landsby hospital focus person also noted that INGO1 had not provided any SGBV training *"to [his] knowledge,"* and that their training was given by GOL, reflecting the **weak partnership** between two key SGBV actors in Landsby.

Bridging the gap: from the hospital to the police

JDJ stated they provided a medical certificate for court but rarely integrated with the police. JDJ noted that the hospital had problems with following up with the police to see whether the case was prosecuted or compromised, highlighting the **lack of cohesion** between the key partners. The participant blamed this on the lack of an established system. However, she also noted that there were plans to open the first 'one-stop shop'. The UN/MOGD explained this would be a location where a survivor would be provided with all their needs (i.e. health, police, counsellor, court advice). Similar problems regarding medical forms and the police occurred in Landsby. The hospital participant explained that there was an "*arch rival between the police and health workers"*. One specific issue that caused friction included the hospital staff refusing to directly hand over medical reports to the police without the survivors' consent.

The legal matters

The police: the structure

The Women and Children Protection Services Head Office was located in the LNP head quarters in Monrovia. WACPS collaborated with numerous ministries and SGBV actors. I was

told a WACPS office was established in every one of the 15 counties (UN/MOGD). Yet the operational activity of some of these offices was questionable on visitation. As a consequence of the war, the public image and trust in the police was a considerable challenge to overcome, according to the Head of WACPS (HOW). She stated that this had improved which has subsequently improved the rate of SGBV reporting. Landsby WACPS was established in 2007. There were four WACPS offices located in the four major districts throughout the county. HOW noted that although they were *"not well constructed, at least we have offices"*.

The procedure

In Monrovia, WACPS HOW occupied their own building (within the LNP compound) where survivors could report cases. In the rest of the country, WACPS did not often have a specific area, but sometimes an assigned room or desk. While WACPS Landsby had their own area within the station, survivors were required to pass the jail cell in order to access it. In theory, the main county police station was open 24hours and WACPS office open from 8am till *"6 or 7pm"* (Landsby WACPS). Ideally, once under police assistance, the survivor's statement was taken, a report is made, evidence is sought, the perpetrator is apprehended if necessary and court proceedings follow. In Landsby, perpetrators were detained in custody no more than three days (NGO3). If perpetrators were convicted, there were 16 prisons throughout the country where they could be incarcerated (MOJ). In July 2013, of the 933 prisoners in the central Monrovia prison 125-150 were incarcerated for rape. The MOJ maintained that there was a need for educational programmes directed towards rapists, as there was no established rehabilitation programme. The MOJ also faced challenges with severe overcrowding in prisons, impunity, corruption and funding.

The challenges at the government level

Funding shortages and distribution adversely influenced the LNP and WACPS, creating disputes between the two units (IRC). The UN/MOGD felt WACPS was not *"truly prioritised at the top-level and was not given equal importance within the police system"*. She felt that it was perceived as, "*a private kind of thing…because they're getting a lot of support from their donors"*. While organisations still provided on-going support like the NRC, it usually involved training (NRC). Similar to the healthcare system, retaining WACPS staff was a fundamental issue as a result of lower incentives and

Photo #6: Police Notice

Reddy, 2013

better employment prospects in other LNP divisions (NRC; MOGD; UN/MOGD). While Landsby WACPS had four officers (2 female), NRC and MOGD identified the sector as being exceptionally understaffed. Similar to the schoolteachers, MOGD commented on the unequal male to female ratio of staff and felt more women should be in the unit. During fieldwork there were posters outside the Landsby office promoting this (photo #6). MOGD criticized the lack of resources WACPS offices had, like *"not even a bike"*. Despite transport being fundamental to WACPS operations, the MOGD as the coordinator of the GBV programme gave the perception that it was not their responsibility or in their capacity to remedy this issue.

The challenges on the ground

Landsby WACPS stressed the logistical challenges they faced on a daily basis. This continually limited and hindered their ability to perform their job (NGO2; INGO1; Landsby WACPS). Like the healthcare system, challenges included staff constraints and the lack of office resources like furniture, a computer and paper (Landsby WACPS). Landsby WACPS emphasised their transportation difficulties in attending crime scenes and apprehending perpetrators. One motorbike was issued to the unit for use of the whole county in 2007. Since breaking down in 2009, it had yet to be fixed or replaced. Consequently, staff had to charter motorbikes at the expense of the survivor (INGO1, NGO2). Alternatively, WACPS officers who owned motorbikes would offer to use it if the survivor purchased fuel (INGO1; NGO2). Survivors were still required to purchase fuel when the office motorbike was operating, as there was no allocated budget for it (INGO1). Occasionally UNMIL or INGO1 would provide assistance. While motorbikes are practical sources of transport, especially in rural Landsby, arresting a perpetrator and attempting to restrain them on the back of a motorbike has its own logistical problems. If officers did eventually manage to get to a crime scene, the perpetrator had often fled. While INGO1 explained that many people said the police took bribes, she defended them by justifying their immobility and lack of resources. Notably, she had a very close working relationship with the LNP/WACPS, which may have influenced her opinion. When questioned about this, she agreed that she might have been treated differently considering her position as an INGO. The Landsby Youth Group argued that WACPS was not effective in their county, lacked mobility and needed significant improvement.

Like Landsby hospital, Landsby WACPS took issue with the complicated and long police forms they were required to complete. INGO1 was collaborating with them to remedy this. The WACPS participant also felt the other WACPS staff needed further training on *"how to handle SGBV cases"*. In reference to this, the majority of actors I spoke to used the term "survivor", while many local staff directly working with survivors, like JDJ, Landsby hospital and

WACPS used the term *"victim"*. Furthermore, WACPS encountered problems with other LNP police officers. They felt that the international community superiorly supported WACPS and thus saw the unit as a separate and fully funded, resource full sector, *"the other police have problem with the WACP officer…when the [LNP] headquarter send transportation here, they say, WACPS office is extra office, so they don't even issue or ANYTHING [sic] from the head quarter"* (Landsby WACPS). If a WACPS officer was absent, some LNP officers were scared to deal with SGBV cases and would sometimes outright refuse, telling the survivor "*I'm not WACPS!"* (Landsby WACPS). Comparatively, some officers wanted to preside over S/GBV cases because they had the ability to receive a bribe (INGO1). This was cause for further argument and distinction between the two units, with WACPS officers contending other LNP officers should not and were not specialised in dealing with SGBV (IRC). Evidently, this had repercussions for survivors.

Bridging the gap: from the police to the court

There remained a significant gap between cases going from the police to the court (NRC; INGO1; NGO3). Contributing factors that influenced this process, included laws failing to be enforced (NGO1), police unwilling or lacking the capacity to follow up on cases (NRC) and severe understaffing of WACPS, which substantially hindered evidence gathering. This understaffing influenced the capacity to apprehend perpetrators as well as ensure offenders appeared in court. Thus, most cases reportedly went no further than the police station (NGO1). Essentially, even if a case reached the courts, lawyers and judges easily dismissed it or found the perpetrator not guilty due to the offender's absence and or the questionable evidence. If individuals managed to physically get to court, they were often told to return later because there were too many dockets on the list (NRC; MOGD; NGO1). Survivors were frequently asked to provide their own evidence. The MOGD considered this unacceptable, especially because perpetrators were often family members making it easy to compromise or influence the case and survivor.

The judiciary: the structure

Liberia's judicial system is exceptionally weak. The court structures established to deal with SGBV cases were especially ineffective and plagued with delays (UN/MOGD; NGO1; NGO2; MOGD; INGO1). The Criminal E Court was established to manage and fast track SGBV cases (Timeline #2). The SGBV Crimes Unit was devised to have prosecutors who explicitly managed rape proceedings. In-camera proceedings and screen dividers were rarely used in Monrovia and never used in Landsby (MOGD; INGO1; NGO2; Landsby Court). One participant cited this as a response to the lack of understanding by court officials, who raised questions like 'is the defendant allowed to see the survivor behind the screen?' (UN/MOGD).

In Landsby, unreliable generator run electricity was taken into consideration and screen dividers were provided. These were unaccounted for in the courthouse. Survivors were thus required to contend with the direct response of the perpetrator, the jury and an audience while being questioned (NGO2). Court poster guides and follow-up trainings on using screens have been scheduled for all prosecutors (UN/MOGD). There are no plea-bargain systems in Liberia and trials are jury oriented, which takes time. The criminal age of responsibility is 16. There are also statutory rape laws (Save). There is a child justice programme that engages diversionary methods in criminal proceedings for minor offences. Yet, this sometimes provides avenues for offenders to lower their age or guardians to raise the age of the survivor (Ibid.).

Some participants highlighted that there were strong laws, but they were not being followed through in the court system (NRC; NGO2). The Landsby Youth Group felt that the *"laws put fear in the young people…young people regard rape and murder as same"*. Comparatively, the MOHSW believed young people did not respect the laws. He faulted the inability to reach large numbers of children and teach them *"replacement behaviour"* during the demobilisation process and de-trauma programmes. This was particularly in reference to receiving 'direct returns' in bribes, goods or rewards during the war. The participant felt this had increased fatal home robberies, which most often involved rape (MOHSW; JDJ; background). Several cases were brought to my attention during fieldwork. SV5 stated that, *"some of the children, some of them are going to school, some of them are sitting out…So some of them are running around, just to go about,"* and causing trouble.

The procedure

The Landsby court system proved highly problematic. Although recently remedied, there had always been two (male) defence counsellors pitted against one County Attorney (male) (INGO1). The INGO1 participant also strongly felt that money frequently exchanged hands between the defence counsellors and the perpetrators, and perhaps even the judge and attorney. She was careful to emphasise she did not have proof of this. NGO1 explained, *"Here, distrust is so high"*. Individuals had to spend a lot of money on psychically reaching court as well on the actual proceedings. Men dominated the courts (NGO1), which most likely had a bearing on female survivors. Several Landsby participants argued that rape cases were never prioritised, especially over murder cases, which seemed to be high (Landsby WACPS; INGO1). UN/MOGD believed a solution involved GOL declaring a specific day of the week set aside to hear rape cases.

The challenges: bribery and corruption

Reports of bribery within the court system were rife throughout Liberia. Judges and court officials were often implicated, *"...even the very judges at the court, might, you know, defend the perpetrator. Because the jurors will start to blame…"* the survivor's actions (INGO1). There were several comments in the community about different levels of *"arm-twisting"* (NGO1) as well as the previous and corrupt, recently deceased judge. The Landsby hospital participant argued the *"need [for] a more rigid legal practitioner that will help in judging the cases."* Landsby Youth Group stated that, *"people linked to people in authority bend justice"*. Moreover, these people in power had stakes in the community and therefore negotiated the court system to their benefit. NGO3 blamed the county court for case dismissal. Essentially however, she faulted police training and procedure methods. Sometimes this resulted in police compromising cases, "*sometimes at the police, confidentiality [is] not maintained"*. If perpetrators had family members in authoritative positions in the police or court, their avenues to compromise cases increased significantly (NGO1).

Corruption was not limited to the courts but extended to cabinet. Nepotism was cited as a significant issue. Common community perception was that many GOL ministers' families, houses and lives were US based. Thus, salaries were primarily being spent elsewhere, reducing investment within Liberia. I met a number of such ministers in this position. While one was adamant in helping to rebuild Liberia, he complained about the low ministerial wages which were inadequate to pay for his children's US based educations and lifestyles, as well as support himself in Liberia. One ex-politician INGO participant argued that such cases were a prime reason for corruption and missing funds. From personal experience, he questioned the ability of ministers to live lavish lives in Liberia while simultaneously supporting families in the US.

The challenges on the ground: understanding the laws and working the system

The general community perception was that the rape law was too harsh at 10-15 years (IRC, community members). The majority of the public believed that conviction denoted life imprisonment (NRC; IRC; INGO1; MOHSW; WACPS HQ & Landsby; Youth Group). SV5 stated that, *"I LOOK up to my people in my government…rape, the government have strong law, anyone who rape go to life prison..."* Whereas, SV7 stated that *"nothing"* made her feel safe, she trusted GOL, yet named UN and INGO programmes. Ineffective awareness campaigns during implementation of the law were largely faulted for this misunderstanding in law (NGO2). Accordingly, educated individuals understood and were more accepting of the laws (MOHSW; INGO1). If the case did reach court, most individuals understood the basics of statutory rape and would accordingly alter survivors' or perpetrators ages, *"... so sometimes a*

20 years old or 21 year old will abuse a child and they will tend to reduce their age…" (SAVE). NGO1 (male) also strongly stated that "**men help men!**" in these matters. Consequently, while some Landsby families were reporting SGBV crimes, many more merely did not bother seeking formal justice, after reflecting on the outcomes and obstacles others faced (IRC; NGO2). Some individuals would seek formal medical care but cease to pursue formal justice due to the lack of trust in the systems (IRC).

4.2.6 Poverty: compromising made easy

All the participants directly or indirectly emphasised the impacts of poverty, *"poor are the victims"* of sexual assault (Landsby Youth Group). As MOHSW explained, "*Poverty come in because if you're from a family that don't have, and I have some money and I came and rape, then I give money and then everything is closed up"*. There are **three** noteworthy points in reference to poverty and SGBV in Liberia. **Firstly**, mothers sent their children out to sell goods for the family (photo #7). Several factors contributed to this common practice.[17] Polygamy was cited to be common in the traditional society. Generally however, it was extremely common for men and some women to have multiple partners and children (INGO1; NGO1; NGO3). Men, who continued to be the initial primary breadwinners in most families, were then subject to split their wages among several families. Almost all the participants discussed acute issues of men abandoning their wives and families (NGO1; NGO3). Consequently, women were left with little income, or had to become the breadwinner (NGO1). This almost always resulted in children street selling (NGO3; MOHSW; Youth Group). Several participants stated that children feared the repercussions of returning home with unsold goods. This pressure inadvertently forced them into comprised and unsafe situations making them more vulnerable and available to potential perpetrators (JDJ; IRC; INGO1). *"Maybe the mother told her, 'make sure this bread finishes before you come home because we have to buy food with this money.' So in that case, she's conscious to do anything"* (IRC).

Friday market day: Landsby girl

Photo #7, *Reddy, 2013*

[17] Children who live with both parents are also expected to sell goods on the street because of poverty, but father/family abandonment almost always puts them in this position.

Secondly, because children lacked basic needs or saw their friends with nice things, they went out into the street and engaged in **transactional sex**, for money or goods. Peer pressure was noted as a strong factor here. SV3 noted that,

> *…lot of girls' this time, they on street like that. That peer pressure, because…when you see me, I dressssing [sic] that kind of thing, I don't know how my friend getting her money…And I want to be like her…they 'love' with many to get material thing.*

The DCM participant similarly stated that, *"They want money! Yeah, they want to dress decent, they want to eat good food, they want to live in good place. So they cannot work too because they not educated to work"*. High rates of child abandonment or trafficking resulted in self-supporting employment like prostitution. Consequently, young mothers were common, with girls having three-five babies before they turned 25 (NGO3). The Church Councilman condemned the very materialistic society where parents *"eat money with clothes, slippers and cream,"* leaving children in deprived situations.

The **third** and omnipresent vulnerability related to poverty was **'sex for grades'** (NGO1; NRC). While many girls strongly wished to attend school, their parents were unable to afford it. Girls' were thus easily persuaded into trading sex for school fees, sometimes known as 'sponsoring'.[18] Some of the interviewed survivors were part of the group involved in the highly publicised case implicating a Lebanese man sponsoring seven known Liberian girls education, in return for sex. Strong debate involved whether the problem stemmed from the teachers or the students (NGO1; NRC; CCF). As HOW explained, *"…there is alleged the teachers are asking the girls' for sex for grades and some of the girls' are giving their bodies to struggle for paper"*. Some participants blamed the ineffective teacher training and education structure (NGO3), combined with the fact that female students were *"not very bright"* (NGO1) thus being easy targets, or that students were too lazy to study (NRC; NGO3; CCF), or that students genuinely sought help and teachers responded with, *"if you don't have sex with me, you are not going to succeed"* (MOHSW). Several participants argued that as adults in positions of power, they were responsible, even if the students were suggesting the exchange (background; NRC; CCF; NGO3). Boys were not exempt from this issue. Various cases about exchanging cash (NRC; Youth Group), and principles or teachers sodomizing boys were raised (NGO3). In addition, the boys felt that they did not have the option of sex for grades (Landsby Youth Group) and were rude to the teachers because they felt like the teachers 'were taking their girls' (CCF; MOHSW).

[18] Sponsoring did not always denote and exchange of sex for fees. In one case, a local female NGO worker merely paid for a girl's school fees, without seeking a return.

4.2.7 Family structures: the breakdown and reconstruction

The Save participant highlighted, pre-conflict *"childcare was the concern of everyone"*. Both Save and the Church Councilman reflected on how the community once collectively raised, reprimanded and protected children. This had mostly ceased due to the breakdown in family and community units, especially in cities. Due to the high mortality rates during the war and the loss of parents, **grandparents**, who followed mainly traditional beliefs, raised the majority of these children (Landsby hospital). SV5 stated that she lived with her Grandmother, but *"I live with her on a certain level and I MOVE [sic], yeah I'm able to sustain"*. Independence was very important to her. Children also lived with extended family members, which included non-biological relatives like stepfathers and step-uncles (IRC; NGO2; INGO1). SV4 had lived with her mother and her stepfather, who had committed the on-going rape. SV8 stated that, *"I live with my mother"*. Later she explained, *"I lived with my uncle wife, which is, I call her my mother, because my mother lost during the war"*. Alternatively, SV3 had lived with many different strangers since she was 14 years old because *"everybody ran away"* when the war came. Other reasons for living with extended family included educational and traditional purposes, or because biological parents were unable or did not want to care for the child (NGO2). The Church and Muslim Councilmen heatedly raised the 'dangers' young children (nine-ten years) were subjected to because of this lack of protection. They both remarked on children's personal phones and video clubs where they watched sexually oriented Nigerian movies, consequently spoiling their education. The DCM participant reiterated the uncomfortable conversation he had with his 28-year-old daughter about sex, the fact that his 32 year old daughter was *"not thinking about it [sex] and she got married"* and his other daughter only found a boyfriend (and sex) at 30, perhaps reflecting the openness between parents and their children (page#51).

> *The one in America was 28…say…I'm reading about certain thing I want experience, I say what is that? She say sex. I say 'GET OUT OF HERE!!' She say, ok when I come back I will already know about it…she walked out. She said, she WANT to know what she reading about. So I should give her experience what she reading…So I said, no, [name] you don't say such things to me. She say, Dad when I go out there, coming back I will already have the experience. And she went...Every time we lecture…my wife always say, 'ah don't talk this thing' and that's how it go. To rape, everyday in Liberia. They want to occur these things, they are not educated.*

The participant criticised the lack of sex education yet was unwilling to educate his own children about it, despite being highly educated, a government minister, a religious pastor and a traditional herbalist.

4.3 Global response to SGBV in Liberia: Monrovia

4.3.1 INGO response, prevention and advocacy

The following table #6 indicates the participating INGOs, the year they began working in Liberia or on GBV issues, their core activities, a brief breakdown of their GBV focus, who they are funded by, the counties where their GBV programmes are located in and their responsibilities.

Table #6: INGO response, prevention and advocacy

INGO	Year	Core Activities & Programmes	GBV Programme Focus	Donors	Donor Restrictions	Counties
Child Fund (CCF)	2003	▪ Child Protection ▪ Maternal health care ▪ Education ▪ **SAFE:** Safe Guarding the Future Effectively ▪ Child Friendly Schools: programme focusing on sexual exploitation and abuse (SEA) → involves child nutrition	Awareness Livelihoods Teacher training Health worker training, legal and security personnel on GBV Constructing skills centres for 'development, health education, literacy, and counselling services' that cater to girls and women Increasing survivors access to medical care Partnerships with Concern	CCF int. I/NGOs UNHCR Global fund	Partly, due to unfunded meals for beneficiaries or 'sitting fees'	Bomi Gbarpolu Grand Cape Mount Lofa Montseraddo
International Rescue Committee (IRC)	1996 (GBV 2001)	▪ Health care ▪ Education ▪ Ivorian Refugee support ▪ Women's Protection & Empowerment **(WPE)** ▪ Child & Youth Protection & Development **(CYPD)**	Prevention, Response, Advocacy Economic empowerment Supports 33 health care facilities & 5 hospitals Health care worker training Provides counselling to SGBV survivors	NOVO Foundation Irish Aid	N/A	Grand Gedeh Lofa Montserrado Nimba (Based on internally displaced persons: IDPs)
Norwegian Refugee Council (NRC)	2003 (GBV 2009)	▪ **IRRP:** Ivorian Refugee Response Programme ▪ **ICLA:** Information Counselling & Legal Assistance ▪ **SGBV**: Sexual & Gender-based Violence ▪ Education Programme	Court monitoring Psychosocial counselling in the counties Community Awareness and Training: (LNP, Wise Men, Wise Women, Wise Schools) Reporting: strengthening data collection & analysis Supports distribution of referral pathway → posters/radio Partners with (Women in Peace Building Network (WIPNET) to manage NRC programs on exit	Norwegian Aid	N/A	Bong Grand Gedeh Margibi Montserrado Nimba (Based on IDPs)
Save the Children (Save)	1991	▪ Primary/maternal health care ▪ Education (primary) ▪ Early childhood development care ▪ Supports teacher training programme ▪ Provides basic materials to schools → books/uniforms ▪ Violence against children ▪ Ivorian refugee support ▪ Institutional care for children ▪ Partners closely with CCF	No direct response on GBV but refers to other services Child Protection programme (2 sub themes) → Children without appropriate care → Children affected by SEA Trains children how to detect and report abuse Community strengthening systems → children's clubs & welfare committees Supports youth friendly centres → access to reproductive health services and information Supports clinics and hospitals (Margibi) → medical supplies & drugs, trains medical staff	Save int. USAID	N/A	Bomi Bong Gbarpolu Grand Gedeh Margibi Montserrado River Gee (Based on IDPs)

Engaging with GOL

Government inter-agency relationships were strained in many cases. Relations with INGOs and the international community were relatively good. INGOs were required to fall within the national GBV mandates rather than implement their own (UN/MOGD). All four INGOs seemingly had close working partnerships with multiple government agencies, like the IRC and Sex Crimes Unit, Save and MOJ, the LNP and WACPS, the NRC and WACPs and CCF and the various other ministries. The lack of effective **implementation** in reference to SGBV management was the concern of all the INGOs. CCF stated, "*thing is there are rules and regulations and patterns and frameworks laid out to address this issue [SGBV]. **Implementation is the problem**".* Save provided similar comments. They were working closely with GOL to ensure the programmes were present and GOL could manage them. Save pushed legislating the Liberian children's law. They are now encouraging the government to use it, *"the next step is pushing them. So you have this law but we don't want it on the shelf".* NRC felt their biggest challenge working with SGBV was not the capacity of government, but *"the willingness of the government to take over"* the programmes. The participant identified GOLs ineffective distribution of funding and resources as a pivotal problem. In reference to WACPS, he stated, "*it all boils down to the government, to budgetary allotment. They don't have enough money to pay the men"* (NRC).

Memorandum of understanding (MOU)

MOUs have been established to ensure that on departure, I/NGOs were required "*to empower Liberians to take over…what they were doing…to provide the same services they were providing"* (MOHSW). Actors were required to inform GOL of their departure and that they had partners to assume their services (MOGD). The MOGD stated that it was their *"responsibility to collect it and analyse the data,"* and that they had mapped all GBV partners in Liberia. However, the NRC performed this task and also trained and provided data collectors with a stipend (NRC).

Under the MOU, since 2012, the IRC had been working with three local partners for case management, economic empowerment and prevention. However, they had several issues with the partner working with case management. Although a large sum of money had been distributed, the partner has not paid any staff, provided a report or completed the project. Other INGOs had similar problems. The NRC has partnered with WIPNET to replace them but stated that, *"although they are not fully capacitated yet. But that's it. There could be a gap, things could go bad, or things could just remain like this. Who knows? We all hope for the best".*

Monitoring and evaluation (M&E)

All of the participating INGOs incorporated some kind of M&E system, either at a national and or international level. However, measuring the effectiveness of programmes both I/NGO and government was a significant challenge when it came to SGBV largely due to its secretive nature. Also, on one hand, increased reporting suggested more individuals were being affected by SGBV. Yet on the other hand, this may have reflected that individuals were now reporting cases, whereas before it was *"family business"* and dealt with secretively. The most common form of evaluation included feedback and testimonies from the community (NRC). Good feedback was rare compared to bad feedback (IRC; NRC; INGO1). However, testimonies about positively changed husbands had also increased with one wife stating,

> *I came to say thank you to this group. I don't know what my husband had been taught in this group but since he's started coming here, things has [sic] changed in my home. So I came as an appreciation to present this rooster to the group to say thank you* (IRC).

While another man in Nimba County openly apologised to his wife *"for everything that I've been doing to she and the children"* (IRC).

Baseline studies, research and mid-project reviews seemed to be another common method to implement or monitor projects (IRC; Save). For Save, it was important to distribute the information learned from these data to other partners. Observationally, the distribution of information and reports seemed to be somewhat of a problem. The CCF participant said there were good reports and documentation, but a lack of distribution and implementation. The UN/MOGD emphasised the importance of frequently monitoring their programmes, to identify the good and bad effects. This was especially so, as they did not implement activities directly, but through partners like the government or INGOs. UNMIL provided countrywide on-going support to the LNP. They played a pivotal role training and conducting weekly checks, which I observed in Landsby and elsewhere.

Engaging with the traditional community and men

The following table #7 indicates the international response in engaging with men and traditional leaders and healers. Only the NRC and IRC definitively engaged men with GBV programmes. Every interviewed actor expressed the importance of collaborating with traditional societies and the impracticability of not respecting the traditional values, *"a lot of modern techniques that are brought in are not accepted by the country…"* (UN/MOGD). Yet, each one noted that they did not currently work directly with traditional leaders or healers on SGBV. Nor, was it in their future plans. This was due to it not being in their core competencies or focus and because of funding or lack of resources. However, they did all state that the community groups they worked with included traditional leaders and healers. Many saw the

importance of understanding and the **need** to collaborate with the traditional societies, especially in regards to practices like FGC (CCF; IRC). CCF took the approach of *"I can't just go to a community and condemn whatever anybody does there. I have to look at what they're doing, the definition, work along with them with mutual respect…"*(CCF).

Table #7: INGOs engaging with the traditional community and men			
INGO	**Engages men**	**Engages Traditional *healers***	**Importance of engaging traditional healers?**
Child Fund (CCF)	Engages with boys (only with men if the father is involved) Rehabilitation centre for boys.	No, but *"respects traditional values very much"*. Does have plans to work with traditional healers.	Definitely a need to engage with traditional leaders.
International Rescue Committee (IRC)	Yes: first INGO to engage with men in Liberia in 2006. 16-week curriculum.	Not particularly. *"We just haven't focused on that yet. But it's important"*.	*"There is a need because they form part of the traditional leaders."* Not sure about future plans, but part of traditional leaders are healers.
Norwegian Refugee Council (NRC)	Yes: began 2010 Wise Men Groups	No, *"we are not dealing with traditional healers"*.	Absolutely sees the need, especially in rural areas where people have a lot of trust in healers. Not sure if any NGOs plan to engage with traditional healers. One programme with UNMIL.
Save the Children (Save)	*"To some extent"* as *"they play a key role in communities"*.	*"To some extent"* Works with traditional midwives.	*"We want to work more with structures at the level of the community so we are working more with these child welfare committees, which is a component of different stakeholders at the level of the community."*

All the INGOs felt that the communities were extremely welcome and their organisation well known in the areas they worked in (CCF; IRC; NRC; SAVE). Opposed to the organisation as an imposition, the IRC felt that the community perceived it *"as their own thing…because we don't tell them that this is for IRC, we tell them that this is community benefit. We say that GBV is everyone's business…we all need to work"*. IRC trainers often stressed that *"we don't live here…it's your community,"* instilling ownership of programmes into the community. Most INGOs in Monrovia no longer directly medically dealt with survivors' post-assault. Instead they used the referral pathway system and focused on prevention and microfinance programmes. The IRC participant felt the contention between the traditional societies and Western organisations lay mainly in the children rights and domestic violence disparities of understanding. SAVE emphasised that the traditional communities felt their children were disrespecting them because of children's rights. While they may have rights, they also had responsibilities, which guardians' felt actors should also be responsible for preaching.

4.3.2 Government response, prevention and advocacy

The following table #8 outlines a basic breakdown of the GBV action plan. Highlighted are the five pillars that aim to holistically tackle the issue, the ministries who are responsible for each pillar, their partners and their main responsibilities.

Table #8: Government response, prevention and advocacy			
Pillars	**Ministry**	**Partners**[19]	**Responsibilities**
Coordination	Ministry of Gender and Development (MOGD)	UN	• Coordinate the action plan • Monitor and coordinate GBV activities • Set up GBV task forces in 15 counties • Chair task force meetings • Liaise with all the other ministries • Liaise with networks: media, religious to create awareness
Medical	Ministry of Health and Social Welfare (MOHSW)	UNFPA	• 'Direct physical health of SGBV survivors' • Medical health care system: referral hospitals and clinics • Some health care facilities (especially in interior) contracted out to partners • Training clinical and psychosocial counsellors on how to manage rape → consultants used when ministry lacks capacity to train → at present majority of trainers are volunteers • Order and distribute rape kits
Psychosocial	Ministry of Health and Social Welfare (MOHSW)	WHO	• 'Emotional well being' of survivors • Train psychosocial counsellors • Find partners to train if MOHSW do not have capacity to do so
Legal/justice	Ministry of Justice (MOJ)	UNDP	• Prisons • Court
Protection	Ministry of Justice (MOJ)	UNMIL	• Child protection programme (with Save) • Child diversionary justice programme

Pertinent GOL actors who influence the traditional community

The Ministry of Internal Affairs primarily deals with the traditional communities. It is responsible for licensing and regulating Zoes (table#9/ table#12). The Division of Complementary Medicine (DCM) is responsible for traditional herbalists, "*…traditional medicine practitioners and to…record, train and monitor"*. It is working to integrate their work into the formal healthcare structure in order to complement Western medicine, like in Ghana and Nigeria. The DCM has been tasked to explore traditional medicine and practices in a controlled environment to determine if it works, how it can be standardised and how it can be used more complementarily. The division was currently holding a clinical trial looking into six illnesses and how traditional medicine can cure them. These included malaria, tuberculosis, HIV/AIDS, sickle cell and diabetes. The project involves several people, including herbalists,

[19] There are also many INGO and local NGO partners which this study was unable to map

orthodox medical doctors and investigators who are carrying out the testing. However, the traditional herbs or amounts used were not being recorded. I was told that there were cures for HIV, malaria and breast cancer, and that many people had recovered from the diseases.

Table #9: GOL actors' responsibilities for traditional communities	
	Responsibilities
Ministry of Internal Affairs (MIA)	• Deals with internal affairs, traditional people and laws • Deals will all the traditional Zoes/medicine/people/practices • Licensing for all traditional Zoes required
MOHSW: **Division of Complementary Medicine (DCM)**	• Clinical trial for complementary medicine (2013) • Documenting herbal medicine (not the actual leaves/ingredients) (2013) • Licencing for complementary medicine physicians (photo # 8; photo #9) • Monitors traditional medicine practitioners • Dealing with patent rights for traditional medicine

Photo #8: Traditional Health Facility Licence

Reddy, 2013

Photo #9: Traditional Healer Licence

Reddy, 2013

Licensing laws

In recent years, GOL in consultation with traditional society leaders have implemented several rules and legislation in order to regulate their activities. Although every Zoe and herbalist was required to have a licence, there were several logistical issues with the system. The UN/MOGD participant defended the process as an endeavour to improve records and knowledge about how and who was practising country medicine. Currently, licensing is centralised to Monrovia requiring practitioners to visit the MIA or DCM. This leaves a wide berth for inaccuracy or even round about numbers of who is practising country medicine. Decentralisation plans have been discussed. The system is highly flawed. Local NGO3 heatedly argued that the impetus for licensing was *"a money making thing…You got money, you go, they will give it to you"*. As the Head Zoe stated, *"nobody fail"*. This also raised questions about the safety of the practices in reference to the spread of HIV as well as the ubiquitously cited liver damage as an outcome of traditional medicine (NRC; NGO2). The DCM participant, responsible for licensing traditional

healers clearly stated that he did not question practitioners about the ingredients or the measurements they used, nor was he doing this for the clinical trail being conducted, questioning the rigour and purpose of the study. When asked about this, the participant raised concerns about Western actors manipulating the lowly educated practitioners surrounding patent rights. GOL has also tried to regulate other traditional rituals like the country devil, which have been equally unsuccessful.

Moreover, the government has recently (2013) implemented a law regarding the *bush schools*, in response to a MOGD (2011) report. Firstly, no individual is permitted to force any person to attend bush school. Secondly, GOL has reduced the period the societies hold the bush from three and four years to three and four months. Thirdly, GOL has stated that if the practice continues it must be done within the July government school holiday (NGO3). Sande 'agreed' to these terms on condition that a school, church or mosque and town hall are built in their respective communities. Moreover, although the Head Zoe suggested that three months was not sufficient enough time to teach the girls the skills they needed, they had seemingly agreed to the regulations because of the importance of education (Head Zoe; NGO2; NGO3).

> *Education was making it now three months and four months. During school vacation. It must not fall within the school…Nobody forcing anybody now…We don't want to spoil the children education…we in modern day now, because the children education too important to us…So that changing time, it not spoiling our culture. Our culture still strong! (Head Zoe).*

Though, she felt that many people were taking their children to Monrovia and not to *bush school*. She was not particularly pleased by this and told the people "*…send them back, your culture here in the bush".* INGO1 and NGO3, felt that despite these restrictions, communities were still able to perform priority rituals like FGC. NGO3 felt that the Sande fought the system because children were still being forced to go to *bush school*, and missed government school. While NGO2 noted that at first the community did not accept the changes, they now are. However, this was still not the case for the men's societies who were continuing to operate *bush school* throughout the year and not confining it to the school holidays, "*the president told them the LAW [sic] of Liberia…whilst we were in session, the men were in the bush"* (NGO2).

M&E and evidence gathering

The MOHSW monitored the hospital and police and looked at best practice methods, followed by recommendations. However, as the MOHSW participant explained, the Liberian hiring system was flawed because, *"…the [HR.] manager…will be sent maybe by one of the bosses. Then they will send someone, say ok employ them whether you have the experience or whether you don't have the experience, then you are employed…yes,* ***because who you know****".* The ministry encountered major issues in M&E when dealing with the informal Liberian *Spoil*

System and the *Merit System*. The Spoil System is where you have a brief amount of time, evaluate a situation and you merely indicate the negative points for the actor to improve on. The Merit system involves evaluating a site, deeming the programme inadequate, terminating it immediately and contracting it out to another actor. At times however, when reports are made, no outcomes occur because *"everybody will just pay a deaf ear to it"* (MOHSW). The UN/MOGD were in the process of establishing a very preliminary forensic laboratory for swab testing the **presence** or **absence** of semen. This will be centralised to one specific hospital in Monrovia. The aim is to determine and provide evidence of sexual assault and reduce the amount of cases reaching court. Prosecutors have been engaged in the process and will be encouraged to use the evidence in court.

Engaging with the traditional community

The level of GOL interaction with the traditional community seemed highly inadequate. The MOGD interacted with leaders and said there was a definite need to make them aware they should refer SGBV cases to the formal pathways. MOHSW reiterated a case about a chief going to court and telling the judge, *"this girl is married to this man,"* resulting in the release of the perpetrator. He noted that it was important you refrained from saying, *"your system is bad,"* but reviewing it with the community to eliminate harmful practices and find replacement solutions. He felt that it had been a struggle for MOHSW to collaborate with the communities, but their presence was slowly being welcomed. The MOHSW stated, *"it's not going to happen overnight…our traditional people will not talk to strangers".* JDJ hospital thought there was a need to collaborate with traditional healers but had no interaction with them, *"we are not working with traditional healers, we have not worked with them, we have not talked to them".* This was despite on some occasions, having to deal with the repercussions of traditional practices. JDJ felt that this seldom occurred in Monrovia and was more of a problem in the interior. In such cases, they would consult traditional midwives. HOW stated that the unit had considerable challenges dealing with the traditional communities beliefs because, *"MOST of the traditional leader will want to settle the matter at home…"* Moreover, because of stigma and cultural beliefs, "*the men from the traditional background feel that women are their property…having sex with a women is nothing,* ***they don't consider it yet as a crime****…"* Landsby WACPS had a tense relationship with the traditional communities because they felt they compromised SGBV cases by relocating survivors. Community people would not provide information about cases *"because they don't want to go against the tradition"* (Landsby WACPS). However, he stated that they did not deal with traditional healers or bad medicine when it came to S/GBV and laughed about it.

4.4 Local response to SGBV in Liberia: Landsby

4.4.1 NGO response, prevention, and advocacy

The following table #10 indicates the S/GBV response of the three local NGOs and one local-office based INGO1, located in Landsby. The year they began working in Landsby, their core activities, their programmes focused on GBV, constraints that hinder their capacity, who they are funded by, the districts they operate in, and any monitoring and evaluation (M&E) they carry out are highlighted.

Table #10: NGO response, prevention, and advocacy

NGO	Year	Core Activities & Programmes	GBV Programme	Constraints	Funded by	Districts	M & E
INGO1 *Local field office*	2004	▪ Disarmament ▪ Child protection ▪ GBV ▪ Focuses on training people within the community to deal with cases	Saving and loans programme: 55 community groups Women action groups: 8 (groups that are trained to handle case management) Girls' groups: 2 Men's dialogue groups: 5 (working through partners – lasts 4months) Psychosocial counselling	Ineffective communication between head office and field office Understaffed	Novo Foundation Irish Aid Nike foundation *(Proposal written 2006, lasted 5 years, extended 3 years)*	3 districts 8 sites	Difficult to measure Based on community complaints
NGO1	2006	▪ Adult literacy ▪ Agriculture ▪ Skill training ▪ Gender	Women Empowerment (especially in politics) Education	No vehicle restricts mobility All projects need approval by donor	Catholic missionary	3 districts	Difficult to measure – community complaints
NGO2	2010	▪ Human rights ▪ Access to justice ▪ Operates county safe home ▪ Monitors prison – cases on SGBV ▪ Provides legal representation to survivors in court	No specific GBV programme but provides psychosocial counselling for survivors	N/A	OSIWA Funding is their *"Biggest challenge in dealing with SGBV survivor support"*	Throughout county. Desire to expand.	N/A
NGO3	2007	▪ Individual and group psychosocial counselling ▪ Family intervention ▪ Scholarship programme for 750 children ▪ Livelihoods training for 250	Psychosocial counselling Awareness training on trauma relate issues	Limited funding impacts staff & transport logistics. Donors have own objectives *"own strategic planning"* - limits activities	Plan Liberia DIGNITY (Danish Institute against Torture)	4 districts	N/A

Engaging with GOL

All the locally based NGOs criticised the **implementation** and effectiveness of GOL and INGO awareness programmes, particularly in the interior. Some GOL and UN staff also questioned it. The local NGOs were more directly judgemental of GOL. A number of participants and community members noted they felt the government was *"doing their part"* (NGO2)[1] in terms of rebuilding the country (Church Council). However, several felt that they really *"need to do more"* and progress was exceptionally slow, especially in the interior (INGO1). NGO1 stated that *"the government, that's the worst one…[receiving] big money everyday,*" and emphasised the high rates and frequency of corruption. The Landsby Traditional Chairlady criticised GOL for not paying the community for work they had completed. All participants commented on the inadequate road infrastructure that significantly hindered and consistently delayed their response and access to some communities. Landsby was highlighted as being exceptionally bad. The yearly rainy season washed away unpaved roads and turned them into muddy rivers (NGO3; INGO1). NGO1 explained, GOL had been working on roads and bridges since 2005 but nearly all were still sticks. Although I did experience the poor conditions of the roads especially outside of Monrovia, I also saw infrastructure and major roads and bridges being built. Yet, ten years post-conflict I anticipated more long-term improvement.

Every single participant stressed the importance and need of **awareness and education** regarding SGBV. *"We need to work on the awareness…our message is dropping and we have already have sent our seeds but it's just that we need to continue to water. Yeah. And we should continue to coordinate and COMMUNICATE [sic]"* (INGO1). Many felt that the international community needed to monitor funding and to send experts to work with GOL to improve roads, hospitals and schools and not merely money (NGO1). This was in direct reference to the high rates of corruption, resulting in resources rarely reaching Landsby.

M&E

Most of the local Landsby NGOs found it extremely difficult to perform M&E or did not perform it because of deficient funding or resources. Community feedback however, played an important role in evaluating how they were doing.

[1] The NGO3 participant was also employed by GOL under another capacity.

Engaging with the INGOs, the traditional community and men

The following table #11 indicates the local NGO response in engaging with men and traditional leaders and healers.

Table #11: Engaging with the INGOs, the traditional community and men			
NGO	**Engages men**	**Engages Traditional *healers***	**Importance of engaging traditional healers?**
INGO1	Yes	Not directly – traditional leaders encompassed community groups they worked in	Very important
NGO1	No	Not currently – did when funding was available	Important
NGO2	No *(prison monitoring for SGBV)*	Not currently – did when funding was available	Very important – especially to educate them on harmful practices
NGO3	No, unless father is involved	Not directly – traditional leaders encompassed community groups they worked in	Important – especially on issues like FGC

All but one of the local based NGOs did not engage with men. INGO1 emphasised the needed to work with the traditional leaders but that it was equally important to find a solution to *"someway to make it more advanced."* While INGO1 did not directly work with traditional healers, they did train and create awareness among the leaders and healers who were part of the community groups. She felt the organisation was culturally sensitive. NGO1 and NGO2 had previously engaged with traditional leaders, but could no longer because *"there's no funding"* (NGO2). NGO3 said the organisation provided *"training for every every [sic] group"* yet could not specifically say if they worked with traditional leaders. Again, they provided awareness to the communities who encompassed traditional leaders and healers. NGO3 raised the difficulties they had with trying to get the different tribes to work together on issues especially post-conflict, as they were all reluctant, with many tribes saying, *"since the war we have not just been friendly and we don't think we're going to be friendly"*.

NGO1 felt that the traditional leaders were *"ignorant of the law",* and that the town chiefs often told people not to talk to the police. She discussed the relatable plays they held in the villages to increase awareness about these issues. Alternatively, INGO1 felt that chiefs in the area did **not** compromise SGBV cases because of the awareness that had occurred. NGO2 thought that it was important to work with them and create more awareness and education to remove the *"family business"* perception. However, she was critical of the traditional leaders and community saying, *"the culture is killing us. The traditional is killing us…there's no good thing…there's not good thing about the tradition. The traditional is killing our people. Women don't talk…the women don't have rights".* She was also unimpressed with the healers who thought they were *"god"* and could cure infertility with leaves.

INGO1 felt that the perception of the organisation in the Landsby community varied. INGO1 stated that many of their management staff were Liberians and it was in the organisation's best interests to work within the local context, *"they don't take the Burundi idea and bring it to us, no"*. She felt that Western ideas were not forced onto the communities, *"we know that everything is a process and adapt manuals to fit their context"*. Giving the beneficiaries the option to be part of the programmes was an important aspect, rather than coercing them to do it. For instance, the participant recounted the issue of FGC and a meeting with a visiting UN representative who was adamant that *"FGM should stop!"* He basically blamed the Zoes for harming 'our sisters'. The participant explained that she understood what he was saying but you had to be sensitive or they would surely tell you to leave. NGO3 was careful discussing FGC with the traditional communities because *"they will not accept you"*. They often *"use[d] the children to talk about it,"* possibly inciting a point of contention with parents.

Observationally, there seemed to be some contention between the national INGO1 staff and some local community members. INGO1 reflected on how some individuals, *"actually say all these [bad] things are happening because the NGOs are here"*. Some community members questioned the future livelihoods of the staff once the rich INGO1 had exited. Others felt that *"the international community had this huge sum of money, they got so much that's why they want to give it out…some tell us we are getting free money because nothing we do"*. While other community members *"really appreciate[d]"* the work they were doing. According to NGO3 there were many INGOs in Landsby. The participant felt that the community really trusted the INGOs and that most organisations, were *"sensitive to the culture"*. The local NGO3 felt that INGO1 did great work and went to many rural places where others would not go. NGO2 felt that the traditional communities did not want the Western approach, which was consequently *"killing"* their people. She chastised the medical doctors for not creating awareness about drinking *"dirty water"* provided by herbalists to cure disease, resulting in liver and heart problems, *"then when they come here, they die. Then when people continue to die in the hospital here, they will say the hospital kill you"*. Every single participant commented on the need for more awareness on SGBV. All the local Landsby NGOs and community members commented how the international community should prioritise needing to *"**empower the local NGOs**"* (NGO2). They aptly justified this, as the local organisations would remain in those communities (NGO3). NGO3 emphasised the need to employ local staff from the areas INGOs were working in. There was a high chance that some may have been SGBV survivors and would have different contextually appropriate approaches to dealing with it. All the I/NGO participants interviewed were Liberians. Most of the INGO employees in Monrovia and Landsby were also locals.

4.5 The traditional community: response, prevention, and advocacy

Traditional healing systems: treating and influencing SGBV

Collecting data on the Liberian traditional healing complex proved difficult due to the secrecy involved. However, the use of traditional medicine seems ubiquitous regardless of religious affiliation and in many cases formal education (CCF). In order to understand how traditional medicine treats SGBV survivors, it is helpful to understand the rituals, practices and practitioners that involve traditional medicine and influence the prevalence of SGBV (table #12). Firstly, it is essential to understand that participants commented on how children, especially younger children did not have a choice of where they went for treatment (NGO2; NGO 3; CCF). According to NGO2, *"it's the parents who tell them…they don't have their own will"*. CCF noted, *"in most areas the children don't have a choice. It's time for you to get up, lets go"*.

Traditional Sande Society

Mama Tormah is considered one of the most powerful traditional leaders in Liberia (photo#10). She is the Head Zoe as the Head of the Traditional Sande Society and originates from Landsby. She is also the Executive Director for Culture and Female Affairs at the Ministry of Internal Affairs. Her role as Head Zoe involves managing the women's society, *"To become a Zoe, you have to come here and learn from me and learn from the old people in the county. I assign them to train you…"* Her capacity in the MIA holds her responsible for licensing all the Zoes in Liberia and seemingly collaborating between the government and the traditional (female) communities, "*They tell me, what you treat, they bring a list, bring a CV there. We give the test. Bring a sick person and tell them to cure.* ***Nobody fail on it".***

Photo #10: Mama Tormah

Reddy, 2013

Mama Tormah stated that SGBV was a large problem. Yet, she was adamant that, "*they will stop it. We will stop it"*. The girl seated next to her during the interview added that the culture was helping survivors to cope. In response to the prevalence of SGBV and women's low status in Liberia, Mama Tormah established a NGO in 2002 called Traditional Women for United Peace to train women in, *"…midwife[ry], country cloth, tie dying and the literacy too...We train them on how to make a life…that women can do themselves…"* The Carter Centre,

Samaritan's Purse and the American Embassy supported her NGO. It effectively aims to train and empower women and girls, so that they are able to provide for themselves and their families. Mama Tormah and her NGO strongly support education, *"because some don't go to school. That's what the organisation is there for"*. The Landsby Traditional Chairlady reiterated this sentiment, "*we want the children to learn, the way you doing it, they must do same"*. Mama Tormah established and operates an elementary till 7th grade school in her Monrovian community. At time of fieldwork (July 2013) the school had 436 students.

In reference to directly treating survivors Mama Tormah provided care in the herbalist clinic located in her community, although she did not clarify what this included. When asked if she dealt with psychosocial care she said, *"Yes! We talk to them…**sometime** take the case to the doctor, **sometime** I get the thing from the clinic. But we never get the supply [drugs] here"*. She also *"sometimes"* talked to the perpetrators and *"sometimes"* turned it over to the police. The woman's needs were always prioritised. She offered for them to attend her free school. Comparatively, the Landsby Traditional Chairlady stated that, *"to my own community it [SGBV] never happen yet…but when it happen we bring it up. Bring it [to] the government. Take to the doctor. Can't make it with country doctor"*. The Muslim Chairman also said there was absolutely no SGBV in his community. He felt it was very low in the wider community in general. The gatekeeper who was part of the Muslim community and also present during the interview later strongly refuted this statement. The Church Councilman noted that the church counsels survivors and perpetrators in prison. He commented on the importance of instilling *"godly fear…once going against God, going against law…"* The church also sometimes acted as a mediator of sexual disputes.

The medicine

More specifically, several community people and participants explained healing SGBV survivors involved collecting a mixture of herbs, boiling these in a pot and making the survivor sit on/in the pot for an extended period of time. This cleanses the body and the mind (IRC; INGO1; NGO2; DCM). As one participant clarified, "*they might use some herbs and other thing, try to cool the pain, try to work on the soul"* (MOHSW). Although NGO2 supported this statement, both she and NGO3 believed that the Zoes did not provide

Photo #11: Palava Hut

Reddy, 2013

any counselling and expected the survivor to just forget about it and *"be strong"*. However, the NRC participant believed there were a few counselling techniques involving talking, like the Head Zoe referred to. The MOGD confirmed this and explained that it involved rural women providing some group counselling in *Palava huts* (photo #11). However, she said this counselling was restricted to domestic violence cases and the Zoes did not deal with rape cases.

The practitioners

There are several roles that involve using or administering traditional medicine (table #12). Essentially however, there are no clearly defined definitions for each position. While similar and very interchangeable, the roles differ between tribes and counties, and thus rely on the individual's personal ability to perform one or all of the practices. The positions are inherited and learned through family members. While the medicine involved herbs it also involved supernatural elements and spirits. Whereas a herbalist could simply learn about the leaves they needed to heal, there were several stages required to become a Zoe, which took time (CCF; Head Zoe). Traditional **healing is not confined** to traditional communities. Nor is it a restricted role. I met a number of government ministers who were herbalists and intricately involved in the societies. Although, Zoes had a *"special gift"* (DCM) and *"everybody, every Liberian have ideas on herbal medicine,"* especially in the interior (NGO2). Many people often self diagnosed and had open access to purchasing prescription drugs in the pharmacy, as I experienced. On many occasions locals would comment on the common understanding that some diseases, like malaria and broken bones were simply treated with traditional medicine. Other diseases would require hospitalisation. These were just known.

I visited a clinic in Monrovia that was run by a medically Western trained doctor (Doc1). Doc1 had an older brother (Doc2) who was a herbalist. When Doc1's medicine did not work or he knew it was a country disease he would call Doc2 in to treat the patient. Doc2 emphasised that he could cure alcoholism, drugs and *"crazy people roaming the streets"* just with herbs. He learnt his practice from his father and so on. I was able to meet one of the clinic's patient's who had a stroke. Doc1 stated that he *"could not do much"* and basically was unable to treat the patient with Western medicine. Doc2 however was able to treat the patient and was making *"good progress,"* which was reiterated by the patient. This **complementary** use of medicine seems to be common in Liberia, *"even some people who say they're so educated. They get sick and they're in the hospital and they will say 'eh, I think I better go to the herbalist…"* (CCF).

The Liberian traditional healing complex (table #12) comprises Zoes, herbalist, country doctors, soothsayers and religious Christian healers. Each position and sector is seemingly very porous and unrestricting. While each position and ability differs, they all combine to cater towards healing the body and the mind. The following table is a summary of traditional practitioners.

Table #12: The Traditional Liberian Healing Complex: summary of traditional medical practitioners[1]

Practitioner	Tools /process	Cures	Learnt from	Other information	Requirements
Herbalist (Country medicine) (Also called a Zoe sometimes)	Uses special herbs, bark, leaves, roots and sometimes animals like snakes and insects Process: Picks ingredients, pounds or grinds and dries it	Impotency Menstrual problems Stomach complaints Sexual disease Tooth ache Ear pain	Most often orally inherited: *"you get it from your family"*	Can be *"given to anybody and the person carry anywhere and they use and it can work"*	Licence: DCM
Zoe (Also traditional birth attendants / midwives)	Performs circumcision Are often traditional midwives	Initiation	Most often inherited		Licence: Internal Affairs
Zoe (Super natural diviner/ witch doctor/voodoo man)	Uses a combination of *"spirits to treat and cure,"* supernatural powers, human body parts and ingredients like chalk Ability: can find, arrest and kill witches (often target children), remove bullets, get promotions, make people fall in love, provide a 'protection' against bad spirits	Impotency Menstrual problems Remove bullets from bone Fertility: *"Some of the Zoe they can make you born baby but that baby almost be like demon. Cause the person they going to get the baby, maybe the spirit will come in"*	Natural ability *"They have source of contact…Yeah, that is demon or some source, somewhere they inform them"*	You have to be part of the secret society for some medicines to work. *"That medicine cannot be given to anybody and if you go anywhere and it will not work. Only THEY use it. And those that catch witchcraft, the witch doctor, the witch master who serve as, who practices. They catch you and kill you if you don't yield. That is common here. That's one type"*	Licence: Internal Affairs
Zoe/ soothsayer	Psychics *"They see the future, they see the past"*	Soothsayer → trial by ordeal: deals a lot with 'exposing' witches			Licence: Internal Affairs
Christians/ Church	Uses *"leaves, pray and water and oil to heal"*	*"They claim to have a gift and their gift they can pray over oil and water. You drink the water, you rub the oil, you drink it and you can be healed"*			
Chiefs/sub chiefs	Decision makers For every chief there is a chairlady		Hereditary	*"Some of them can be traditional healer"* Some are also now women	

[1] Information primarily stemmed from the Division of Complementary Medicine, a department under the MOHSW. However, data were supported or altered from information either provided by the MOHSW (psychosocial), the Head Zoe of the Sande society and I/NGOs. All quotes by DCM.

Traditional justice systems: dealing with SGBV

Participants were unable to explain in great-depth about traditional justice systems that dealt with sexual violence, bar the fact that they were present and damaged due to the war. As the MOHSW explained,

> *Before the war…the rules of law were very strong, were stronger than now…but right now it's weakened…In the traditional setting, there were rules and regulations that if you even go after your friend wife this is what you have to do. If you go after a young girl this is what you have to do.*

Liberia had a constitution pre-conflict. Understandably, considering Liberia's formation, participants felt it was largely restricted to the capital. Accordingly, the once powerful chiefs primarily dealt with any matters of SV in the rural areas, ***if*** they were reported. The Landsby Traditional Chairlady pointed out that the chief's still tried to deal with SGBV and the perpetrators. If they were unable to remedy the case, they would then take it to the government. Alternatively, cases would be settled directly between families because of the stigma attached to it, *"…the family people will come and just try to settle it…maybe they pay simple thing and…walk away"* (MOHSW).

Engaging with GOL and the international community

The Head Zoe was not opposed to working with Westerners and recently engaged in a meeting with the UN, GOL and Zoes from all the counties regarding *bush school.* The Landsby Traditional Chairlady was adamant that GOL should help the traditional communities. She felt that INGOs efforts had been unsuccessful, *"no help, plenty try, some from the states, some of them country men..."* For her, a good life meant a good business would be established, which could provide employment for the community and thus be able to build *"hospital, school hall!"* The Church Councilman blamed other ideologies which brought individual oriented and gendered statuses into Liberia during the war. He blamed refugees for exposing Liberian children to many things and for *"unnecessary sex with children".* Similarly, the Muslim Chairman believed that there were many complex ideologies moving together, brought in by Western organisations. He was not pleased with this. He commented on how women and men now worked and learned together. Consequently, no one was home to care for the children as young as four to five years who were now being exposed to different ideologies than their parents in day care. The Landsby Youth Group participants felt that there were positive and negative aspects to Western ideas. Education provided interchanging ideas but Western concepts were impairing the good aspects of traditional culture. They felt that traditional healers and leaders were abandoning ways of secretly dealing with SGBV because of sensitisation.

4.6 SGBV survivors' experiences

(Survivor tables: #4 appendices). **SV1** (15years) chose not to discuss the incident. Instead she talked about a lot of girls getting pregnant and about how girls in her community took care of themselves by going out to clubs and being out on the streets (page#97). **SV2** (15years) chose not to discuss the incident. She stated that rape did not happen in her community. She did however name another community where it did happen and where a *"man raped a little girl…they say she not born again"* [i.e. not give birth]. There is a possibility she could have been referring to her own incident. **SV3** (19years) did not go into detail about her multiple sexual violence incidents. She requested I find out from the INGO1 participants who had case records. She commented on the effects of alcohol and *"that sexual feeling"* which led men in forcing girls passing on the street, *"…some men when they in alcohol they can do ANYTHING, but after that thing pass and they come to theirself [sic]…"* **SV4** (13years) was 12 years old when her stepfather began sexually abusing her. He was also her schoolteacher in the rural community. As she explained,

> *I go home and he tell me, he say he want me. Say he like me. If I not do it he will fail me, that teacher. I go to school in the morning, I say no. I say I not do it, he fail me… My mother tell the people there…She the one who complain. Mmm [sic], the man causing my mother… He say he not do nothing.*

Her mother only found out about the abuse months after it began, when the girl began refusing to go to school. According to the INGO1 participant, the people from the man's town defended him during the trial and he was found not guilty. The mother's own brothers testified against her and the survivor because of the shame that such an incident brought on the family. The perpetrator was free and back in the village. According to the participant there were also reports of bribery that took place with the jurors (INGO1). It was very difficult to decipher SV4 during the interview. She was very young (13) and she had also just given birth a week ago as a result of the rape. However, another contributing factor was that she was speaking very softly. Only after the interview, I discovered that the NGO manager had gone into the adjoining room during the interview, possibly in the intention of listening to the conversation.

SV5 was part of the group abused by the Lebanese businessman who owned a company in her community, as explained by **SV8** below. **SV5** thus knew her perpetrator *"by face and name…"* The police found out after a nurse had contacted them. **SV6** also knew the perpetrators. She was gang raped by 10 community boys. She stated,

> *That rape brought me there. The boys, they raped me. I go on the road to go [call] my friend to go buy something. Then the boys they catch me. They tie my feet, they tied my feet, they put cloth in my mouth, then…the boys then rape me. That what brought me here…About my experience.*

Now now [sic]. I feel, what I have to be…because, for about two weeks, I can be happy here, the people helped. My mother not helping me…I can stay, I can feel well. But only if my parents were helping me…

SV7 chose not to talk about the incident. **SV8** was part of the group aged between 7-15years who were raped and video taped by a Lebanese man in the community, as she pointed out. He was an acquaintance with all the girls through family members and owning a business in the community. The abuse was on going for some time. The case was discovered only when the police was given a tip-off and searched the man's house. They found videotapes, which is how they identified some of the girls, as no one came forward. As the survivor stated,

They not really attack me, I was…there was a male who was doing this to ***sponsor me for education*** *and the police came to know. He was doing it to children, that how they got rid of him…I was among one of the victim. So they brought me here…for safekeeping.*

She did not tell anyone because, *"he threatened to kill [me]"*. Perpetrators threatening survivors with *"I'll kill you"* was widespread and an effective deterrence preventing survivors from revealing the abuse (NGO3).

Police involvement

SV1 trusted the police, *"if a man do bad thing, take the man to police"*. She was not aware of WACPS. She noted that if something bad happened in her community, *"they go to the city mayor first. You go and talk to them. From there, if the case is big, you take the case to the police"*. **SV2** also said she trusted the police, but did not think they would come if something bad happened. **SV3**, stated, *"GBV, police people they come into the hospital"*. However, after a number of sexual abuse incidents, she went to the human rights officer at the UN, *"the white man that here"*. The most recent incident was done by her boyfriend who ran away after the incident, *"They used to say each time I go to court, they say my file lost. The one that the man, my boyfriend apparently tell me, if you love me lot of things that will pass through, he denied"*. **SV5** did not *"tell nobody o. If I feel, anybody now can keep it to myself. If I tell someone, all I'll be thinking…so the person won't be helping me. So I don't tell someone, I try to keep it within myself"*. A community member had called the police for **SV6** after she told her mother. She was taken to the hospital and then to the police station where her statement was taken. She wanted her *"mother to send [me to] school"* and the perpetrators, *"to be there. In the cell"*. **SV7** first said she did not tell anybody. Then she said she told her aunty about something her mother did that she did not like, which is how she ended up in the safe home. Her aunty informed the police. **SV8** stated, *"yeah the police came"*.

Health care and psychosocial support

All the survivors said they preferred to go to the hospital for treatment. Notably, they all had been treated in the hospital. **SV2** and **SV5's** mothers were nurses. **SV5**, *"No, I don't really like herbalist o...Country medicine not good"*. Whereas **SV6** stated, *"I go to the hospital…I love the country doc […paused] the hospital doctor…No. I don't use the country doctor here"*. **SV1** liked the country doctor for treatment like broken bones but went *"to the hospital mostly"*. **SV3** preferred the hospital because they had the ability to do certain surgeries that country doctors could not do. She noted that some people felt hospital medicine was slow and thus resorted to country doctors. The safe home supposedly conducted psychosocial care based on western methodologies. Yet there were disparities among the reports from the girls. **SV8** stated that when she arrived, *"people tell me not to think over what happened. You should think positive thing, ask Christ…"* **SV7** learned *"about sexual abuse"* through the counselling sessions at the home. **SV6** had been at the home for three months and talked to the 'nurse aid' once. All the girls liked the safe home and said the staff treated them well or were *"alright"*. The home also had a schoolteacher who was supposed to teach everyday. However, the girls all commented on the constant absence of the teacher, *"our teacher not here, our teacher needs to come to come teach us"* (SV8).

Families will often tell survivors *"this is a family matter, you don't have to tell anybody"* (NGO3). NGO3 reiterated a case where a 9-year-old girl visited her older teenage sister and the man who her mother had given her to,

> *When the girl come there, the man raped the girl. So when we try to intervene on the case, they said it was nothing…they force the child to say nothing happen…because she felt that, the boyfriend of her elder daughter, was supporting her family so even if he did that…*

they had to accept it. Save retold a similar account of a family withholding the rape of a 12-year-old girl because the brother of her stepfather was the perpetrator. *"He got this child pregnant at one point. Kept it secret. Went for abortion. That was covered by the family"*. Two years later, it happened again. The girl is again pregnant but this time reported it to the police. Her mother was furious. She felt that because of the perpetrator's **relationship**, her relationship with her husband who was also the primary income for the family would be destroyed. NGO3 reiterated a case where a principle was sodomising boys. One of the boy's mother's repeatedly beat him because he refused to go to school. They finally asked him why he did not want to go to school and he said, *"when I go to school, they [sic] teacher take me in the back room, take off my trousers and put his penis in my butt"*. Other boys repeated similar accounts. While the medical doctor proved them true, the principle was not prosecuted. The participant believed he was still teaching (NGO3).

CHAPTER 5: DISCUSSION

Findings suggest that as a whole the formal and informal approaches dealing with SGBV in Liberia appear fragmented and incomprehensive. There is little true collaboration or syncretisation between actors including INGOs, NGOs, networks, the government and the traditional communities. This is despite how these formal and informal structures deeply influence and interact with each other. Some studies (Kruk et al., 2011, Pajibo, 2008) found that informal traditional medical and judicial techniques are used as complementary methods, or in absence of formal structures in Liberia. However, this study revealed that in specific reference to SGBV the structure pursued is often the one that proves more beneficial to the perpetrator rather than the survivor.

The following discussion will isolate **three** key areas that bear a pervasive influence on SGBV in Liberia. These areas significantly influence the response to and prevention of SGBV in both the informal and formal approaches and consequently syncretisation. The **first section** will discuss some **underlying causes** (internal determinants). The **second section** will discuss some **contributing factors** (external determinants). This will shed light on how internal and external clashes in social norms, belief systems and thus management approaches have a pivotal impact on managing SGBV in Liberia. The **third section** will discuss several rather unsuccessful attempts at **syncretisation** in reference to the politics and implications of humanitarian and supply driven aid and perhaps why syncretisation has yet to occur. The findings will be interpreted in the context of existing literature.

5.1 Underlying causes: *Internal determinants, Reddy, 2014*

Figure #2: Internal determinants that influence prevalence, management and outcome of SGBV

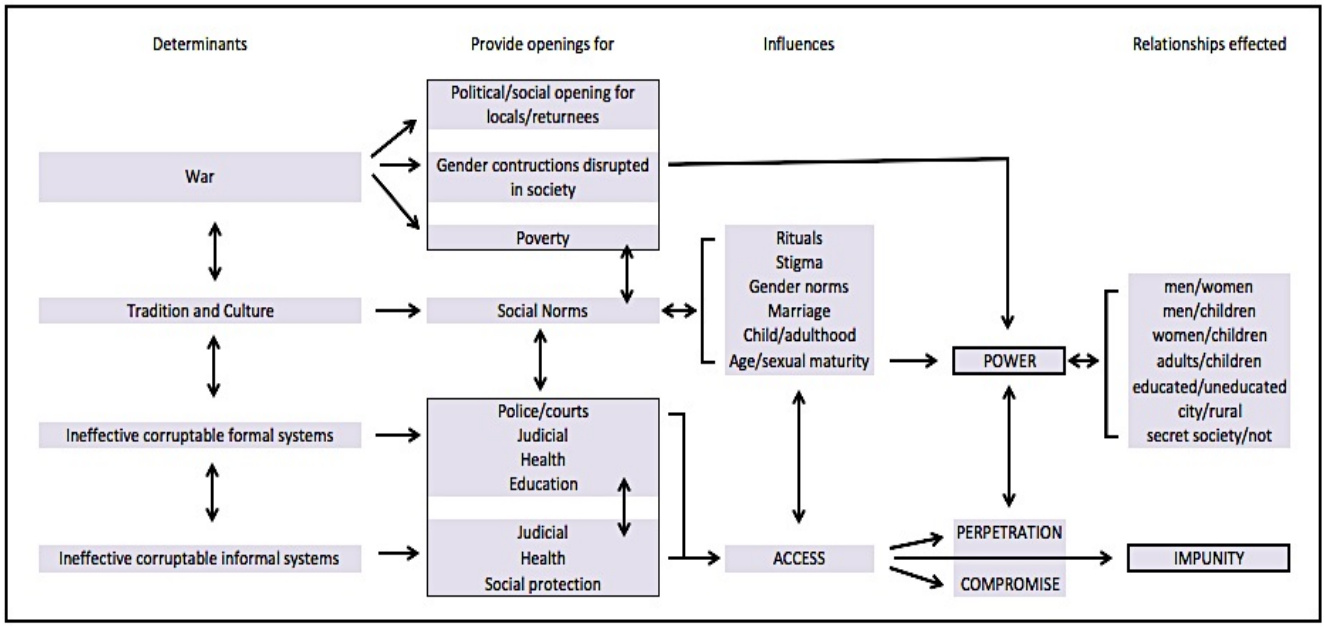


Figure #2 is based on an overview of the findings. It looks at four internal determinants that were highlighted by participants, including war, tradition and culture, ineffective formal systems and ineffective informal systems. It summarizes how and in what form each factor eventually influences SGBV. It thus provides areas of important focus emphasised by the participants, which GOL and the international community can consider when implementing programmes. Figure #2 fundamentally aims to shed light on the key role **power and impunity** play and how the **societal, community, relationship and individual** levels interact within the ecosystem. Social norms may be based in history but they are not rooted to any particular time point. As a point of reference, I chose to briefly start at the arrival of the Americo-Liberians as the 'creation of Liberia' played a pivotal role in creating and influencing this ecosystem. While it cannot be isolated, for the purpose of analysis, main reference will be taken from the end of the war. Notably, the internal determinants are intricately interlinked and overlap with the external determinants (figure #2/figure #5). Thus, as aforementioned, defining determinants as simply internal/underlying or external/contributing factors is a far more complex process, especially in regards to the formal systems. However, for the purpose of this study, and for analytical reasons, figure #2/figure #5 have been drawn up as such. These internal determinants will be further discussed below.

5.1.1 The influence of war

Liberian society was exposed to an acute culture of violence during the 14-year civil war. The turmoil and anarchy of the conflict and its remnants persistently influenced the daily lives of Liberians, which was referred to by every participant. Unease, animosity and psychosocial deterrence to interact with other tribes continued to be widespread, especially in Landsby (NGO3). Most participants noted that while formal medical and judicial structures were mostly limited to Montserrado County, structures were completely devastated due to the war. They commented on how the traditional systems and values were also shattered by a war-fuelled culture of violence. Correspondingly, in a 1998 West African post-conflict workshop, *"women from Liberia said 'if only those [traditional] structures had survived, we could use them to our advantage, but they have been destroyed"* (Himonga, 2008:81). Other accounts from West Africa, including Sierra Leone supported this, with women reporting similar stories about the neighbouring war and their traditional structures (Ibid.).

Participants provided varied responses about the presence or absence of SGBV pre-war. This perhaps reflected how the war exacerbated an already present but underlying issue, but also how the presence of the international community, the TRC, education and sensitisation significantly influenced the understanding and thus reporting of SGBV, where before it was

not considered a crime (page#76). Nevertheless, as cited by several participants the lawlessness the conflict generated and the absence of formal and informal conviction for sex crimes reinforced SGBV as an unpunishable act. Liebling-Kalifani et al. (2011) study substantiates this idea by discussing the persisting 'culture of violence' witnessed during the Liberian conflict, where violence was indoctrinated and provided moral corruption. Consequently, Liberian societies were subject to the *"militarization of intimate relations"* that has left an enduring legacy (Liebling-Kalifani et al., 2011:196). As Enloe (2000:281) explains, militarisation is the *"step-by-step process by which something becomes controlled by, dependent on, or derives its value from the military as an institution or militaristic criteria"*. Military values or ideologies can establish patterns of behaviours, values and hierarchy (norms) when embedded into society like during the Liberian conflict, thus impacting how society operates post-conflict (Enloe, 2000). Correlatively, another study in South Africa by Moffett (2006:129) argues that, *"contemporary sexual violence in South Africa is fuelled by justificatory narratives that are rooted in apartheid practices that legitimated violence by the dominant group against the disempowered…"* Evidently, Liberian post-conflict systems and mismanagement are incompetent in managing SGBV as of yet. Since rebuilding society and social norm change (prevention) take considerable time, SGBV crimes continue to be widespread. Justifiably, the need to incorporate additional and alternative mechanisms in curtailing SGBV is conceivable.

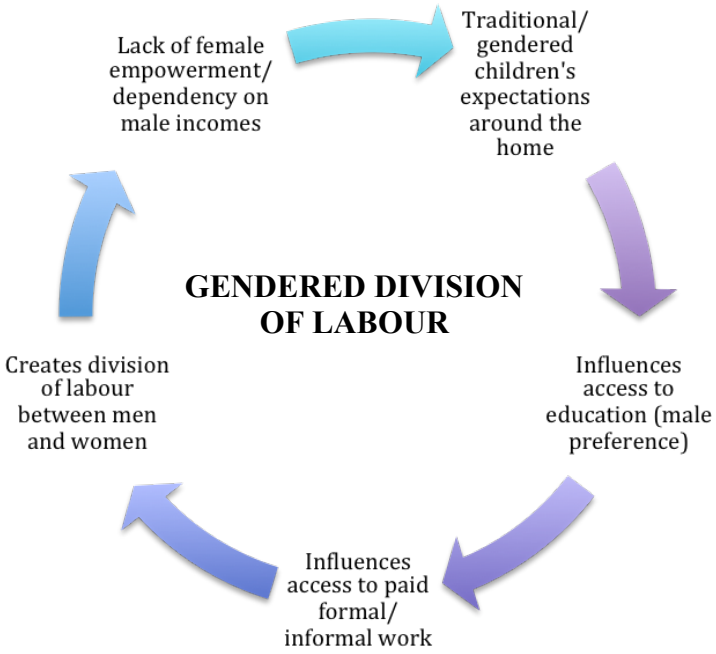
5.1.2 Power and gender relations

'Power' touches every aspect of the Liberian society and plays a critical function in the incidence and management of SGBV. Participants highlighted various power dynamics that overlap and interact on several different levels; from who does and does not have it and who can and cannot manipulate it to their advantage. Relevantly, Connell's (1987) overlapping tripartite Theory of Gender and Power provides a lens to discuss how gendered power interacts and re-imposes itself on the societal and institutional levels. This effectively influences the prevalence of SGBV as well as the management of it.

The **sexual division of labour** defines the economic inequality between women/girls and men/boys. Reflected in the results, gendered and traditionally grounded work prevails, particularly in Landsby. Gendered orthodox work is not isolated to Liberia, but is found elsewhere in Africa as Manzini (1997) features similar accounts about Zimbabwe. Consequently however, some participants indicated that while it is improving, access to education between boys and girls is imbalanced (figure #3). Subsequently, this suggests that future paid in/formal employment is influenced which in turn impacts levels of poverty and

access to other social, economic, health and political provisions. A **dependency** on male incomes is nurtured which **enforces** power dominant relations and notions of the empowered (men) and the powerless (women), influencing gender relations and thus SGBV. Evidently, this power dynamic extended into Liberian and INGO working environments, as observed and discussed by some organisations. It encouraged sex for employment/promotion, particularly between men in authority and women seeking employment/promotion. While this phenomenon is not in the least limited to Liberia or the global south, statistics are deficient as incidents are rarely reported. Yet, in 2011, 11,364 sexual harassment complaints were reported to the US Equal Employment Opportunity Commission, where women filed 83.7% of the reports (USA. Gov, 2014). A study commissioned on workplace sexual harassment by UK law firm Slater & Gordon Lawyers (2013), found that out of 1036 working women, six in ten had been sexually harassed.

Figure #3, *Reddy, 2014*



Despite two Nobel Peace Prize Laureates, including a female president, and more women holding GOL positions, at the community and household level, participants felt that women's status and economic power remained relatively unchanged. They felt many men exploited this. Resultantly, a number of I/NGOs focused on microfinance and economic empowerment initiatives for women and girls. While powerful men may help other men as cited by one male participant, several Liberian women, including female GOL ministers and members of the Association of Female Lawyers of Liberia argued that this was not the case for women, shedding light on the power dynamics between Liberian women (Kvinna till Kvinna, 2013). Tripp (2013) reflects on the substance of women's legislative representation in post-conflict African countries, namely Uganda, Liberia, Congo and Angola. While quotas and laws are an apt stimulus and provide a more level playing field to avoid women becoming socialised in male dominant environments, real **long-term social change** is necessary. Moreover, national level changes to policy and legislation do not always make changes at the local level, as observed. Connell (1987) references this, in that social norms and structures at the societal

level remain unchanged for extended periods of time, whereas, institutional level changes occur more quickly. Moreover, as illustrated in Landsby, the male domination in SGBV services like clinics and WACPS influence survivors' comfort in seeking help. This impacts the outcome of cases especially if men are in positions to help other men. Replacing all male staff that directly deals with survivors is unfeasible, especially considering the reluctance and manner of female staff as indicated by INGO1. Yet, providing access to qualified, professionally and socially supported female staff may have positive effects. This is an avenue the international community could pursue with more rigour, especially considering MDG 3 *"to promote gender equality and empower women"* (UN, 2013:18).

Connell's (1987) **sexual division of power** emphasises male power and dominance over women in relationships and society. This pervasive unbalanced power dynamic at the **societal** level is seemingly supported and exploited at the **institutional** level. Participants provided different reasons for why rape was perpetrated (i.e. ritual, drink, dress). Overall, seemingly the most dominant line of thought was that rape was **not** about sex. Rather that it was about **power**. Suggestively, here, rape is used as a weapon, as commonly described about wartime SV (Turshen, 2001, Enloe, 2000, Nordstrom, 2004, Meger, 2011), where the act of making an individual submit to your will is the objective. If rape is a weapon, then someone has to be accountable, and someone also has to be the perpetrator and the victim (Baaz & Stern, 2013). Yet, this line of thought is questionable in Liberia. As indicted, rape on one hand is specifically used as part of a ritual to **attain power**. Yet, on the other hand, it is seemingly just about attaining sex where individuals use their perceived 'power' and status to overpower and make another individual, usually a woman or child submit to their will to gain sex. This perception of power and status may be tied up in traditional Liberian beliefs that have typically bestowed power onto men as aforementioned. Yet, the Liberian conflict also significantly influenced how perpetrators accessed individuals, especially in the absence of protection mechanisms.

Women's rights awareness, protective laws, education and involvement in local community initiatives have increased in Liberia, especially in Monrovia (GOL/UN JP, 2011). However, while women's ideas about human rights and SGBV may have shifted, men especially challenge the platforms they speak from as referred to by some participants (page#52). However, challenges for improvement stem from both males and females. For instance, the Head Zoe conclusively stated that she strongly supported and engaged in women's rights and empowerment. Yet, she also stated that women did not know and did not want to know about 'men's business' and vice versa (Head Zoe; MOHSW; page#52). If the secret societies are unwilling to collaborate, yet are advocating different stances on domestic abuse and SGBV,

contention is inherent. Moreover, this distinction provides a space for conflict with the international community advocating for human rights, female empowerment and children's rights that focus on women and children. This emphasises the need for organisations to continue and also begin engaging with men.

The third level of division is the **structure of cathexis**. It looks at the affective emotional attachment in relationships and the social norms dictating them. More specifically, it references women's appropriately considered **sexual behaviour** and sexual attachment to men. This may be bonded to the aforementioned traditional expectations of men, women, and marriage. These values limit and shape experience and thus influence how women and men express themselves. The Head Zoe and other participants expressed how the Poro (men) were far more powerful than the Sande (women). This was echoed by some young women, some who seldom questioned this norm (page#52). Perhaps this was one derivative of inferred ownership regarding bride price and early marriage. Firstly, the authority of a much older husband is unquestionably more easily enforceable on a child bride, where objectification and imposed monetary value may have psychosocial influences. As UNICEF (2001:2) warns, *"For both girls and boys, early marriage has profound physical, intellectual, psychological and emotional impacts, cutting off educational opportunities and chances of personal growth"*. Secondly, a man stating that he wants a girl 'for sex' provides transparent intentions (page#53). While parents may agree to this, there is no room for the girl to then refuse sex. Nor the idea that you can rape your wife because you paid for her, thus making her your property as some participants stressed. As a result, if a woman acted inappropriately based on a man's perception, men saw no issue in beating them (INGO1). This sense of entitlement over women who are deemed as personal property has severe implications as to how I/NGOs should go about discussing this with men and women. As referred (page#53) older men may superficially participate in programmes, with no intention of trying to understand or change behaviours towards beating women, perhaps as a result of the manner the programme approaches them. This emphasises the need to simultaneously engage with men and women on SGBV.

Sande society's process of initiation and subsequent marriage, involving FGC and the sexual and cultural norms associated with it seem appropriate here. Explanations for why FGC was performed varied. ***If*** its primary purpose was to protect girls' value in curbing ***their*** sexual desire so that *"**they** will not be promiscuous*," (NGO3) this fundamentally evokes notions of responsibility, in/appropriate and im/moral behaviour and ultimately the right to blame. SGBV thus **becomes** *"women's business"*. This simultaneously objectifies females and elevates male sexual pleasure, influencing sexual and emotional relationship expectations. Again, the

responsibility of self-protection and then blame is assigned to female survivors. As two GOL male employees and SV3 stressed, men had absolutely no control over their sexual urges past a certain point. This commonly led to rape when combined with the effects of short skirts, alcohol, drugs and women 'playing around men'. Interestingly, if short skirts and girls' behaviours resulted in them being raped then why were men and boys also being raped? Most participants could not provide any reasons for this, bar for sheer 'wickedness'. Yet, a few noted that gender did not matter, thus refuting the effects of how an individual dressed or behaved, suggesting a greater need to focus on perpetrator behaviour and awareness. Correlatively, a HRW (2001:27) book quoting one South African, Gauteng study by Andersson et al (1999) found that, *"eight in ten young men believed women were **responsible** for causing sexual violence and three in ten thought women who were raped **"asked for it"**. Two in ten thought women **enjoyed** being raped"*. This validates a shift of focus from *"women's business",* not merely to 'men's business' but the need to see it as 'community business'.

5.1.3 Perpetrators and impunity: a sense of immunity

Impunity has a fixed and underlying existence in Liberia. It influences the prevalence and type of medical and judicial care sought for SGBV. Impunity and corruption were not limited to SGBV but affected the entire fabric of society, and was referred to by almost all the participants (page#65). Corrupted in/formal systems provided favourable environments for individuals to **compromise** the protection of children and the outcome of SGBV cases. While endeavours like the forensic laboratory test (page#76) is a step forward, it does merely detect the presence or absence of semen. Combined with all the underlying factors and avenues to compromise cases, the concern is that defendants can simply argue the semen does not belong to them, or alternatively destroy the evidence. Mechanisms like the referral pathway system have been successful in providing one uniform countrywide system. Yet, as cited by some participants, by following it they were **knowingly** sending survivors to structures and professionals who were unable to cater to their needs, and who could also compromise the case if bribed. Moreover, the referral system was redundant in some places where formal structures were absent. This was mostly outside the hub of Montserrado County, where traditional beliefs and approaches were strong.

While corruption is a worldwide problem, Liberia's ineffective formal and informal systems are rife with fraud. Transparency International's (2013) annual Corruption Perception Index scores 177 countries and territories from 0 (highly corrupt) to 100 (very clean). No country has ever scored 100. Denmark and New Zealand equally rank at number 1 with a score of 91. Somalia and North Korea rank at 176 and 177 with a score of 8. In 2012, Liberia scored 41 out

of 100 and ranked 76. In 2013, they scored 38 out of 100, and ranked 83, indicating deterioration. Nepotism and 'compromising' was commonly cited and seemingly widespread and expected. Yet, internal corruption can be fuelled and exacerbated by symbolic north-south partnership mechanisms tied up in money. This can lead to exploitation and 'fudging' of information, where positive outcomes are exaggerated and negative ones are downplayed (i.e. downplaying the incidence of FGC) (Corbin et al., 2011). Moreover, if cabinet ministers are members of the secret societies, which was often pointed out, the challenges for expecting actual change is inherent, ***if*** their interests and beliefs primarily lie with the traditional communities.

Participants' comments on the presence of acute social stigmatization, weak legal, investigative, health and logistical resources and the perception and reality of police corruption that frequently led survivors and their families to withhold reporting crimes due to the perceived outcome of cases, were supported by findings in other studies (Tayler-Smith et al., 2012, de Carvalho & Schia, 2009, UNMIL, 2008b). The stigmatisation of rape is a ubiquitous problem even in developed states like Norway. As shown in a recent survey conducted by the Norwegian National Centre for Violence and Traumatic Stress Studies of 2435 women and 2092 men, found that 9.4% of women and 1.1% of men had reported being raped in Norway. 49% of the incidents had been committed to the survivors when they were children (under 18). Yet, few (11%) had reported it to a **comparatively effective** functioning system. Correspondingly, the report stated that perpetrators were often acquaintances (Thoresen & Hjemdal, 2014, The Local, 2014). Liberian survivors are confronted with this stigma, but also lack the confidence in the ability of the formal services established to protect and care for them. Reports go unheard, are ignored or are dismissed, while perpetrators boldly commit crimes on the perception and reality that they can get away with them.

Resilience: navigation and agency

Resilience is a positive strength based approach. It engages with an active and enduring process and is used by individuals overcoming severe traumatic or vulnerable events. (Kelly et al., 2011). According to Kelly et al. (2011:72), *"women's responses to IPV [intimate partner violence] are active processes, requiring creativity, perseverance, and inner strength".* These assumptions can be applied to instances of children and SGBV in Liberia. Boyden & Mann (2005:20) discuss how, "*resilience provides a useful metaphor for the empirical observation that some children, possibly the majority, are surprisingly able to adjust to or overcome situations of serious adversity".* Kelly et al. (2011:64) illustrate the importance of both ***"perceived and tangible"*** support (resources) within social ecologies that significantly

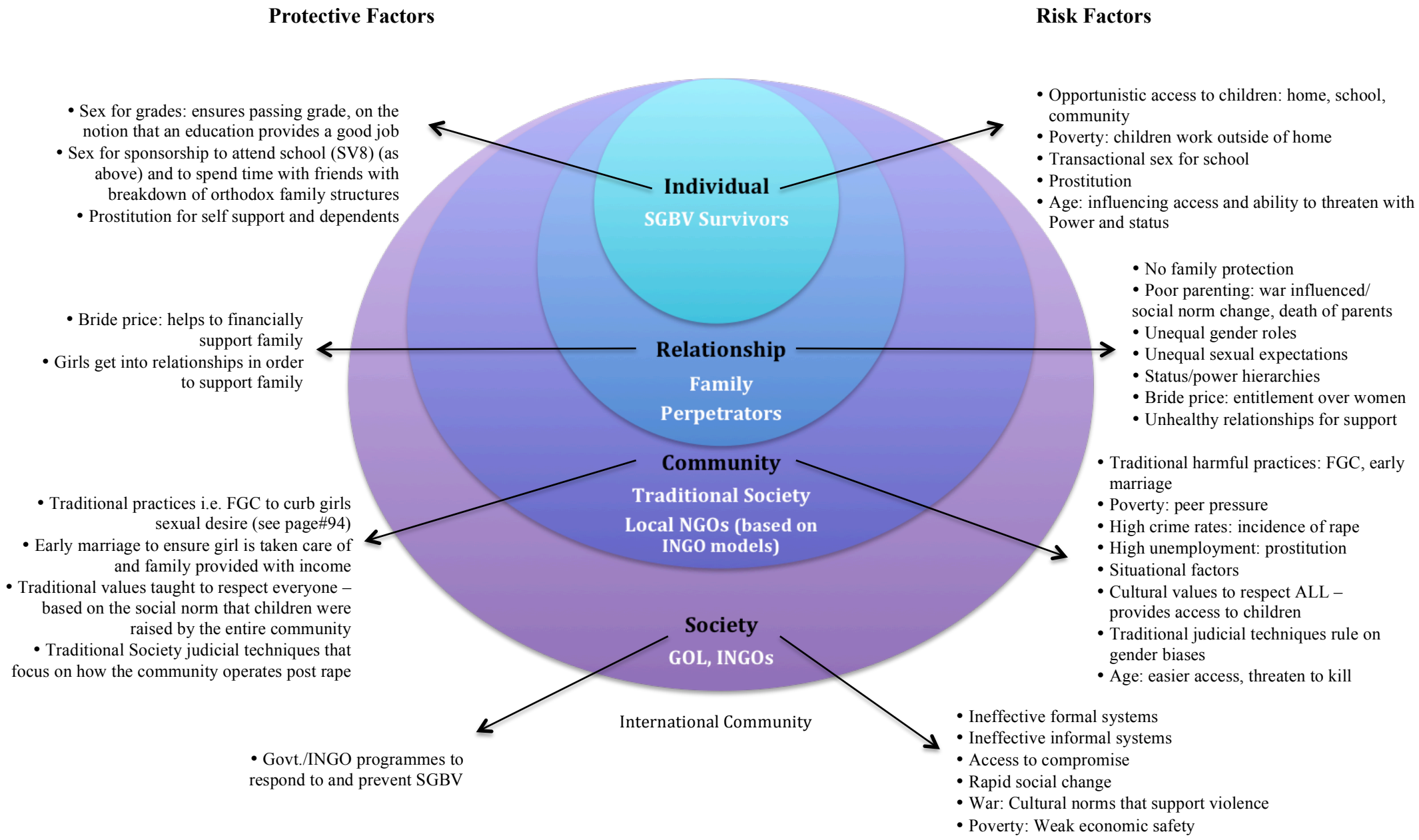
influence survivors' actions and responses to abuse and adversity. Ungar (2011), argues that a shift from understanding resilience from a purely individual level to a **social ecology** is needed, indicating the importance of the ecological model. Children's social ecologies and factors of age, status, relationships, access and level of power influenced the level of agency they had in determining in/formal care or the choice to attend *bush school*, as noted by some participants. The aforementioned perceived and tangible support is largely lacking in the Liberian context, which provides many **risk factors** (figure #4 (page#99)) for children in their social environments. However, there are also several unorthodox **protective factors** (figure #4), depending largely on ones perspective, which shed light on how children are resilient. The actors who provide this perceived and tangible support are highlighted in figure #4. Each actor fits and interacts with all the other levels in the ecosystem, but ultimately bears an influence on the individual as the centre.

Nsamenang (2004) argues that in the African setting, the family is the most important 'social security system,' especially when the state provides no protection. The destruction of this protective Liberian family and community unit has been referred to, along with many of the other **risk factors** like early marriage, FGC, poverty, the influences of war and the ineffective in/formal structures. Yet, the child participants in this study were seemingly exceptionally resilient. While a western perspective may reject many of the points listed in the protective factor column in figure #4 as human rights violations, in a sense they are very much protective mechanisms. It can be difficult to differentiate between survival and protection from risk in different cultural contexts. For instance, participants recounted anecdotes of girls trying to get into relationships with older men in order for them to support her family. While participants were mostly negative about the impacts of early marriage, another Liberian based study found that the practice was conducted in order to **protect** girls from *"unwanted sexual exposure,"* alleviate family financial trouble (poverty) and show loyalty to 'big men' who could financially support the girl's family and family honour (Abrahams, 2011:28). Moreover, several participants referred to the contention between age and sexual maturity. The aforementioned study also noted that by marrying a girl off when she hit puberty or when her *"breasts are not hard"* supposedly avoided unwanted sexual attention that may have led to unwanted pregnancy (Ibid.), possibly on the understanding that the girl would be the responsibility of the husband and then be protected from shaming herself and her family. This practice occurs elsewhere in Africa, like Zimbabwe, where lost virginity before marriage results in lower *Labola* (bride price) (Manzini, 1997).

All the interviewed survivors preferred to seek formal health and judicial providers for SGBV (see section 5.4). While most survivors wished their perpetrators were convicted, the majority were aware of the most likely outcome. Thus, their resilience to cope involved forgetting about the incident(s) and as they all stated focusing on attending school with their friends. Moreover, some of the survivors and other participants indicated that even in formal care, they were **told** to forget about the rape. This diverges from an orthodox Western approach of psychosocial counselling and talking through the incident, thus acting as both a protective and risk factor, and a contention for syncretisation. The girls themselves highlighted more of these unorthodox protection mechanisms, as SV1 indicated when asked about girls in her community, *"they **protect** theirself! [sic]...By going out, going to the clubs, yeah on the streets. Yesss [sic]"*. When questioned if anyone forced them to have sex, she responded *"nobody"*. This could mean that 'by going out' and actively engaging in prostitution they were protecting themselves by earning an income. Thus, this could act as a protection mechanism against poverty (and 'balance' unequal access to education page#91) in not having to rely on anyone else (power relations), and provide financial security to families or act as a method of attaining desired material goods (page#67). When asked about problems in her community, SV8 responded that, *"**I was not facing problem, I was being raped**"*. On one level (risk factor), as a child, she was being manipulated and exploited and exposed to on-going rape. On another, she pursued a path in which she achieved her desire to attend school. Suggestively, this indicates that she perceived not attending school as more of a problem. Expressing the absence of existing safe guarding Liberian mechanisms and spheres of agency that protected children would be offensive to the complex systems operated by the indigenous and Americo-Liberian communities. Expressing that these mechanisms and structures are based on very different social standards and beliefs, compared to the ones being advocated for by the international community is however significant. This emphasises the importance of considering these factors when aiming to manage SGBV when different understandings in knowledge and practice are present and contradicting.

Despite this contention, the international community have the opportunity to work within these **grey spaces or areas for negotiation**. For instance, indicating that children do have rights but also responsibilities, was highly important to several participants. While child labour like street selling may be pushed as a rights issue, as one participant highlighted it is also teaching children practical skills, which influences livelihoods and whole families.

Figure #4: Ecological model: actor location and protective and risk factors influencing SGBV, *Reddy, 2014*



Notably, there are several critiques of resilience (Boyden & Mann, 2005). Its terminology is vague and limited. It assumes a 'normative' childhood that is derived from a particular place and culture (global north/Western). Its scholarship and interpretation defines **who** determines how children are coping with adversity in different cultures and notions of self (Ibid.), highlighting how the aforementioned unorthodox protection factors could be missed. Ungar (2011) argues that resilience is a socially constructed culturally laden concept. This study engaged with child survivors to broaden and include how children perceived **they** dealt with adversity, rather than having a merely adult analysis (Boyden & Mann, 2005). The following statistics provide another view in numbers of the situation in Liberia. Prevalence of FGC was 65.7% between 2002-2012. Child marriage under 15 years, between 2002-2012 was recorded at 10.8%. Statistics did not indicate whether these results demarcated only girls under 15 years or both boys and girls under 15. Child marriage under 18 years, between 2002-2012 was 37.9% (UNICEF, 2013). Convincingly, the adversities children face makes an appealing call for a child-centred approach. However, as will be highlighted through the children's rights laws, this would most likely prove unfeasible. SGBV is a whole community problem and crosses all **social ecologies**. Programmes and discourse would benefit from being tailored accordingly. Yet, there seemingly does need to be more focus on child/adolescent protection and children's social ecologies, despite the seeming reluctance of some participants to confine these parameters.

5.2 Contributing factors: *External determinants. The clashes*, *Reddy, 2014*

Figure #5: External determinants that influence prevalence, management and outcome of SGBV

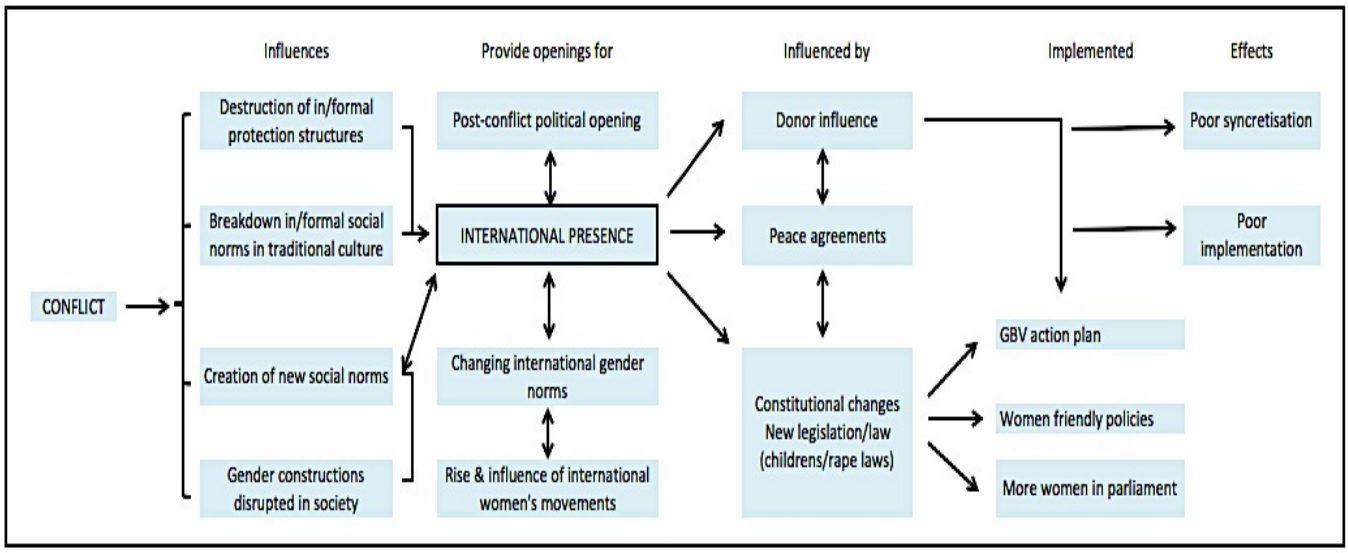


Figure #5 sheds light on some of the external determinants, particularly influenced by the conflict. Significantly, post-conflict allowed a political and social opening for the **international community** to enter Liberia. It provided a space for **gender discussion** as

traditional gender constructions were disrupted. This allowed the introduction of new legislation and new social norms. This provides a location in which to explore how external determinants (western approach) influenced internal determinants (traditional approach) and how they become more salient on the binary, especially when they are contradictorily juxtaposed.

5.2.1 Education and its effects

All the participants referred to the importance of education. The formal institution of education is not a new social standard in Liberia, essentially due to the Americo-Liberians. Higher education was introduced as early as 1851. Yet, the continued disparity of access to such institutions between Americo-Liberians and indigenous peoples cannot be ignored. Formal education was entirely disrupted due to the war as specified by some participants. As a result children rights to education were lost, of which the influences are indicative of the statistics. Literacy rates for males 15-24 years between 2008-2012 were 63.5%. Literacy rates for females 15-24 years between 2008-2012 were 37.2% (UNICEF, 2013). Moreover, according to some participants, the long absence of formal education bore an influence on how parents and older guardians like grandparents treated and disciplined their children, largely due to war-induced psychological impacts and the breakdown of society and family structures, particularly in Landsby. Participants commented on the lack of role model behaviours parents who openly engaged in 'dangerous' social or unfitting behaviour. While children may be more susceptible to adopt these behaviours especially as they get older, as the Head Zoe referred to SV during conflict, effectively disciplining children also becomes a difficult task when family and community structures are damaged (page#56). Moreover, many children, like SV3 were orphaned or were abandoned at young ages, completely losing any sort of protective family structure. This has wider implications for society who no longer see raising and thus also disciplining children as a community task as referred (page#68), possibly as a result of the war and/or changing social and cultural norms. The responsibility to discipline children is thus seemingly and unfairly mostly placed on teachers and the education system. If unqualified teachers are being relied on to discipline classes that range in age from 14-26 years, with little government or parental support, the weak education system in not unexpected. Nor is it unexpected that it provides an environment for SGBV and **sex for grades** to occur especially when parents struggle with poverty and meeting the cost of schooling. Although compulsory primary education is supposedly free in Liberia (MOGD, 2011) students noted that school fees were commonly charged due to a lack of funding and basic supplies.

Interestingly, this high prevalence of sex for grades is contradicting. The importance and desire for education was widely referred, theoretically on the basis that an education provides a (good) job. Yet, in reality, the education that students are receiving is failing to qualify them for employment, as observed and pointed out by community members. As Nsamenang (2004) argues the formal education systems in Africa cater to **Western economies.** Thus, these structures are inappropriate for students who need to fill largely agrarian economies, and essentially set them up for failure. He comments on how in Liberia youth still see education as the *"golden key"* to their future (Fricke, 1979 as cited in Nsamenang, 2004:99). While the survivors in this study reiterated this response, it was refuted by a number of teachers and community members. Yet, society continues to place significant importance on attaining good or passing grades, resulting in girls trading sex (for what ever reason page#56) or teachers exploiting this social norm. This social norm also contradicts the often cited, 'it is who you know' that gets you a job in Liberia (page#75). Other studies conducted elsewhere in Africa confirm these findings as a HRW (2001) report indicated that teachers in South Africa used their authority to intimidate their students into sexual relations. Moreover, the children were frightened of reporting sex crimes due to the negative repercussions from their teachers.

According to two GOL ministers as a result of the conflict, Liberia also lost the majority of its educated population contributing to the state's slow redevelopment. This, in combination with the current education system is evidently completely insufficient and unable to produce the necessary qualified individuals for re/development for either a Western or Liberian economy. While the education system may be completely wrong for the context, there is hardly any investment being made in education. Liberia's budget for 2013/2014 is US $553.3million, of which US$222.5m (41%) was assigned to *"public administration, municipal government and 'transparency and accountability'"* (Outram, 2013:707). 15% was allocated to rule of law, 14% (79.5m) to education and 11% (60.8m) to health. It seems pertinent that the UN, INGOs and donors establish **measurable investment standards**. Education for All (EFA) goals states that the minimum countries should spend on education is 15-20% (EFA, 2014). In 2011, Liberia spent 3% on education (Outram, 2013). Moreover, the average Liberian teacher wage varied between sources but ranged somewhere between US$100-500 per month depending on the level of teacher education (Education International, 2011, Butty, 2012). As the results reflected, the quality of the majority of teachers is questionable largely due to the training. Typically though, new graduates were in the lower income bracket, which accordingly was not sufficient to survive on. Investing in rural areas and providing incentives to teaching graduates like a living wage and free housing, is a plausible space for negotiation. Elsewhere, like in south east Asia, the Malaysian government implements a teaching bonded scholarship (VUW,

2013). This covers university fees and living expenses for student teachers. In return, they are paid but are bonded to work as teachers for the government for a period of time after graduating, mostly in rural areas. The implications for GOL and the international community failing to fully invest in education and teacher training are clear; where at the end of they day, Liberian children become the losers.

5.2.2 Understanding the children's law and the rape law

Childs rights do not always improve the lives or agency of children. The presence of the international community significantly swelled as a consequence of the war. Along with the assumed responsibilities of these actors, different social norms, programmes and Western idea(l)s most notably concerning human and children's rights were introduced. Liberia's Children's Law continues to provoke disharmony as referred to by several participants. Clearly, Liberians and the international community define children and childhood differently. One defines it by biological age. The other determines childhood/adulthood to be contingent of a number of factors, which does not necessarily relate to age, but sexual maturity. The Children's Law is based on biological age and largely contradicts customary and Liberian culture, as cited by several participants. This is a major challenge for implementation and syncretisation. The inconsistency **within** Liberian communities on the definition provides a further level of confusion. Himonga (2008) notes the central role that customary law plays on children's lives in Africa. Recognising customary and cultural rights is therefore often necessary in implementing children's rights in Africa. MOHSW stated that the large uneducated population felt that, "*you have gone to the Western world…most of them feel…the white man want to change us, they want to turn our kids against us,"* (page#51) illustrating the need for syncretisation, but perhaps also the **poor implementation** of education and awareness thus far. In Liberia, participants concern was that actors were educating children on **rights and not responsibilities**. Perhaps education needs to begin with the parents first to avoid this contention. Contrary to an accepted Western approach, NGO2 explained how her organisation successfully imparted the understanding of child rights to men, based on a monetary value. The NGO would explain that if they beat the child, they then had to spend money to take them to the hospital. Whereas, she explained if they talked to the child they would not have to spend that money. While placing a monetary value on a person in this sense could be affiliated with notions similar to bride price it also provides **direct results**, until long-term change can occur. Yet, this also navigates around the harmful practice making initiatives tricky and emphasising the complexity of the situation.

Hilhorst & Jansen (2010) question the impacts of rights education, particularly for those confined to refugee camps. They argue that one unintended consequence involves *"creating a permanent sense of dissatisfaction"* among the beneficiaries (Hilhorst & Jansen, 2010:1136). Similarly, children in Liberia are being taught they have rights but are being condemned by cultural norms in the way that it is being played out, which is causing contention. Moreover, international legislation can often ignore the importance of children's incomes to their families (figure #4). Nsamenang (2004:52) argues that an African education that involves participation legitimates that a child should work, as they are being taught important skills for their future. Yet, the CRC sees it as child labour and condemns participatory approaches (Imoh & Ame, 2012). Imoh & Ame (2012) reference a Bangladesh case where child labour under 15 was banned. This did not result in more children attending school but rather resulted in them turning to prostitution. Alternatively, according to Imoh & Ame (2012:7) the ACRWC considers *"the cultural heritage of the continent"*. It provides a higher level of acceptance, particularly in regard to child participation. Moreover, the ACRWC *"prides itself on its African perspective on rights"* (Lloyd, 2008:182). Yet Lloyd (2008) criticises the substance of this on the basis that it was created as a merely complementary legislation to the CRC so the UN could enhance child rights in Africa, by any means. In any case, when a rule criminalises a culture or practice, especially without social norm change and education, local communities often reject the rule and use their agency to navigate the systems to fit the culture (page#94) (Imoh & Ame, 2012).

The definition of a child subsequently has a bearing on who and what constitutes rape and thus the implementation, acceptance and use of formal structures. A challenge child advocates commonly met with was the invisibility of child violence and child protection policy, especially in West Africa due to the dearth of knowledge on the topic, which was supported by participants (UNICEF, 2009; Save). The unclear and misinterpreted definition of rape and rape laws that were referred to in the findings caused more controversy. Most participants reflected on that the general community perception was that the rape laws were too harsh, with many believing that it entailed life imprison. This led to families wanting to resolve it between the families and not through formal channels most often at the expense of the survivor's care (page#55). Evidently there was contention between the male and female participants about why rape occurred and who was to blame (dress code/sexual desire). In reference and a further complication, was the practice by some women and girls who did try to trick men into having sex with them after which they would claim to have been raped (page#54). Other studies based in Liberia, emphasised the problematic unclear understanding regarding the **terminology** used to describe SGBV on both a local and international level (Liebling-Kalifani et al., 2011, de

Carvalho & Schia, 2011). For example, Liberian law includes sections about minors, consenting minors and *"intercourse between 'underage' adolescents"* (Tayler-Smith et al., 2012:3). Perhaps this is an attempt to syncretise the in/formal child/adulthood contention. Yet, the inclusion of these two groups provides implications for psychological care in regards to un/consented rape among minors. While sexual intercourse may be consented, children may not understand what this means, and thus fail to seek the appropriate care.

5.2.3 The problem with normative identities

Mohanty's (1988:333) ground-breaking criticism of the production of the *"Third World Woman" as a singular monolithic subject,"* by some Western feminists, which *"discursively colonize[d]…the lives of women in the third world"* can effectively be extrapolated to the 'third world child'. Mohanty talks of feminists looking at gender issues through a 'colonization' lens. This creates and reinforces a relationship of domination (West) and suppression (other). It rejects repressive power imbalances. It randomly constructs an image of the *Third World Woman* who all share the same characteristics, needs and desires. This in turns fosters a binary between the reduced life of the uneducated, domestic, victimized and ignorant third world women and the educated, modern, self-represented and sexually empowered Western women (Mohanty, 1988, Brooks, 1997, Bryson, 2003). Similarly, this fundamental creation of a cohesive global sisterhood also helps to explain the creation of a **normative childhood** (Imoh & Ame, 2012). This creation fails to acknowledge the complexity and importance of inherent diversity in ethnic and class structures and cultural and historical contexts, which already exist (Imoh & Ame, 2012, Butler, 1990, Brooks, 1997, Bryson, 2003). Anything that differs from these moulds needs to be 'fixed'. In the process African childhoods become condemned and criminalised (Imoh & Ame, 2012). They are put up against a benchmark based on an exported Eurocentric concept of childhood, which largely dominates the discourse (Imoh & Ame, 2012). These normative ideas about women and children significantly influence the way governments and the international community react to gender and child issues (Imoh & Ame, 2012, Mohanty, 1988).

Squires (1999) highlights the danger of feminism identity politics. If this created collective *we* is being asserted by only a small advantaged group of women for the entire female sex (or on behalf of children) it considers all women/'subjects' in the same light. Fundamentally, the divide between **policy** written in the West, and the implementation on the ground is significant and will continue to hinder efforts. Nsamenang (2004) contends that research has typically left out African histories and systems, which may be more effective and contextually based. He argues that Eurocentric expertise has been *"ignorant of local wisdom and knowledge… Experts*

are compelled by institutional philosophies and norms that stifle rather than enhance innovation and creative improvisation" (Nsamenang, 2004:20). This same discourse has the ability to marginalise and oppress the status of practices like FGC (Mottin-Sylla & Palmieri, 2011, Nchogu, 2010). Seemingly, only one (Western) perspective that severely condemns the practice is played out on the international platform for debate (Wells, 2012, Boyle, 2002). This perspective of total eradication (Wells, 2012) is mainstreamed and vehemently used by international organisations, campaigns and debates, which periodically flare up (TheGuardian., 2014). Yet, genital cutting **has to be understood in light of the cultural logic behind it**. This helps to illustrate why abandonment is so difficult to even contemplate, as it is a process founded and tied up into notions of adulthood, respect and marriage in the Liberian Traditional Societies (Wells, 2012). Moreover, if *bush schools* are the primary incomes for Zoes as a MOGD (2011) report supports, limiting the process significantly influences Zoes livelihoods, fostering more secrecy around the process. Enloe (2000), argues for a 'feminist curiosity', which is the active questioning of what is perceived as 'natural' or 'normal' about being a woman or child. Beoku-Betts (2005) calls these gender myths *"justifying acts of rescue"*. She argues that perceiving women (and children) in a certain light, as oppressed and in need of saving has funding benefits. Moreover, gender myths regarding motherhood and the supposedly natural inclination to protect children has implications for SGBV in Liberia and thus for programmes. Four survivors stated, *"I live with my mother",* although they also lived with their father and siblings. While the survivors answers varied about who supported them the most, six survivors stated that they trusted their mother's the most. Evidently, some mothers 'betrayed' this expectation when siding with a husband or boyfriend who had raped their daughters, in fear of losing the relationship. This emphasises the importance of looking at gender as simply one characteristic, encompassed in a variety of intersectionalities within a social ecology that helps to define a person. So, while gender as a policy tool can be problematic because is can mean 'women', it can also be a good analytical tool.

5.3 Syncretisation? Unattainable or undesirable?[22]

Local NGOs and communities called for the international community to **empower** them with the tools they needed for sustainable development. Very little of this was directly happening. INGOs tended to focus more on improving the systems, like re-establishing the rape law and finding partners that were already competent in taking over programmes. Syncretising these two concerns seems pertinent.

[22] **N.B.** section 5.3 onwards is literature heavy. This is in the attempt to provide an analysis and possible explanations to objective #3 as to why syncretisation has not effectively occurred. While the section is based on broader findings, participants did not provide in depth descriptions to why their programmes did not fully engage with the traditional communities and thus draws on literature. Yet, this sheds light on how the structure of aid has contributed to this lack of syncretisation as well as in some cases why the formal systems are mostly ineffective.

Customary and GOL laws were not harmonised as stated by several participants. GOL was aware that customary laws were being used especially in the interior, but not to what extent. In order to help answer this question, one seemingly appropriate line of questioning includes asking, 'well, how effective are the formal systems in the interior?' In many of the interior locations, they were **redundant.** So while the official stance may be *"the government law supersedes"* (MOGD), Liberia seemingly embraces a dual judicial system which is supported by other studies (Pajibo, 2008). Yet, in reality this has not been openly accepted and provided the necessary room for discussion. Some participants reflected on how the customary processes are no longer given the respect they once held. A Liberian based study by Pajibo (2008) criticises IJS, and particularly the Liberian *Palava Hut* process calling it tainted and corrupted since the state intervened in the selection of traditional leaders in 1940, undermining and exploiting the system. The study also refers to IJS's lack of record keeping which hinders understanding to rationale past decisions. Moreover, as an oratory process, values and principles can get lost or manipulated by those in power (Pajibo, 2008). Participants commented on how chief elders and community men presiding over SGBV cases may judge incidents on pre-conceived unequal gender biases, to the detriment of the survivor (page#76) which was supported by another Liberian study (GOL/UN JP, 2011). Similarly, statutory rape laws may not be considered due to the disparity in understanding age (page#66) (Ibid.).

Most participants stated that there were good aspects to the traditional culture, but rarely provided details of what these consisted. Yet, there are several benefits of using and integrating IJS in Liberia, especially in Landsby. Persson (2012) discusses how informal power and wartime rebel networks have lingered on in Liberia. The government's inability to provide its citizens with formal security has remobilised these structures to provide personal security. Persson emphasises the need to thus go **beyond** formal structures and seek alternative mechanisms, especially with such distrust in formal institutions. She posits, *"the informal and formal security structures of Liberia must not be understood as each other's antithesis, but rather as an intertwined, interacting web of official and unofficial links, shaping Liberia's contemporary security context"* (Persson, 2012:102). Persson emphasises that the informality and access to these informal structures are what makes it appealing and effective. Moreover, IJS is present and often preferred due to the inadequacy of the formal systems. It is cost-effective, timely, accessible, and culturally and locally relevant and may be more accepted as a 'home-grown' structure (Flomoku & Reeves, 2012, Pajibo, 2008, GOL/UN JP, 2011, Abrahams, 2011). It also has the capacity to resolve disputes and SGBV cases. This is relevant while the formal centralised Liberian systems rebuild and remedies its on going infrastructural and governance problems, transport and staff restraints, communication, coordination and

widespread corruption problems, and works to syncretise traditional approaches (Flomoku & Reeves, 2012, GOL/UN JP, 2011). Moreover, IJS can provide an avenue to monitor corruption at a local level (Flomoku & Reeves, 2012). However, it **must be understood** in correlation to *"traditional beliefs, values and practices that legitimise and therefore, perpetuate violence against women"* (GOL/UN JP, 2011:51).

Medically, in Liberia, it is vital to ask 'what is considered illness?' Generally, the Liberian and contemporary Western concepts greatly differed. Liberian health involves levels of the natural and spiritual worlds, subsequently making merely a doctor's report insufficient as highlighted through several informal conversations and supported by a GOL/UN JP report (2011). Self-diagnosing was very common (page#84). It was aided by open access to prescription drugs in pharmacies often run by untrained pharmacists. Moreover, some doctors tell patients that it is not a hospital disease so they therefore cannot treat them (page#83). Findings from a Liberian study by Bryant-Davis et al. (2011:320) reinforces this idea by noting that that the *"avoidance of the spiritual is not only negligent but insufficient"* to healing survivors. Moreover, in neighbouring Sierra Leone Utas (2009) argues that the international organisations are driving Western trauma healing. These organisations are also stigmatising customary healing and cultural norms due to some harmful practices, pushing practices underground. Moreover, he posits that in reference to psychosocial healing, the majority of locals learn Western healing through community training and workshops, but with limited knowledge. Circumstantially, counselling is thus a vague and confused concept, as reflected in this study's results (Ibid.). However, some participants noted that some Liberian tribes did operate similar techniques of talking through problems (Landis, 2012). Pre-conflict traditional-based rape counselling may have been downplayed and advised as something to be forgotten about after payment or marriage to the perpetrator. Yet, post-conflict, SGBV counselling was specifically excluded from traditional healing largely as a result of formal awareness campaigns urging individuals to seek formal care and telling healers that it is not something they should deal with (MOGD). This is a **grey space** where collaboration between partners and the traditional communities could occur.

For Western trauma healing to make a difference, mass investment in education, structures and resources is needed (Utas, 2009). Findings indicate that this is unlikely to occur in the near future. de Carvalho & Schia (2011:136) point out how the UN has indicated the importance of customary mechanisms and has been for years working on and aiming to deal with *"harmful traditional practices"*. Nonetheless, they posit that governments are not interested in dealing with these harmful practices, which could be seen in Liberia. The widespread lack of

coherence and commitment will continue to significantly hinder syncretisation. Adamu (2013) argues that it would be difficult to integrate all traditional medicine. Yet, localising and syncretising some Western healing methods to the Liberian healing complex, which still has strong foundations, would seemingly have massive benefits. Villa-Vicencio (2009) makes the apposite point that it should be the **values and ideas inherent** in the traditional structures put forward and not the structures themselves. This would likely be culturally appealing.

Justice and the medical care of SGBV survivors' will always be compromised because of broader issues like ineffective judicial and health systems. de Carvalho & Schia (2011:136) argue *terra nullius* and the unwarranted response of the UN and INGOs in Liberia largely creating processes *anew*. The international community and UN fundamentally lack a comprehensive understanding of the how Liberians address related issues, and thus deal with single issues rather than whole problems (Ibid.). For instance, one of de Carvalho & Schia (2011:137) Liberian interviewees highlighted, *"GBV is the most overlooked problem of violence in Liberia…everyone looks at GBV at the expense of a holistic picture of the criminal justice system"*. Consequently, funding is channelled into projects aligned to *"donor perspective(s) rather than community needs"* (de Carvalho & Schia, 2009:2). This reflects issues like providing new techniques and equipment for WACPS, like motorbikes, but not fuel or effectively communicating to GOL that is their responsibility to provide this. There is **room and desire** for meaningful collaboration and discussion to revisit these traditional practices and reduce negative themes. Though, if it is not taken seriously, Liberians will continue to utilise and sustain patriarchal biased and accessible methods to treat SGBV at the expense of the survivors. Beneficiaries will superficially join donor-funded projects and 'agree' with expected outcomes merely to appease trainers (page#53). Arguably, while the state and INGOs can use tools like community participation as a control mechanism (Desai, 2008), participants also have the agency to influence the state or superficially participate and collaborate in order to attain goods and services they want. While change takes time, the aforementioned insincere acceptance of traditional licensing regulations, practices of FGC and regulations of *bush school* are some examples of this. A number of participants commented on the fact that many GOL ministers, including Tolbert, Doe and Taylor (Waugh, 2011) were in fact part of the secret societies and played key roles in the war. Expecting to implement foreign approaches with the aid of ministers who have interests and are part of the secret societies seems counter-productive. Moreover, with the ever-increasing fight for and need to **rationalise aid**, this questions the essential purpose of aid and the discourse justifying it. Essentially, if the stated concern of all actors, both Western, traditional and local is to heal and provide justice, then syncretisation of both systems should seemingly be prioritised.

5.3.1 The aid complex: from humanitarian to development aid

The nature and history of aid in Liberia is complex. Aid can often be counter-productive to its fundamental purpose in alleviating suffering. Development aid aims to implement and tackle more long-term socioeconomic change. Humanitarian aid is the first response assistance to natural and manmade crises. It aims to save lives. Generally, it is short-term, project-based and reliant on funding cycles (O'Keefe & Rose, 2008). Initiatives like TRCs in South Africa, Sierra Leone and Liberia, contradictorily in reference to the humanitarian code of conduct and impartiality **move beyond crises**. They facilitate a particular *form* of justice and recovery in psychosocial healing. The UN/MOGD participant essentially highlighted three phases of aid, in reference to the GBV JP programme; *relief* in initial response, *rehabilitation* in rebuilding and establishing management systems and prevention, and finally *development*. In places of on-going conflict, like Liberia, Angola, Afghanistan and Sudan, humanitarian aid becomes **long-term** (Fowler, 2008). This permanence in ensuring stability deviates from the short-term nature of humanitarian endeavours. When do you stop calling a state post-conflict? While there seems to be levels of acuteness, participating organisations seemingly have the ability to determine what is in their capacity and focus, and when to close a project, effectively ending the humanitarian phase. As Tayler-Smith et al. (2012) note, concentrating on long-term issues regarding cultural and behavioural beliefs, like stigmatisation, were not within the scope of MSF who left Liberia in 2010. This suggests a validation and escapism that humanitarian and especially medical aid, short or long-term are permitted, stressing **accountability** concerns. Arguably, this answers one facet to the superficial collaboration between the international community and the traditional societies.

Liberia is still in the **grey area** between humanitarian and development assistance. Major shifts from **response to prevention** have and will continue to occur in the following three-five years. However, it is crucial for the international community, both humanitarian and development agencies to reassess and to go beyond merely acknowledging the traditional Liberian societies exist, but **truly engaging** with them. Duffield (2002) suggests that if care is not taken, this is a prime opportunity for imperialism. In reference, UN/MOGD definitively outlined that the UN was a consultant on the GBV JP programmes. They made recommendations (and provided funding), but ultimately it was GOL's decision and responsibility to implement them. She shed light on a principle point of debate, contention and need for clarification between partners in Liberia. When a project is given **initial** support like funding from international donors in order to establish structures like WACPS, GOL feel that they do not need to support the project. This was regardless of if the programmes had been handed over to GOL, and was under their management and payroll. de Carvalho & Schia (2011) argue that it is necessary for Western

organisations and donors to evaluate that real changes have occurred, rather than merely ticking the boxes that treaties have been ratified. Seemingly, these 'ticks' effectively remove the **responsibility** from organisations and fundamentally breaks the olive branch and bridge building. Outwardly, the international community is 'partnering' with GOL and giving them the responsibility and agency to implement and foster long-term behavioural change and development based on a Western standard. In reality, GOL evidently **lacks the capacity**, which the international community supposedly fostered, to do so. Moreover, in specific reference to some traditional society practices, GOL's implementation of 'suggestions' seem more to **appease**, rather than to foster sincere change, perhaps on the notion they are captive to aid. The need to appease the international community to ensure donor funding is problematic. GOL relies on external donors, especially the children division under the ministry of gender and development. Correspondingly, Magesan (2013) questions why developing countries implement Human Rights Treaties (HRT). The author highlights that it is often due to **economic incentives.** Moreover, aid donors use past HRT implementation as criteria for future aid allocation. The real effect of this aid on local human rights is therefore highly questionable, especially when harmful practices are downplayed, but still rewarded with more funding. Impartiality is moreover questioned. Hilhorst & Jansen (2010:1134) note that aid beneficiaries

> *have certain pre-described roles in humanitarian aid, ranging from expressing their needs to recipient participation in the selection of beneficiaries for programmes. It is the **prerogative** of the humanitarian agency to define its beneficiaries. The question of who is eligible for aid is determined on the basis of vulnerability categories and needs analyses.*

Yet, the authors note that in their case the role of the recipients might have been far greater than first thought. So while community participation and 'partnerships' are indispensable buzzwords that underline diverse organisations and were used by many of the participants, its effectiveness and meaning is questionable (Desai, 2008, Kelly et al., 2011, Rimal & Real, 2003). Abramowitz & Moran (2012:122) argue that *"NGOs have hegemonic authority in the context of global-local dialogues…NGOs and local communities seek cooperation and engagement but fumble in the face of how gender, culture and GBV practices are defined in everyday life"*. In general a 'partnership' is an agreement between two or more parties who **collaborate** on the understanding of **mutual benefit** (Desai, 2008). Partnerships provide many positive and ethical promises, especially in giving a voice to the global south. There is ample research on partnerships concepts, which has been mainstreamed in development and aid policy since the 1980s. 'Partnerships' also fortifies the MDGs and is specifically included in MDG 8, *'to develop a global partnership for development'* (UN, 2013:52). Yet, in reality it has been fairly unsuccessful in Liberia in dealing with SGBV. While the history and political formation of partnerships is important to understand, it is well discussed and critiqued (Barnes

& Brown, 2011, Corbin & Mittelmark, 2008, Corbin et al., 2011, Mosse, 2004). Fundamentally, acknowledging its formation as a **strategic** and normative guiding tool that continues to underpin policy and the majority of worldwide I/NGOs and government organisations is important. Mosse (2004) emphasises the significance of policy and our need to understand it in a more mature way, rather than with the simplistic and suggestive view that many agencies choose to perceive and implement it into their decision-making processes. The true use and implications of partnerships bears an influence in collaboration between the international community, the traditional and the local communities in reducing SGBV.

5.3.2 The paradox of aid: money woes

Debates about the negative and positive effects of aid are numerous (Moyo, 2010, Friedman, 1995). Yet, the increased global reduction of aid rouses implications of supply driven aid. There is an increasing need to **rationalise aid**, which ultimately affects programmes like SGBV and child protection. The growth of the non-profit industry increased 25% between, 2001 to 2011, from 1,259,764 million to 1,574,674 million non-profits, *"surpass[ing] the rate of both the business and government sectors"* (Urban Institute, 2013:1). The **global model of aid** and culture of competitiveness in attaining **donor funding** has two major implications. The first includes shifting relationships between I/NGOs and donors. The second is perhaps the unintentional but seemingly widespread act of sensationalising and framing data.

Most of the INGO participants could not definitively highlight the extent to which donors influenced their SGBV programmes. This reflected the extent to which specifically employed individuals source and apply for aid grants. What was nevertheless apparent was that the organisations looked for grants that tailored their aims. Thus, donors irrevocably influenced what kinds of projects were being funded and for how long. While INGO participants felt they were not being restricted, many projects had been terminated and their capacity, for instance, to engage with traditional leaders ceased. Perhaps, setting a negative precedent, some mentioned the struggle to explain to donors' concepts like 'sitting fees' or providing meals for the beneficiaries during community projects. On arrival at a NRC GBV training outside Monrovia, the town mayor unexpectedly raised the previously agreed upon, already higher than usual fee for use of the town hall. The training was delayed by 3hours. When questioned if this was a result of my presence, national staff responded with, *"eh, no he's just trying to eat my eyeball! He thinks NRC has lot of money, we only get certain budget for projects"*. In other words he was 'trying to pull one over on them' and earn some extra cash for himself. Aid is a resource like any other. Whatever reasons are given that aid is provided; in Liberia it is seemingly

becoming a priority for local leaders over entrepreneurship. Aid can also support corruption and divert money, a significant problem in Liberia and for SGBV.

Fowler (2008) discusses the logistics of **partnerships** of I/NGOs and donors 'in an era of disrupted continuity.' He argues that INGOs become implicated in *"government reactions against terrorism, insecurity and instability"* (Fowler, 2008:535). Duffield (2002:1049) calls this post Cold War merging of development and security the *"radicalisation of development."* This new perspective of aid and policy shift from *"saving lives' to supporting social process and political outcomes"* sees underdevelopment as a major threat to the West (Duffield, 2001:95). Duffield contends that part of the problem is the exclusion of the global south from the global north. Exclusion creates insecurity. Criteria for inclusion and exclusion are thus formed and aid becomes very targeted. If conflict is linked to development, and development to peace, rationally, actors' commitment to prevent and resolve conflicts justifies intervention. Essentially however, aid becomes a strategic tool for donor countries to resolve conflict and ***reconstruct*** post-conflict societies on plural but individualistic values like children's rights (Duffield, 2002, Fowler, 2008). One key frontline player to execute this 'peace' is the INGOs. Seemingly, despite the humanitarian imperative indicating codes of impartiality, independence and neutrality, fighting for funding involves several levels of politics (Hilhorst & Jansen, 2010). This financial dependence on donors and the ever-threatening nature of conflict threatens this code of conduct (Curtis, 2001). Moreover, the humanitarian imperative calls for neutrality. Yet, Anderson et al. (2011) argue that international organisations have to consider the context of the crises, as in Liberia's case, it played/s a key role. Merely treating the results does not provide lasting assistance. The need to **reanalyse** traditional foundational ethical frameworks that have seemingly digressed is thus emphasised. As Chambers (1997) posits, we need to really consider, *"who's reality counts?"* Do African's consider themselves suffering, in chaos and disaster like the continent is often framed? While this may be true in the context of the Liberian conflict, it is nevertheless still relevant to ask 'who's questions are being asked', 'who's realities are being (re)presented, 'who's knowledge matters' and 'who's evaluations count'. It is equally important to ask what questions are we not asking as all knowledge is situated and biased. To paraphrase Einstein, it is impossible to solve problems with the same ideas we used to create them. Paradoxically, on one hand, the West creates and encourages disparities in economies, politics and societies. On the other hand, buying a conscience, or security, currently means alleviating, but rarely eliminating disparities. This reflects the need for a completely new way of managing the global system that dictates aid. Appeasing the argument that underdevelopment creates conflict (Duffield, 2001), and that poverty reduction strategies based in the global south have been largely unsuccessful over the

last 50 years; like SGBV, greater structural and social norm change needs to occur at the **source** of the effect, rather than merely at the outcome. In the mean time, the negative impacts of aid can be significantly reduced. All the interviewed I/NGOs commented on the importance of **local context,** yet, on the ground level, the superficial engagement with traditional societies spoke otherwise.

5.3.3 Discourse: the power of words, creating and avoiding buzzwords

The second implication of supply driven aid synonymised with effectiveness and efficiency, is **statistics and framing**. Aid is conditional on certain factors. Results based management; short time frames, certain outcomes, physical structures and importantly measurable results are fundamental (de Carvalho & Schia, 2011, Cohen & Green, 2012). Short-term projects conducive to donors become the expense of long-term development, which ignores informal mechanisms. More specifically, the need for **verifiable statistics** and claims, influence the politics and policy regarding human rights and future epidemics. Information politics according to Keck & Sikkink (1999:95) is *"the ability to quickly and credibly generate politically usable information and move it to where it will have the most impact"*. Organisations may find credible results, but sensationalising and dramatizing results to create public outrage, can create conventional knowledge. Cohen & Green (2012) reflect on the issue of 'information politics' in reference to how organisations use inaccurate claims and statistics to advocate for SV programmes in Liberia, thus creating a 'duelling incentive'. They posit that this effect is wrapped up in *"the conflict between advocacy organisations' needs for short-term drama and long-term credibility"* (Cohen & Green, 2012:445), where discourse language can act as a form of colonisation, used to control and exploit groups. Using inflated statistics (page#14) or marketing 'saveable women and children' is used to justify programmes and funding. Statistics are important when fighting for SGBV or indicating the number of people killed during a war. 'Rape sells'. Yet, rape is only one form of SGBV. While some participants noted that domestic violence was far worse in Liberia, rape was often framed as the flagship offence. Mohanty (1988) argues that the collective grouping of violations including rape and sexual abuse reduces the impact of each violation as a human right. Like many gendered stereotypes, peacekeeping can also be considered a production and reproduction of assumptions and myths. The obsession with civilian protection however and funding, necessitates the creation of the 'victim', which some of the participants referred to themselves as. Yet, I also felt that at times certain participants directly working with survivors were prompted to use the term 'survivor' due to my use of the term, rather than stating 'victim' like the hospital and WACPs participants, again adding to the confusion of the terminology and discourse. While the focus is on women, the impact of SGBV gets lost on men, as participants

referred to the lack of reporting among this cohort. Moreover, laws including the Geneva Conventions incorporate provisions for women, yet do not recognise fathers in conflict zones. When human protection and concepts like Responsibility to Protect (R2P) becomes a policy, the parameters to define it are broad and it ends up including everything, making it difficult to move from **policy to practice.**

Current programmes in Liberia are mostly based on **conflict data** and post-conflict long-term funding, as indicated to by the INGO participants. The need for long run data and intellectual rigour in policymaking is needed (Cohen & Green, 2012). A common challenge includes, how do you measure the results of SGBV and child protection programmes? In Liberia, more cases are being reported. Does that indicate failure, or does it indicate effective awareness and improvement to reporting systems, where rape was going unreported? This inability to have strong measureable results proves damaging to child protection. 'Child protection' (welfare) is not often mainstreamed as a separate sector, but included within other sectors like education and health, as indicated by several participants (in line with MDGs). Thus, they may be the first components of programmes to be downgraded. Yet, it is evidence that needs to inform policy rather than trends or the Western need for targets. While the NRC was one of the INGOs who were particularly focusing on SGBV data collection most organisations particularly local NGOs lacked the money, resources and the time. While I encountered the difficulty in obtaining data due to its inherent secretive nature, it is attainable. Yet, not a single person could reference where the commonly cited statistic derived, stating that 70-75% of children comprised SGBV survivors. Cohen & Green (2012:445) highlight how population surveys referencing SV on Liberian women indicate around 10-20%, *"during their lifetimes, including periods of war"*. These numbers are significant, but 10-20% does not carry the same effect as '75% of children are targeted by SGBV in Liberia'. This study aimed to use verifiable statistics. The importance of sourcing statistics and conducting research with rigour, while being careful to indicate full results like 70% out of 300 participants was emphasised. As indicated, the possible implications of organisations framing, exaggerating or using ambiguous and unclear statistics benefit the short-term, at the expense of the long-term. Intense competition for funding, direct measurable results, aid accountability and the need to sensationalise already atrocious problems will have impacts on future epidemics, programmes and resources. This may also raise the bar for statistics where 10-20% is not credible enough for funding. Moreover, information and statistics (page#14) are continuously repeated and become 'fact' and are used locally by GOL and community members. While some I/NGOs and governments may not intentionally use information politics, the competition for funding necessitates strong claims (Cohen & Green, 2012).

Women's business: engaging men with words

Landsby men often complained that SGBV actors only preached about children's and women's rights and never men's rights (INGO1). Perhaps this reflected the power they felt they were entitled to, while not realising the power they have always been afforded. Alternatively, it highlights the importance and effects of inclusion/exclusion and the monopoly that women share in wartime, post-conflict and general S/GBV discourse, which can be a focus for the international community. Connell's sexual division of power could be extrapolated to how the external sexual division of power in **language** is used in the internal practice of describing SGBV in Liberia. Excluding or failing to entirely engage with dialogue about men's **behaviour** as a key source of the problem significantly hinders long-term prevention initiatives. The IRC and NRC expressed the importance of framing. The majority of SGBV programmes initially victimised and negatively reduced all men to perpetrators. This also alienates potential allies (Baaz & Stern, 2013). The IRC, since 2006 and the NRC since 2009 have made important steps towards addressing this issue. Positive language like 'partners not perpetrators' has resulted in constructive and positive outcomes, shifting male stance from defence to understanding. Empowering and educating women and children on SGBV is essential. However, failing to focus on the **source behaviour** and mainly male perpetrators, exacerbated with the persisting underlying and contributing factors seems **counterproductive.**

Universally, statistics and information on male rape is scarce. Omitting rhetoric of males as SGBV casualties infinitely hinders, masks and further stigmatises the incidence and protection of male survivors. While efforts have been made in the past including a shift from Women in Development (WID) to Gender and Development (GAD), globally, gender is still commonly perceived as 'women' or 'women's business'. Men seem to be present only in two areas, including HIV and violence. Such phrases, fused into traditional and historically embedded notions of gender pose severe consequences for boys and men who are sexually violated by other men (background). A rising trend, cases were rarely voluntarily or otherwise reported and were often long-term incidents (background; JDJ). During fieldwork, various participants' highlighted how motorbike riders were increasingly targeting and raping young boys (Ibid.). Sexual crimes against males had only a small chance of discovery, ***if*** somebody suspected or coincidently found out. Thus, the Ugandan Refugee Law Project (RLP, 2013) case emphasises the need for discourse and practice to include this invisible and most often overlooked cohort of males. They argue that males may experience significant psychosocial impacts of emasculation and confusion, causing wider impacts on society, in communities, schools and homes. This also socially excludes the lesbian, gay, bisexual and transgender communities.

The creation of buzzwords is unavoidable in discourse. While you cannot really remove different interpretations of concepts it is important to question the chain of equivalence.

5.3.4 Monrovia vs. the Interior: the geography of partnerships

An individual's **space, place and location** matter. They influence social ecologies, agency and protective factors, risk factors and access to resources (Cummins et al., 2007). Disparities between Monrovia and the counties were continuously present, through observation and participant experiences. Inconsistencies included logistical, monetary and infrastructural support. Most INGO and GOL resources were centrally biased. All INGO and government head offices were centralised and the majority of programmes were based in the capital. Resources like motorbikes and rape kits rarely reached the intended interior locations. This deficiency and mismanagement reduced or made the services provided for SGBV survivors non-existent in some places in Landsby. The NRC participant commented on how Montserrado County accounted for almost 70% of **reported** cases. Thus, awareness was more acute in the capital. However, the population in the capital is dense. This, combined with more awareness effectively should make rates of reporting higher. International presence and rule of law in Liberia was also largely constricted to the **core** of Monrovia. In rural areas, especially in the counties GOLs judicial system and formal medical care was almost non-existent. Customary law was thus most often exercised, which is supported by other case studies (RLP, 2013). Moreover, in the counties, judges who were incompetent in understanding the penal code and rule on gender biased traditional norms exacerbate the weak legal system. As Schia & de Carvalho (2009:1) were told by one legal professional in the capital, *"The problem in Liberia is not that victims of rape don't get justice, but that **no one** gets justice!"* These **periphery** areas are generally where traditional practices and beliefs are the strongest, emphasising the importance of syncretising customary law and medicine.

Moreover, the core-periphery relationship between the INGO1 head office and the field location in Landsby was a concern. Information sharing at appropriate times was a particular problem for the INGO1 participant. The participant highlighted several important factors between Monrovia and the Landsby INGO1 office. These included understaffing with, *"more staff in the smaller place and less staff in the bigger place,"* lack of resources and 'easier' jobs in Monrovia because of the *"nice sites,"* not requiring them to travel to far *"isolating"* places and into the bush. The INGO1 field office, like many other organisations had been significantly reduced due to budgetary constraints and the organisation planning to exist Liberia, placing considerable pressure on the remaining staff. The acting project manager (PM) felt that she was doing the work of a PM, in addition to her own work. However, she felt she was not getting paid accordingly. Nor did she have the access to important information like the

programme budget. She felt this was the result of the new management. As she emphasised, *"They have smaller place. Monrovia they have all the bosses, they have almost all the support…"* As a consequence of the reduced programmes, the awareness projects that were occurring in the possibly most needed and traditional remote areas have ceased. The government have not continued such outreach programmes to the periphery, and seemingly do want, *or* do not have the capacity to do so.

5.4 Limitations

There were various limitations to this study. Time constraints and logistical issues contributed to many of the limitations. Secrecy played a vital role and hindered some data collection. Only survivors who had received formal care were engaged with and not those who had received traditional judicial or medical care. In order to narrow inclusion criteria, no orphaned, independent or trafficked children who experienced SGBV were included. However, there were reports that a significant number of children were included in these cohorts, impacted by SGBV. I was unable to schedule a focus group and thus build rapport with the survivors prior to in-depth interviews. This may have been useful in engaging with the participants and fostering conversation in a more relaxed environment. The study was not limited to only one tribe or secret society. This may have had several benefits for more in-depth results. However, the hierarchical Sande and Poro societies are the most powerful in Liberia. SGBV is also not confined to merely one tribe. Being a member of a certain tribe does not mean an individual is more or less likely to be targeted. Access and time to engage with more traditional community members, herbalists, Zoes, Chiefs and elders on traditional culture would have been beneficial in attaining more in-depth information. No female participant was able to attend the Landsby Youth Group interview due to logistical constraints, providing only a male perspective. Participatory methods may have been beneficial. Getting the survivors to write their own stories or use alternative participatory methods to interviewing them may have been more conducive to the sensitive nature. Spending more time with the survivors may have influenced the openness of the interviews and thus data produced. While levels of illiteracy were an issue here, I was unable to attain the police/medical reports taken post incident to verify stories. Having the ability to test the interview guides would have been helpful. Moreover, the ability to return to participants to confirm or clarify answers would also have been beneficial. Participants spoke English but a form of *Liberian English*. While I felt that I grasped the language and terminology, there may have been limitations in some participants understanding my English.

CHAPTER 6: CONCLUSION

Findings suggest that both the Western and traditional approaches to dealing with SGBV in Liberia are a **complicated, intertwined and fragmented process**. The approaches rely on several different ineffective structures that are influenced by a number of internal and external determinants. There is little syncretisation within the ecosystem of the simultaneously operating systems. This is despite the realised importance by the international community of engaging with traditional and local Liberian structures. This is also despite a 'comprehensive' and 'holistic' framework that aims to guide all key players, legislators and organisations. This study set out to explore 1) the Western response in medical and judicial practices dealing with SGBV, 2) the local and traditional response in medical and judicial practices dealing with SGBV in Liberia and 3) the syncretisation and local perceptions of these two structures.

The **Western response** to managing SGBV in Liberia is based on formal structures and mostly Western idea(l)s and techniques. The international non-governmental organisations more or less conform to the multi-vocal 'holistic' post-conflict approach set forth by the government of Liberia and the United Nations. Yet, they also have significant autonomy as to what programmes they operate and where they fall under the government's gender based violence framework. They are also constrained by donor funding. Liberia has on various occasions been touted a success by the international community. However, the international community managing SGBV have yet to accomplish many specified goals. While the dangerous environments and short-term nature of humanitarian organisations work is comprehensible, ten years is not short term. Seemingly, the legacy of humanitarian programmes and techniques have shifted into development programmes and techniques taken on by the government. Considering how knowledge and culture develop sheds light on the problem of transposing one type of (Western) knowledge onto another. If the international community in Liberia works on the presumption of a shared conceptual apparatus ('one size fits all') applicable to all contexts, this is clearly problematic. While on the ground, the importance of context is stressed and actors do have some agency; much of the international community can still be confined to government and thus UN mandates and frameworks.

The **traditional response** to SGBV in Liberia is largely based on pre-war structures and techniques. This is despite the fact that while a form of these systems were present during the war; they were significantly impacted and changed as a result of the conflict. The traditional Sande (female) and Poro (male) Secret Societies continue to have a substantial bearing on Liberian culture and belief systems. This in turn, influences the incidence of SGBV as well as

the outcome in terms of justice and medicine to treat survivors. There is a pervasive battle between definitions and concepts between the international community and the traditional communities in Liberia. Concepts including childhood/adulthood, rape, marriage, sex, human rights, poverty, relationships between survivor/perpetrator, education, awareness, discourse, corruption and ineffective formal and informal systems all have a bearing on the outcome of SGBV cases. While the Sande are ***seemingly*** more open to shifting some harmful practices and ideas, like women and children's rights, it is unclear what the Poro society is advocating. The male society is outwardly less willing to collaborate with the government or international community. Bridging this division between the two societies is crucial to improving SGBV in Liberia, and engaging with men. Ultimately however, both societies continue to strongly embrace traditional culture and beliefs. At times these beliefs embrace gender-biased ideals, and influence several layers of relationships, ultimately impacting SGBV.

While there are positive and negative aspects to both Western and traditional approaches, they should not be seen as an **antithesis but rather a synthesis.** The international and Liberian communities **can mutually benefit** from each other's concepts and techniques. Liberian traditional culture should not be seen as a cultural boundary but rather a frontier, with grey accessible space for discussion and collaboration. Attempts at **syncretisation** have been fruitless in Liberia. While there have been several noteworthy endeavours by the government of Liberia and the international community, they have seemingly missed the mark. Attempts have been significantly impacted by a number of internal and external underlying and contributing factors. These include supply driven aid, social norms, acute social stigma and severely weak and corrupted legal, investigative and logistical resources. Contributing factors like poverty frequently lead survivors or most often their guardians to suppressing or compromising reports and seeking traditional care rather than going through formal legal and medical routes. There is no trust in the formal systems. Consequently, even if traditional healing practices were not a first choice, it may be the only choice. Secrecy is also emphasised in the traditional communities. Yet, while this removes survivors having to deal with formal structures, justice and proper medical care remains elusive for survivors. Moreover, it is seemingly the more the older generations who choose or prefer to use traditional medicine and judicial systems to deal with SGBV in Liberia, particularly in the interior.

The implementation of generic Western programmes that do not align with or truly accommodate cultural norms, make long-term success seem idealistic. Superficially accepting 'changes' by the traditional communities will always be a problem in Liberia. If this does not change the **parallel, sometimes interacting, often-contending** systems will continue. This

effectively allows individuals, including family members and perpetrators to pursue the system that is more beneficial to their cause. This is typically at the detriment of the survivor. Implementation efforts will continue to be hindered due to the **lack of research** on traditional societies, social norms and the judicial and medical mechanisms they operate within. Yet, traditional justice and medical practices offer various good mechanisms that could be utilised, especially in the interior. In the post-conflict setting responding directly to the impacts of war are necessary. However, the shift to treating the **underlying root causes** and not simply the symptoms is necessary to prevent and respond to sexual and gender based violence. Involving men as perpetrators as well as survivors should be a key focus for actors working on prevention. It has been widely understood that violence undermines development and restricts women's participation. Yet, the international community have been relatively slow in responding and dealing with it. While women and girls are told to protect and empower themselves, perpetrators also need to be educated that they should not be committing these crimes.

Understandably, social norm change takes time. This is not just in Liberia as rape is a worldwide problem and not merely isolated to conflict zones or developing states. Although many of the I/NGOs have shifted their response to awareness, failing to engage with the traditional societies and men seems futile for long-term change. While focusing on the overall goal to reduce SGBV is important, nurturing the habits and routines and adapting the underlying and contributing causes to reach that goal is seemingly more important. Thus, while it is important to care for the women who take care of children, Liberian children live in a variety of households. They are self-supporters, orphans, child carers, and mothers themselves. It is necessary to look at the **reality** of children's lives and experiences. It is necessary that programmes also respond to the fact that rape is dealt with as a 'family matter' in Liberia. The onus is being placed on the government to fix these problems. While ***it is*** the government's responsibility to take action and not merely make political statements, they clearly lack the capacity in resources, trained labour forces and logistics to do so. Laws and infrastructure are a great start but do not change social norms and the systems operated within these structures. This is where the international community can really support them further.

6.1 Recommendations

The findings in this study clearly indicate the importance of needing to syncretise the formal and informal structures that cater to SGBV survivors; as a result of the interplay and influences each system bears on the other. As reflected in the results, children had little agency in deciding whether they attended *bush school* or what kind of medical or judicial care they

sought. **'Power'** and proximity played a critical role in accessing, overpowering and manipulating individuals, especially children. The power dynamic intertwined in age, relationship, trust and status and the **lack of basic** needs in the home, school and community made children more vulnerable to SGBV. Participants noted that it also influenced whether cases would be **compromised** to bribery, and thus directly impacted the type of health care and justice sought. **Protective** family and community structures played a decisive role to children's safety and availability. These shifting family structures seemingly made perpetrators more receptive to misusing their power and committing SGBV crimes. Children, women and men were not able to enforce certain boundaries, nor were the systems or people (family, community, government, INGOs) expected to enforce them effective enough to significantly curtail sexual violence. Based on this,

Recommendation one: **Reforming and strengthening the formal medical and judicial systems in genuine consultation with local government, community groups, the international community and the traditional societies.** *Taking into consideration children's social and cultural ecologies, the reality of their lives and access to formal and informal structures in important here. The necessity to bridge the gap and rivalry between the hospital, police, Women and Children Protections Services and courts is essential to reduce corruption and increase cohesion. SGBV training on how to deal with survivors and perpetrators within these sectors is also recommended. The necessity for INGOs and GOL to collaborate on matters like staff wages and incentives also needs to come to a consensus.*

The traditional societies continue to bear a substantial influence on the culture and belief systems of most Liberians, regardless of religious affiliation. This ranges from traditional power rituals and beliefs, gendered roles and expectations and the definition of a child and sexual maturity. These expectations in turn influence practices like female genital cutting, early marriage and sexual violence. There is also seemingly an untapped resource in the traditional healers throughout the country, in many places where formal mechanisms do not reach.

Recommendation two: **Direct collaboration and discussion with the Sande/Poro Societies on harmful practices and appropriate awareness campaigns aimed at reducing SGBV**, *initiated by the government and the international community in order to reach common consensus. There is a need for critical comprehensive* ***research*** *on what traditional medicinal and judicial mechanisms dealing with SGBV actually involve. The need for the international community to actively engage and understand these ideas and structure programmes accordingly is stressed. It is recommended that research and funding for initiatives like traditional medicinal centres and testing to complement western approaches is supported. Bottom up projects based on a hybrid of what communities highlight as their needs, should be bound from the top. Investing in training of local leaders, facilitators and healers should be a priority for long-term development. Good traditional practices should be commended and a hybrid system that involves both Western and traditional Liberian approaches should be encouraged.*

Lastly, the majority of current programming is seemingly based on conflict data. SGBV post-conflict involves various different aspects and ecologies in comparison to the war. These programmes are also being taken over by the government.

Recommendation three: **There is a significant need for more research on SGBV in Liberia on the post-conflict situation and the shift of first response aid to development aid.** *Data focusing on males as perpetrators, and as survivors of rape is necessary. The need to fully engage with men in both roles in highly recommended.*

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APPENDICES

#1 Norsk Samfunnsvitenskapelig Datatjeneste (NSD) approval

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
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Marguerite Daniel
Institutt for geografi
Universitetet i Bergen
Fosswinckelsgate 6
5020 BERGEN

Vår dato: 08.04.2013 Vår ref:33743 / 3 / IB Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 06.03.2013. Meldingen gjelder prosjektet:

33743	*Sexual Gender-based Violence (SGBV) in Liberia: An Investigation into the Dual System of Traditional and Western Healing*
Behandlingsansvarlig	*Universitetet i Bergen, ved institusjonens øverste leder*
Daglig ansvarlig	*Marguerite Daniel*
Student	*Dashakti Reddy*

Etter gjennomgang av opplysninger gitt i meldeskjemaet og øvrig dokumentasjon, finner vi at prosjektet ikke medfører meldeplikt eller konsesjonsplikt etter personopplysningslovens §§ 31 og 33.

Dersom prosjektopplegget endres i forhold til de opplysninger som ligger til grunn for vår vurdering, skal prosjektet meldes på nytt. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html.

Vedlagt følger vår begrunnelse for hvorfor prosjektet ikke er meldepliktig.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

Inga Brautaset

Kontaktperson: Inga Brautaset tlf: 55 58 26 35
Vedlegg: Prosjektvurdering
Kopi: Dashakti Reddy, Fantoft Studentboliger, Postboks 71, 5075 BERGEN

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 33743

Meldingen gjelder et masterprosjekt om barn som har vært utsatt for (gender-based) seksuelle overgrep i Liberia, og hvilke helsetilbud (tradisjonelt eller vestlig) de får.
Data innhentes ved observasjon av et støtteprogram drevet av Den norske flyktningehjelpen (NRC) i Zwedru/Liberia, samt ved intervju med NGO-ansatte, samfunnsledere/eldre, tradisjonelle healere, og jenter (15-18 år) som har vært utsatt for overgrep.

Personvernombudet kan ikke se at det i prosjektet behandles personopplysninger med elektroniske hjelpemidler, eller at det opprettes manuelt personregister som inneholder sensitive personopplysninger. Prosjektet vil dermed ikke omfattes av meldeplikten etter personopplysningsloven.

Observasjonsdata innhentes i form av notater som ikke vil inneholde personidentifiserende opplysninger (jf. telefonsamtale med veileder 05.04.13).

Intervjudata registreres i form av elektroniske lydopptak og transkripsjoner. Informantenes navn skal ikke inngå i, eller knyttes til, datamaterialet for det konkrete intervjuet. Det skal heller ikke registreres opplysninger som gjør det mulig å identifisere enkeltpersoner indirekte. Om jentene registreres kun bakgrunnsopplysninger om kjønn og alder, samt stemme på lydopptak. Disse opplysningene vurderes ikke identifiserende, da flere hundre jenter totalt mottar hjelp gjennom NRCs støtteprogram i Zwedru. Om øvrige informanter registreres arbeidsplass, men ikke nøyaktig stilling/rolle dersom dette kan bidra til identifisering.

Personvernombudet legger til grunn at alle opplysninger som behandles elektronisk i forbindelse med prosjektet (i observasjonsnotater, lydopptak og transkripsjoner) er anonyme. Med anonyme opplysninger forstås opplysninger som ikke på noe vis kan identifisere enkeltpersoner i et datamateriale, verken direkte gjennom personentydige kjennetegn som navn, indirekte gjennom kombinasjonen av bakgrunnsvariabler, eller gjennom kode og koblingsnøkkel (som navneliste).

Personvernombudet vil for øvrig bemerke at prosjektopplegget innebærer endel etiske utfordringer, siden unge jenter som har vært utsatt for seksuelle overgrep inkluderes i forskningen. Disse utgjør en svært sårbar gruppe, og veileder og student vil dermed ha et særskilt ansvar for å ivareta den enkelte informanten, både under rekrutterings- og samtykkeprosessen, i intervjusituasjonen og i etterkant mht. mulige reaksjoner og behov for oppfølging. Vi viser til NESH sine forskningsetiske retningslinjer:
http://www.etikkom.no/Forskningsetikk/Etiske-retningslinjer/Samfunnsvitenskap-jus-og-humaniora

#2 Consent/assent forms

Explanation of the study for participating children

This Informed Assent Form has two parts:

- **Information Sheet (gives you information about the study)**
- **Certificate of Assent (this is where you sign if you agree to participate)**

You will be given a copy of the full Informed Assent Form

Title of the Study: Sexual gender-based violence (SGBV) in Liberia: an investigation into the dual system of traditional and western healing.

Who am I and what am I doing?
My name is Dashakti Reddy. I am a student at the University of Bergen in Norway. I am doing research about the different healing practices for children who have been sexually assaulted in Liberia. I would like to find out what type of healing you have been given and how it has helped you. This information will be part of my Master's thesis. I am going to give you information and invite you to be part of this research study. You can choose whether or not you want to participate.

Choice of participants: Why are you asking me?
I would like to learn from you how YOU are coping with SGBV. I would also like to know what YOU think about the different healing systems in Liberia and what you recommend for others. Your experiences can give important information to the study.

Participation is voluntary: Do I have to do this?
You do not have to take part in this research if you do not want to. I have discussed this research with your parent(s)/guardian and they know that I am also asking you for your agreement. If you are going to participate in the research, your parent(s)/guardian also have to agree. But if you do not wish to take part in the research, you do not have to, even if your parents have agreed. You may discuss anything in this form with your parents or friends or anyone else you feel comfortable talking to. You can decide whether to participate or not after you have talked it over. You do not have to decide immediately. There may be some things in this form you don't understand or things that you want me to explain more about because you are interested or concerned. Please ask me to stop at anytime and I will take time to explain.

What will happen to me if I choose to be in this study?
If you participate in the study you will be invited to an individual interview with myself. This interview could last up to 1 hour. Things that you say during interviews will not be told to others or your caregiver. You can refuse to answer any questions without any specific reason. A tape recorder will be used during the interview if this is ok with you. You will also be invited to take part in one group discussion. There will be other girls your age in the group. This group discussion will last for about 1-2 hours.

If something makes you feel sad or uncomfortable during or after the interview or group discussion, you do not have to talk about it. You can also talk to me, or someone you trust if you have personal questions or concerns before, after or during the interview and discussion group.

Compensation: do I get anything for being in the research?
You will not be given any kind of payment or gift for taking part in the study. If there are any expenses like travel costs as a result of taking part in the study, that will be repaid to you.

Confidentiality
If you agree to participate in the study, your own name will not be used in the written report and it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community. Recordings of the interviews or group discussion will be destroyed after they have been written down.

If you agree to participate, please read and sign the statement below.

Thank you for your co-operation,
Dashakti Reddy

Written consent (assent) for children

The purpose of the study has been explained to me and I understand what it is about. Participation will involve an individual interview and a focus group activity.

It has also been made clear that if I agree to participate in the study, my own name will not be used and, in the written report, it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community. Recordings of the interviews or group sessions will be destroyed after they have been written down.

I am free to withdraw at any time or may refuse to answer any of the questions asked of me.

Name: _____

Signature: _____

Date: _____

I have accurately read or witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely.

A copy of this assent form has been provided to the participant.

Parent/Guardian has signed an informed consent Yes No

Name of researcher: _____

Signature of researcher: _____

Date: _____

Explanation of the study for caregivers of participating children

This Informed Consent Form has two parts:

- **Information Sheet (gives you information about the study)**
- **Certificate of Consent (this is where you sign if you agree for the child to participate)**

You will be given a copy of the full Informed Consent Form

Title of the Study: Sexual gender-based violence (SGBV) in Liberia: an investigation into the dual system of traditional and western healing.

Who am I and what am I doing?

My name is Dashakti Reddy. I am a student at the University of Bergen in Norway. I am doing research about the different healing practices for children who have been sexually assaulted in Liberia. I would like to find out what types of healing children have been given and how it has helped them. This information will be part of my Master's thesis.

Your child's experiences with the traditional or western healing systems can give important information to the study. If you agree that your child may participate in the study, the child's own name will not be used in the written report and it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community. Recordings of the interviews or group sessions will be destroyed after they have been transcribed (written down).

Your child will not be compensated with payment or gift for being part of the study. Any expenses incurred, such as travel costs as a result of taking part in the study will be repaid.

If you agree that your child may participate in the study, the child will be free to withdraw at any time or may refuse to answer any of the questions asked of him/her.

If you agree that your child may participate, please read and sign the statement below.

Thank you for your co-operation,
Dashakti Reddy

Written consent of caregivers of participating children

The purpose of the study has been explained to me and I understand what it is about and how my child will be involved. Participation will include an individual interview as well as a group discussion.

It has also been made clear that if I agree that my child can participate in the study, the child's own name will not be used in the written report and it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community. Recordings of the interviews or group sessions will be destroyed after they have been written down.

The child is free to withdraw at any time or may refuse to answer any of the questions asked of him/her.

Name: _____

Signature: _____

Date: _____

Explanation of the study for participating I/NGOs and GOL

This Informed Consent Form has two parts:

- **Information Sheet (gives you information about the study)**
- **Certificate of Consent (this is where you sign if you participate)**

You will be given a copy of the full Informed Consent Form

Title of the Study: Sexual gender-based violence (SGBV) in Liberia: an investigation into the dual system of traditional and western healing.

Researchers: Dashakti Reddy, student from the University of Bergen, Norway.

What is this research study about?

This study is about children who have been subject to sexual gender-based violence (SGBV) and the types of healing they receive. This project will seek to explore the provision of Western medical and psychological services for SGBV child survivors. Healing practices provided by traditional healers will also be explored. Differences and areas of contention between these two systems will be discussed. Local perceptions of these two types of care will be sought.

The results of the study will be written in a report, which will be part of my Master's degree. The end report will be made available to your organisation.

Your experiences with your organisation's programme can give important information to the study. If you agree to participate in the study, you will be involved in an interview (up to an hour). With your permission, interviews will be recorded. Recordings of the interviews will be destroyed after they have been transcribed. Your own name will not be used in the written report and it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community.

If you agree to participate in the study, you are free to withdraw at any time or may refuse to answer any of the questions asked of you.

If you agree to participate, please read and sign the statement below.

Thank you for your co-operation,

Dashakti Reddy

Written consent for participating I/NGOs and GOL

The purpose of the study has been explained to me and I understand what it is about. Participation will involve an individual interview.

It has also been made clear that if I agree to participate in the study, my own name will not be used and, in the written report, it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community. Recordings of the interviews will be destroyed after they have been written down.

I am free to withdraw at any time or may refuse to answer any of the questions asked of me.

Name: _____

Signature: _____

Date: _____

Explanation of the study for participating traditional healers and community members

This Informed Consent Form has two parts:

- **Information Sheet (gives you information about the study)**
- **Certificate of Consent (this is where you sign if you agree to participate)**

You will be given a copy of the full Informed Consent Form

Title of the Study: Sexual gender-based violence (SGBV) in Liberia: an investigation into the dual system of traditional and western healing.

Researchers: Dashakti Reddy, student from the University of Bergen, Norway.

What is this research study about?

This study is about children who have been subject to sexual gender-based violence (SGBV) and the types of healing they receive. I am interested in exploring healing practices provided by traditional healers. This project will also explore the provision of Western medical and psychological services for SGBV child survivors. Local perceptions of these two types of care by respected community elders will be sought.

The results of the study will be written in a report, which will be part of my Master's degree.

Your experiences can give important information to the study. If you agree to participate in the study, you will be involved in an interview (up to an hour). With your permission, interviews will be recorded. Recordings of the interviews will be destroyed after they have been transcribed. Your own name will not be used in the written report and it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community.

You will not be compensated with payment or gift for being part of the study. Any expenses incurred, such as travel costs as a result of taking part in the study will be repaid.

If you agree to participate in the study, you are free to withdraw at any time or may refuse to answer any of the questions asked of you.

If you agree to participate, please read and sign the statement below.

Thank you for your co-operation,
Dashakti Reddy

Written consent for participating traditional healers and community members

The purpose of the study has been explained to me and I understand what it is about. Participation will involve an individual interview.

It has also been made clear that if I agree to participate in the study, my own name will not be used and, in the written report, it will not be possible to trace who said what. Whatever is said in interviews or activities will not be passed on to other people in the community. Recordings of the interviews will be destroyed after they have been written down.

I am free to withdraw at any time or may refuse to answer any of the questions asked of me.

Name: _____

Signature: _____

Date: _____

#3

Interview Guide 1: I/NGOs and GOL

1. Can you tell me about SGBV in this community?
2. What are the underlying causes of SGBV in this community/Liberia?
3. What is the status of children in this community?
4. What is the situation of children regarding SGBV?
5. Who are the perpetrators of child sexual abuse?
6. What is the procedure to help children after sexual assault?
7. What are the challenges for NGOs/ GOL working with SGBV, specifically with children?
8. How do you measure the effectiveness of your programmes for children?
9. Does your head office/donors limit what you can do in any of your programmes?
10. What are your organization's views on traditional healers in Liberia?
11. Do you ever engage with traditional healers/medicine in this community? How? Why, why not?
12. Do you think there is a need for international NGOs/GOL to work with traditional healers?
13. Does your organisation have plans to engage with traditional healers? Why, why not?
14. Is there anything else you would like to tell me?

Interview Guide 2: Traditional Healers

1. Can you tell me about the life situation of children in your community?
2. What keeps children safe is this community?
3. How would you describe a whole/complete or healthy child in your community?
4. How many children experience sexual abuse?
5. How long have you been a traditional healer?
6. How did you become a traditional healer?
7. How do you heal children who have been sexually abused? What does it involve?
8. Do many children come to you to heal?
9. Who are the ones sexually abusing children?
10. Why are children are being abused?
11. What are the dangers for children in this community?
12. What do you know about western NGOs and their programmes in healing children who have been sexually abused?
13. What is your relationship with the NGOs/government organisations that treat children?
14. How might you and other traditional healers work with NGOs?
15. Is there anything else you would like to tell me?

Interview Guide 3: Local community members/police

1. Can you tell me about the life situation of children in your community?
2. What is regarded as sexual abuse?
3. What is the situation of children regarding sexual abuse?
4. How can children be protected in your community?
5. When are they no longer protected? When are they regarded as adults?
6. Where do children go to get healed in your community?
7. When children are sexually abused, what is done locally to heal them?
8. How can children who have been sexually abused get help?
9. Do you know where to find these services? (NGO offices/traditional healers)
10. What is the best care/healing you recommend for children?
11. Can you tell me about the government programmes for children who have been sexually abused?
12. How do people report cases to the police or SGBV Crimes Unit?
13. Who are abusing children?
14. Why are children being sexually abused?
15. Is there anything else you would like to tell me?

Interview Guide 4: Children survivors of SGBV

1. What is it life for children living in your community?
2. Can you tell me about the people you live with?
3. Can you describe the relationship with your family/the people you live with?
4. Who is the person/ organisation that supports you the most in your life?
5. Who do you trust the most?
6. What makes you feel safe?
7. Can you tell me about your experience of sexual violence?
8. Could you describe what happened to you after it happened?
    a. Did you tell anyone about what happened to you? Who did you tell?
    b. Were the police involved?
9. Did you know the person who abused you?
10. What did you do/are you doing to heal?
11. Who decided to get this type of healing?
12. How did the healing make you feel?
13. Do you know about other types of healing?
14. What type of healing do you think is most helpful?
15. Do you think people like Western healers or traditional healers more?
16. If you knew another girl in the same position as you what would you recommend she do?
17. Is there anything else you would like to tell me?

#4 SGBV survivors' experiences

Appendix # 4: SGBV survivors' experiences								
	Age	**Lives with**	**Relationship with people she lives with**	**Person that supports her the most**	**Trusts the most**	**Safety**	**School**	**Employed**
Landsby								
SV1	15	"My parents" (1 brother, 1 sister)	"They help me good. They take care of me. Yeah, they send me to **school**. And the they protect me"	"My mother"	"My **mother**"	"My mother protects me"	7th Grade	Market selling when on school vacation
SV2	15	"My mother" (1 sister)	"They are very good for me" Get along – sister just gave birth	"My mother"	"I trust my **mother**"	"I feel safe"	6th Grade	Swamp work to help mother during vacation
SV3	19	Varied – many strangers		The yard people help her with the baby	N/A	Commented on using condoms and unwanted pregnancies	Can no longer afford	Market selling: "any small small job"
SV4	13	Mother & Stepfather	No longer lives with them (since 1 year)	N/A	N/A	N/A	Left due to pregnancy	N/A
Monrovia								
SV5	15	Grandmother (5 sisters; brothers live with father)	"Good. She send me to **school**. She do EVERYTHING for me. She help me good, she take good care of me…but I live with her on a certain level and I **MOVE,** yeah I'm able to sustain."	**Grandmother**: "I live with my ma, but I come, when I was small I was living with my ma, I sat with my grandma, she told me I should be with her."	"I trust my **ma** and my **grandma**"	"Because I live with people, that taking good care of me"	6th Grade	N/A
SV6	14	"I live with my mother" (father, 3 brothers, 3 sisters)	"They send me to **school"**	"My father"	"I trust my **mother**"	"Myself. To protect myself…How I protect myself. I come here to be protected."	10th Grade	"My mother send me to go sell. I go sell. I sell, I sell bathing soap"
SV7	15	"I live with my mother. My father travel America."	"It's very good. She send me to **school**, she my father, she clothes me, she do a lot of thing for me."	"My father"	"My **mother**"	"Nothing."	9th Grade	N/A
SV8	14	"I live with my mother*" (*Aunt)	Not very good	"That was the man who they arrest for the crime of rape. He was sponsoring me at that time my Pa left and we were in the bush"	"My **ma**"	"Nothing, Nobody here no."	5th Grade	N/A

	Age	Life in the community for children *answered in terms of what liked/don't like	Knowledge about police/ knowledge of WACPS	Where they go to heal/get better	Perpetrator known
Landsby					
SV1	15	Likes: friendly relationships community members have Does not like: fighting (on the road) "when they drink, they fighting, destroy things. Not fine" Children (her age) getting pregnant	No knowledge of WACPS Trusts the police, think they will come Stresses: "If bad things happen you must go to the city mayor first." He will stop the fighting	"To the hospital mostly", but people like to go to traditional healers Likes the **country doctor** (but hasn't been?) better for things like broken bones but has not been to one Says when a rape happens, you must "go to the hospital"	N/A
SV2	15	Feels safe: "It's good" Does not like: "Some girls' are on the street…They don't sleep with their parents and they giving theirself up to men"	No knowledge of WACPS Trusts the police but they will not come if something bad happens	"I like the hospital" (mother works at the hospital) "my mother work at the hospital" - nurse	N/A
SV3	19	"The situation in our community because some of it is bad because some people, most of them are unfriendly."	No, but knowledge of the police	Differed – hospital, UN man for help, NGO lady	Yes, multiple incidents
SV4	13	Not good: Being raped by stepfather who was also her school teacher	N/A	N/A mother found out months later	Yes, stepfather
Monrovia					
SV5	15	N/A	"I don't tell nobody o. If I feel, anybody now can keep it to myself. If I tell someone, all I'll be thinking (about myself?) so the person won't be helping me. So I don't tell someone, I try to keep it within myself." Police involved only after community people called them – "I in trouble, that lady, the police rescue me and bring me this side."	Taken to hospital "I don't really like herbalist o…country medicine not good."	Yes "by face and name"
SV6	14	"I love school" "Problem not there, no problem"	Police involved 'They take me to the hospital and then they carry to the police station"	Taken to hospital "I go to the hospital" "I love, I love the country doc…the hospital doctor…no I don't use the country doctor here"	Yes, gang raped by 10 community boys
SV7	15	"Children in my community, some of them are good, some of them not good. So I can't/don't go around them, because my mother told me I shouldn't go around bad friends. So I aint go around them. After school I take my book, I study from there, I go and see her." "I like the way the community act"	Aunty contacted the police, once SV7 told her about what her mother had done to her.	Taken to hospital (JDJ) prefer ("the hospital"	N/A
SV8	14	N/A	"Yeah the police came."	"Yeah, they carried me to hospital. I go to hospital"	Yes, perpetrator sponsoring her education

5 Coding table

Global themes	Global Response (research question1)				Local Response (research question2)	Local Perception (Research question3)	
Organising themes	Government Response, prevention, advocacy INGO Response, prevention, advocacy	Understanding the system Perpetrators: conditions that allow perpetrators to access children	Underlying causes influecing SGBV	Contributing factors of SGBV	NGO Response, prevention, advocacy Community Response, prevention, advocacy	SGBV survivor experiences	Challenges for NGOs/Govt working in SGBV
Basic themes		Relationship between perpetrator and survivor and perpetrator and survivors mother/family Power dynamic between perpetrator and survivor Trust between perpetrator and survivor Impunity Lowering age of perpetrator to avoid conviction or regarded as minor	The break down of society during war and the social norms created around SGBV Culture/tradition roles and expectations Impunity	Children vulnerable at home, in the community and at school Children being 'available' in the community Economic power of men who can provide schooling/needs and desire for education Societal roles and statuses of children, women and men Family structure: children living with extended family due to war and abandonment Physical age vs. sexual maturity			Inefficient and corrupt system catering to SGBV survivor needs Unclear understanding of rape law and children's law Hand over from humanitarian aid to development aid Insufficient funding and funding being misappropriated Monrovia vs. the Interior Severe implementation issues
Codes		Acquaintances (perpetrator 'known') Men Boys Uncles & 'uncles' Stepfathers Grandfathers Teachers People in authority Neighbours Age of perpetrator Age of survivor Power Trust	War Culture/tradition Sande/Poro bush school Healers Ritual/power Polygamy Marriage Impunity	Poverty (lack of basic needs: food, clothes) Children lacking access to education Rape law Children's law: children no longer respect parents/elders Economic power Gender roles Children's roles Caregivers Abandonment Age of survivor Breasts Sexual maturity Forced consent Dress code Stigma: keep it in the family Compromising cases Trust of perpetrators Peer pressure Sex for grades Forced/coerced consent			Corruption Poor and rebuilding judicial system Poor and rebuilding health system Police Hospitals/clinics Lack of resources Sex for Grades Sex for employment Donors limitations/preferences Lack of trust in Govt. Children's law Rape law Lack of awareness Humanitarian aid to develoment aid Funding Creating awareness about age vs. sexual maturity Compromising cases

Table #1: Time plan

	May 2013	June 2013	July 2013	Aug 2013-May 2014
Place	Monrovia	Landsby	Landsby	Bergen
Participants	INGO offices Government offices SGBV focus persons Girls who have survived SGBV Head Zoe	Regional I/NGO offices Regional government staff Community leaders Girls who have survived SGBV Traditional healers		
Methods	In-depth interviews Observation Participation in trainings Document analysis	In-depth interviews *Informal focus group* Observation		Analysis of data and writing thesis

Table #2. INGOs interviewed in Monrovia and Landsby

Monrovia			Landsby		
CCF: ChildFund	Female	Local	INGO1	Female	Local
IRC: International Rescue Committee	Female	Local	Local NGO1	Female	Local
NRC: Norwegian Refugee Council	Male	Local	Local NGO2	Female	Local
Save: Save the Children	Male	Local	Local NGO3	Male	Local

Table #3. Government SGBV focus persons interviewed in Monrovia and Landsby

Monrovia			Landsby		
UN/MOGD GBV Joint Programme: Coordinator	Female	Expat	LNP: regional WACPs	Male	Local
MOGD (GOL) GBV Unit: Coordinator	Female	Local			
LNP: Liberian National Police: Head of WACPS	Female	Local	Regional hospital:	Male	Local
MOHSW: Director for Psychosocial Support	Male	Local	SGBV focus person		
MOHSW: Div. Complementary Medicine (DCM)	Male	Local			
Ministry of Justice (MOJ)	Male	Local			

Table #4. Community leaders interviewed in Monrovia and Landsby

Monrovia	Landsby	
Head of the Women's Traditional Council:	Christian Leader: Head of the Minstrels Council of Churches	Male
Sande Society (female secret society)	Muslim Leader: Chairman of Muslim Committee	Male
	Traditional Head of General Chiefs: Landsby	Male
	Traditional Chairlady: Landsby	Female
	Youth Group Leaders: Chairman and member	Male

Table #5. Girl survivors' of SGBV interviewed in Monrovia and Landsby

Landsby	Monrovia	Cancelled interviews
SV1 x 1 (INGO1)	SV5 x 1 (safe home)	x 1 cancelled (by parent) Landsby
SV2 x 1 (INGO1)	SV6 x 1 (safe home)	x 1 cancelled (by parent) Landsby
SV3 x 1 (INGO1)	SV7 x 1 (safe home)	x 1 cancelled (by parent) Landsby
SV4 x 1 (NGO2)	SV8 x 1 (safe home)	
x 8 (informal focus group)		

Table #6: Interviewed participants providing background information on SGBV in Liberia

Monrovia		Landsby	
LNRCS: Liberia National Red Cross Society	Female	MOGD: Gender Coordinator (Landsby)	Female
Monrovia GBV Task Force Meeting	Mix	Local Landsby NGO	Male
Psychosocial Pillar Meeting: MOHSW	Mix	Young women community group	Female
NGO seminar (Kvinna till Kvinna)	Mix	District women's community organisation	Female
NRC trainings & observations	Mix	Carter Centre	Male
UN Women	Female		
UN Gender Office	Female		
James David Jr. Hospital	Female		
Local community clinic	Male		
Safe home	Female		

Table #7: Summary of abbreviations and participants' gender

Monrovia	Gender	Landsby	Gender
CCF: ChildFund	Female	INGO1	Female
IRC: International Rescue Committee	Female	NGO1	Female
NRC: Norwegian Refugee Council	Male	NGO2	Female
Save: Save the Children	Male	NGO3	Male
UN/MOGD: UN Representative	Female	LNP WACPS	Male
MOGD: Ministry of Gender and Development	Female	Landsby hospital	Male
LNP Head of WACPS: (HOW)	Female	General Chief	Male
MOHSW: Min. of Health and Social Welfare	Male	Muslim Chairman	Male
DCM: Division of Complementary Medicine	Male	Church Councilman	Male
MOJ: Ministry of Justice	Male	Traditional Chairlady	Female
MIA: Ministry of Internal Affairs	Male	Landsby Youth Group	Male x2
Head Zoe: Sande (Women's) Society Leader	Female		