Country Profiles from Africa

Republic of Congo
Rwanda
Sierra Leone

Post-Conflict Situation in the *Republic of Congo*

January 22-31, 2001

Background

Historical Context

The Republic of Congo (hereafter referred to as Congo) lies in the western shadow of its imposing and fractious neighbor, the Democratic Republic of Congo (formerly Zaire, hereafter DRC). To the south, where the Congo meets the Atlantic Ocean, it shares a small portion of its border with Angola. Both neighbors are engaged in seemingly intractable conflicts, DRC as the central African repository for regional conflict, and Angola as the site of a civil war notable for its human rights violations. Against this backdrop, and following a decade in which widespread killing, torture, rape, and detention of Congolese civilians were the norm, the Congo entered the new millennium in a state of relative peace and stability.

In the early 1990s, suffering a dire economy and riding the tide of post-cold war global democratization, the Congo made a peaceful transition from thirty years as a Marxist-Leninist single-party state to a multi-party democracy. The peace was short-lived; groups opposing elected president Pascal Lissouba mounted campaigns that by 1993 erupted in violence and established a pattern of militia-based partisan conflict that twice more climaxed in broad-scale civil war.

Violence exploded from June to October 1997, when an armed militia supporting former single-party president Sassou-Nguesso battled with forces respectively representing the interests of Lissouba and former prime minister Bernard Kolelas. Sassou's Angolan-aided forces overthrew Lissouba's government and forced him and Kolelas into exile. Newly established as president, Sassou quickly proclaimed his Fundamental Act, which replaced the 1992 constitution, and established a transitional council to serve as a three-year interim parliament. Violence again escalated, and in December 1998 rebels launched an offensive on the capital, Brazzaville, looting and burning much of the southern part of the city and displacing an estimated 250,000 Congolese. In early1999 militia-based incursions continued throughout regions south of Brazzaville, further displacing an estimated 500,000.[1]

In his press for peace, Sassou announced in August 1999 an amnesty for surrendering militia combatants. In November an initial cease-fire agreement was signed, followed by a more comprehensive accord in December 1999. Signers of the accord agreed to demilitarization of political parties, forfeiting of arms, and amnestied reintegration of all combatants who fought between June 1997 and December 1999. The reintegration process has resulted in outbursts of vigilante violence, and the government's security forces reportedly continue to commit smaller-scale human rights breaches, but there have been no major affronts to the peace initiative. By the end of 2000 most of the 800,000 internally displaced Congolese had returned to their homes.[2]

Status of Women

The Congolese population, however, still suffers the effects of a decade of conflict. According to the

United Nations, poverty—estimated at 70 percent in 1997—is currently a "near-universal phenomenon" throughout the country.[3] Women and children, who were ongoing targets of the militias' civilian rampage, continue in peacetime to be at risk. Although the current constitution provides for equality of all citizens, and though the government has ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), per capita income for women stands at 54 percent of that of men.[4] Women are underrepresented in the formal sector, and in rural areas they are largely confined to small-scale farming and petty commerce. An analysis of extended food assistance beneficiaries in Brazzaville found that 70 percent were female-headed households, likely reflecting a post-war increase in single mothers.[5] Although there is a Ministry of Public Service, Administrative Reform, and Promotion of Women, only two out of twenty-five cabinet members in the national government are women, and women have virtually no representation at the local level.[6] Maternal mortality rates reportedly worsened throughout the 1990s, and in its Plan for 2001-2002, the U.N. estimated that only 2 percent of Congolese women have access to contraception.[7] Abortions, illegal except when pregnancy poses a danger to the mother, nevertheless appear to be discreetly available. According to one local clinic willing to share information anonymously, twenty abortions are performed there per day. HIV/AIDS is currently estimated to be the leading cause of death among the 19 to 45 age cohort.[8] These negative indicators make it difficult for women to recover from the war, especially in the wake of well-documented and pervasive GBV.

Gender-based Violence

Nature and Scope

Although rape outside of marriage is illegal in the Congo, widespread sexual violence against women and children during the Congo's three waves of conflict illustrate long-standing cultural traditions supporting the exploitation of women. The Congo is a patriarchal society in which violence against women is normative and rarely reported. There are no legal protections specific to domestic violence, and marriage and family law discriminate against women, allowing polygamy and adultery for men, but prohibiting both for women. In rural areas the traditional interpretation of dowry and inheritance laws generally restrict women's ability to divorce or otherwise live independently, and domestic conflicts are typically settled by male heads within the family or, in more extreme cases, by local male officials or chiefs. Forced sex in marriage is often considered the husband's right, a conviction exacerbated by the dowry tradition. Sexual harassment and sexual assault in the workplace and schools are also apparent problems. Although public sex solicitation is illegal, remunerated sex is not. The economic collapse during the 1990s combined with the rise in female-headed households may be contributing to the reported upsurge in informal prostitution.

Early Programming Activities

Subsequent to the conflict of 1997, the International Rescue Committee (IRC) conducted a baseline reproductive health assessment that tentatively surmised "hundreds to thousands" of women may have been sexually violated by militia forces.[9] The assessment further concluded that health personnel were generally uncomfortable discussing GBV with their patients, cleaving to a long tradition of silence.

Following from the assessment, IRC instituted the first—and, evidently, the only—program designed to address issues of GBV in Congolese society. The program launched a Brazzaville media blitz, using street theater, songs, radio, television, billboards, posters, pamphlets, and T-shirts to sensitize the population about basic issues of sexual violence against women. All the messages—some with very explicit illustrations of violence—were approved by a Congolese project advisory board comprised of government, local NGO, church, press, and community representatives. After several months of sensitization, the IRC GBV program facilitated curriculum development (by recruiting local experts) and subsequent GBV trainings to health centers and social workers on emergency reproductive health and psychosocial response. Curricula were also created for training judiciary, police, military personnel, and psychologists.

During and following the rebel incursion into south Brazzaville, displaced populations began arriving at multiple Brazzaville-based reception centers in early 1999. The IRC GBV program, primarily in collaboration with International Federation of the Red Cross (IFRC) and Médecins Sans Frontières (MSF), provided initial support to victims, ensuring that

survivors received free medical treatment and social services. Approximately two thousand women from Brazzaville came forward to acknowledge sexual victimization by militia and military forces, with close to 10 percent reporting related pregnancies.[10] Extrapolating from estimates of the numbers of survivors who never sought treatment, the U.N. has suggested that five thousand women in Brazzaville alone were victims of war-related sexual violence.[11] Cases were reported of infanticide and maternal suicide, as well as rejection by the victim's husband of the unwanted child and its mother. With financial support and staffing from international organizations, some twenty-five local NGOs, hospitals, and health programs were equipped to provide basic GBV counseling and medical management.

During 1999 GBV programming existed exclusively in the Brazzaville region. As refugees began returning to Congo's southern cities in 2000, IRC staff were positioned in Dolise, the capital city of the Niari region (one of the most affected by the civil war of 1998-1999). Again, IRC's program was the first and only in the Niari region to explicitly address sexual violence. The GBV team conducted similar sensitization as that launched in Brazzaville (though on a smaller scale) and established free medical and psychosocial programs for rape survivors. IRC also moved further inside the bush to Makabana, where they trained medical providers to conduct rape exams and provide IRC-supplied medication. By mid-2001, IRC had identified close to five hundred survivors, three hundred of whom were assisted in IRC-facilitated health centers. During this period, IRC also retained a Brazzaville lawyer to examine existing legislation affecting survivors of violence in order to increase capacity for legal advocacy regarding GBV. Most recently, IRC's GBV operations have been initiated in the Loukoulela and Betou regions of northern Congo, where the United Nations High Commissioner for Refugees (UNHCR) has established services for an influx of refugees from DRC.

Current GBV-related Programming

War disrupts absolutely, and in the case of IRC's Brazzaville GBV program, the 1998-1999 conflict had an impact on the vision and execution of the project. Although IRC had anticipated transferring the program into a two-and-one-half-year United Nations Development Program (UNDP) "Integration of Women in Development" project, funding was stalled in early 1999 because of the new fighting. The GBV program has since been operating mostly according to emergency needs. In 1998 and early 1999 NGO and donor interest in issues of war-related sexual assault was relatively strong, with organizations such as the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) proposing complementary projects with GBV components, but in late 1999 MSF's international denouncement of the Brazzaville rapes received little attention from the international community.[12] Donor enthusiasm has since waned, perhaps because of increased attention afforded the conflict in neighboring DRC. Even so, the ongoing efforts of IRC, IFRC, and MSF, in collaboration with local programs, have succeeded in significantly changing the landscape of medical response to survivors of GBV, to the extent that the Ministry of Health's national plan of action now includes a component on sexual violence and rape during war.

Brazzaville

IRC's GBV program substantially reduced its activities in Brazzaville when it moved its efforts to Dolise in early 2000. The several local NGOs that had developed community education and response protocols on violence are currently operating with limited to no international funding and locally based GBV sensitization activities appear to have languished. For example, the local advocacy and direct service NGO, Thomas Sankara Association, continues to provide brief counseling and medical referral for victims, but does so primarily with volunteers and funds collected from association dues. A prominent Brazzaville theater group, originally supported by IRC to develop anti-violence scenarios, similarly continues its educational street theater on a variety of topics dictated by funding incentives, but has not recently received support to conduct sensitization on GBV. Both organizations express concern that rape, domestic violence, and sexual harassment will continue to pose serious risks to Congolese women and girls in the absence of ongoing sensitization.

UNICEF, IFRC, MSF, local social workers, and an association of Congolese psychologists support or directly provide clinic and hospital-based curative services for victims of violence. Hospitals are requested to submit their sexual assault statistics to the Ministry of Health, though the Ministry's compiled

statistics are not available to the public, and it is unclear how the Ministry intends to use the data. One hospital gynecologist reported seeing approximately twelve to fifteen rape cases per week—with about one-third of the rapes committed post-conflict—and at least one domestic violence case per week.

Even in the presence of ongoing violence, few initiatives are forthcoming. UNICEF plans to target the adolescent population by supporting the local Brazzaville-based NGO, ACOLVEF, to provide assistance to sexual assault survivors through counseling, training, education, and micro-enterprise opportunities. UNDP and UNFPA have recently initiated data collection on sexual violence cases in southern Congo and are also funding locally produced television broadcast videos on sexual violence against women. Both UNDP and UNFPA are interested in addressing the need for GBV-related legal reform, but have not collaborated with IRC's legal expert retained to explore the application of national and international laws on violence and women's rights. At present there appears to be little coordination among local and international agencies, and no active working groups dealing with GBV.

Dolise

IRC's GBV activities in Dolise are similar to those developed in Brazzaville, but staff work in a more constrained environment, with limited infrastructure and material resources. When IRC entered Dolise in March 2000, the displaced community was in the first phases of return. Local government and institutions were only beginning to regroup. The IRC GBV program initially consulted with the mayor of Dolise, and with his approval created and posted a series of billboards on sexual violence. IRC also provided training for health and hospital workers on rape response protocols and established a delivery system of free gynecological examinations and basic medications to survivors. An IRC social worker currently makes home visits to identify sexual assault survivors, offering psychosocial support and medical referral, as well as support for other issues such as domestic violence. A theater group commissioned to conduct GBV sensitization has done so in Dolise's streets to wide audiences.

Local health representatives and members of Dolise's women's organizations strongly support IRC's activities, but are concerned that the limited sensitization activities and medical services are insufficient to change the culture of violence against women. In a focus group with women victims of military and militia rapes who received assistance from IRC, they expressed similar frustration with the medical care available, particularly the absence of post-natal care for babies produced from their rapes and lack of hospital services for more severe gynecological complaints, such as chronic bleeding, that surfaced after their assaults. Notably, all of these women identified themselves not only as rape survivors but also as victims of domestic violence, and all expressed fears about their HIV status. Most of the women felt stigmatized and ostracized by their community, if not their families. Other forms of violence identified by Dolise officials, health care providers, and local men and women include sexual harassment of women by bosses and teachers, incest and other forms of sexual violence against children, forced sex in marriage, ongoing coerced sex by the military, and high rates of prostitution among adolescent girls and single mothers.

Makabana

Similar types of violence were identified by a health care provider in Makabana, whose clinic is funded by IRC. Trained by IRC to conduct free gynecological exams and provide basic medications to rape survivors, he sees patients whose predominant presenting complaints are symptoms related to sexually transmitted infections. The health care provider has also been confronted with cases of domestic violence—such as one woman whose hand was chopped off with a machete by a jealous husband—for which he has no expert resources or referrals.

Initial sensitization activities in Makabana were brief and limited to community education about the availability of free medical services to rape survivors. IRC staff judged that the military presence in Makabana and unresolved political hostilities resulted in a potentially incendiary environment not yet stable enough to examine issues of GBV.

Summary

GBV activities initiated by the IRC program and taken up by other international and local organizations have had a marked impact in the Congo:

sensitization and training have led to medical and psychosocial services that were previously non-existent and have resulted in rape survivors seeking assistance. Standardized health protocols utilized by Brazzaville hospitals have facilitated the collection of prevalence data, which has in turn contributed to advocacy efforts. Concern about GBV has been stimulated in government and local organizations, and sexual violence is on the national health agenda. Most recently, IRC has taken on the additional task of analyzing local and international legal texts on violence against women—a critical area of investigation, given that survivor retribution for war-related rape is at risk because the government's amnesty program may provide blanket immunity for perpetrators.

The success of IRC, IFRC, MSF, and others in garnering the support of a local community previously unfamiliar with GBV prevention and response programming may be partially attributable to their ability to meet the emergent health and psychosocial needs of those traumatized by war. It is surely also attributable to participatory methods: as a matter of course, IRC first approached community representatives to engage their support for GBV activities, and consistently used local experts to develop and conduct sensitization and training activities. Another component to their successful strategy was the provision of free health services—in both Brazzaville and Dolise it was widely announced that survivors of rape could receive free services at select health clinics and hospitals. (Potential lack of confidentiality was reduced by ensuring that multiple services were offered at the clinics.) However, the general focus on short-term, emergency-oriented GBV activities has thus far limited the Congo's ability to lay a strong foundation for ongoing GBV programming, particularly outside the health sector.

Although the GBV services currently provided are critical, they are neither comprehensive nor sufficiently long term to have an impact on other forms of GBV, such as domestic violence, spousal rape, and harmful traditional practices, or on the basic attitudes that inform all types of GBV. In one telling theater campaign against sexual violence, condom distribution was discontinued because male participants reportedly associated the condoms with the necessity to protect themselves while committing rape.

Sustained programming currently exists in the form of curative rather than preventive activities. Furthermore, hospitals and health clinics have protocols and financing to provide treatment for rape, but they have not had similarly comprehensive training to respond to domestic or other forms of violence. Local NGOs experienced in GBV sensitization activities have received inconsistent support and do not have the resources to continue to expand their outreach. Brazzaville-based security forces, including police and military, participated in IRC trainings, but there appears to have been little follow-up or monitoring of GBV-related protection protocols; in fact, the military's resistance to GBV sensitization precluded further training. Similarly, judges and lawyers have received basic sensitization, but the current judicial process remains reliant on customary procedures that undermine the victim's ability to seek prosecution, such as the general requirement that victims must pay in order to retain a lawyer and process a complaint. There are few corollary support programs —income generation, social support, etc.—for women reporting violence, and local women's organizations in both Brazzaville and the Dolise area have not organized themselves around combating ongoing violence, especially in the context of larger human rights issues such as gender equity and equality.

Recommendations

1. If the Congo is to combat GBV, government, international, and local institutions should be catalyzed to coordinate their GBV-related activities so that prevention and response evolve to embrace issues of GBV beyond sexual violence, such as domestic violence and coerced or forced prostitution. Success in future programming will be directly related to the extent that government and donor institutions shift from remedial to forward-looking and comprehensive strategies to prevent GBV. An inter-agency working group should be established that includes representatives of the national government, international U.N. bodies, international and local NGOs.

2. UNDP and UNFPA should follow through on their stated interest to examine laws related to GBV, from which more equitable and protective legislation may be drafted. In the immediate future, the government should institute legislation that holds perpetrators of war-related sexual violence accountable for crimes committed

during the civil conflict, and the government should support federal courts to prosecute those crimes.

3. Health services for all rape survivors—not just those reporting war-related sexual assault—should be free of cost. The Ministry of Health should institute and monitor the implementation of policies requiring that designated medical doctors throughout the Congo are trained in sexual assault forensic examinations and in providing expert testimony. The Ministry of Health should assume responsibility for collecting and analyzing data on GBV from all of Congo's hospitals and health centers, rather than only those in Brazzaville.

4. Ministries for the interior, justice, and social welfare should support the systematic integration of GBV prevention and response mandates in social services and protection sectors. The ministries should be accountable for ensuring that social workers, police, lawyers, and the judiciary are well trained in laws related to GBV, as well as in response protocols, and data collection and analysis.

5. More comprehensive research initiatives should be initiated by the government to better clarify the scope of GBV, so that programming can be adapted to address issues such as domestic violence and coerced or forced prostitution.

6. Media campaigns using radio, television, and street theater should be spearheaded by the government in collaboration with appropriate U.N. institutions, including UNFPA, UNDP, and UNICEF. These campaigns should expand their current focus beyond the issue of sexual violence.

7. In order to extend the reach of their initial successes, existing Brazzaville-based organizations already experienced in GBV sensitization and service delivery should be financed to provide training in other regions of the Congo. Community development activities should be undertaken to stimulate the formation of women's organizations, and thus create a broad local GBV advocacy base, as well as a network for general empowerment initiatives.

8. Similarly, men's organizations, churches, and local government structures should be used to involve men and male community representatives in ongoing prevention efforts.

9. GBV issues, especially in terms of mutual respect, conflict management, and sexual health, should be introduced into school curricula, and teens should be recruited to advocate against violence to their age cohort. Targeting schools will be critical in addressing the culture of violence spawned by Congo's years of civil conflict.

Notes

1 United Nations, *U.N. Plan: Republic of Congo, 2001-2002* (Brazzaville, 2001), 4.

2 U.S. Department of State, *Country Reports on Human Rights Practices, 2000: Republic of Congo* (Washington, D.C., 2001), 1.

3 U.N., *Plan: Republic of Congo, 2001-2002*, 3.

4 U.N., *Plan: Republic of Congo, 2001-2002*, 20.

5 U.N., *Plan: Republic of Congo, 2001-2002*, 11.

6 U.N., *Plan: Republic of Congo, 2001-2002*, 22.

7 U.N., *Plan: Republic of Congo, 2001-2002*, 28.

8 U.N., *Plan: Republic of Congo, 2001-2002*, 28.

9 International Rescue Committee (IRC), *Addressing Emergency Reproductive Health Needs: Pilot Minimum Initial Service Package Project Report* (Brazzaville, 1998), 1.

10 IRC, *Gender-based Violence Program in Republic of Congo Project Report* (Brazzaville, 2000), 3.

11 U.N., *Plan: Republic of Congo, 2001-2002*, 18.

12 L. Shanks, N. Ford, M. Schull, and K. de Jong, "Responding to Rape," *The Lancet* 357, no. 9252 (January 2001): 304.

Post-genocide Situation in *Rwanda*

February 18-28, 2001

Background

Historical Context

In 1994 Rwanda distinguished itself in the annals of world history by concluding a one hundred-day genocide during which militia groups worked in methodical concert with the ruling Hutu government's Forces Armées Rwandaises (FAR) to hack, rape, burn, and otherwise brutalize to death an estimated 750,000 Rwandan Tutsi and Hutu moderates. The searingly efficient success of the genocide was in part the result of an unresponsive international community; it was also the realization of a well-orchestrated, government-supported fomentation of ethnic hatred between the Rwandan Hutu majority and their minority Tutsi colleagues, neighbors, and relatives.[1]

Whether or not the Hutu-Tutsi divide that precipitated the genocide can be legitimately expressed in terms of ethnic difference—an issue of debate among historians—it does seem clear that the colonization of Rwanda exacerbated class distinctions among the Tutsi elite and the Hutu populace. The Belgians, for example, issued ID cards for Tutsi and Hutu based on the numbers of cows they had, thus solidifying a previously porous social structure. During Rwanda's post-World War II transition from colonial rule to independence, the Hutu launched a rebellion against the Tutsi monarchy. The related 1959 massacre of Tutsi was for the Hutu a socialist victory; for the Tutsi it was the "beginning of ethnic fratricide" that resulted in the first mass exodus of Tutsi refugees to neighboring countries. [2]

Hutu rule, including discriminatory practices against Tutsi, remained largely uncontested for the next thirty years. In the early 1990s the increasingly empowered and aggressive rebel army Rwandese Patriotic Front (RPF), comprised mostly of exiled Tutsi advocating for Tutsi repatriation and democratic government, laid claim through a series of armed offenses to territories in northern Rwanda, displacing some one million Hutu. Although Hutu President Habyarimana formally acceded to opposition requests for democracy by signing the Arusha Accords in 1993, his government continued to foster ethnic hatred and instill fears of a return to Tutsi hegemony. Habyarimana's assassination in April 1994 (allegedly by Hutu government radicals) was seemingly the call to action required by Hutu extremists to launch their Tutsi and moderate Hutu extermination campaign.[3]

The RPF advanced on Rwanda's capital city of Kigali in July 1994, definitively defeating the FAR and the militias, and clearing the way for an RPF-dominated "Government of National Unity." Fearing retribution, Hutu genocide leaders, as well as hundreds of thousands of other Hutu, fled to neighboring countries, crossing borders in advance of a tide of exiled Tutsi making their return to Rwanda. In 1996 many Hutu refugees, who had managed for several years to survive disease, militia control, and host government hostility in highly unstable refugee camps, opted or were forced to repatriate, so that by the late 1990s post-genocide Rwanda had evolved into a society of collective traumas.[4]

The genocide exacted a heavy toll on families and communities and also destroyed the country's economic, social, and political infrastructure. Thousands of genocide suspects have been summarily arrested, even absent a formal charge; some of the more than 100,000 currently awaiting trial have been detained since 1994.[5] In spite of the relatively high level of international aid per capita following the genocide, the numbers of returnees and shifting population movements, as well as repeated Hutu-based insurgencies in Rwanda's northwest region, considerably slowed the country's ability to move from emergency to development.[6] Although social and economic initiatives are gaining ground, an estimated 70 percent of the population lives in poverty, and 90 percent are engaged in subsistence agriculture.[7]

Status of Women

Surviving women and children remain among the most affected; in some communities widows make up 60 percent of heads of households.[8] Despite recent notable gains in the numbers of women in key government positions, women are still underrepresented in the ranks of power, both within the government and in civil society posts.[9] A post-genocide proliferation of local NGOs providing education, social, and financial assistance to women have in some measure redressed this void.[10] Their work has been strengthened and reinforced by the advocacy efforts and support of the relatively new Ministry for Gender and Women in Development (MIGEPROFE). The international community has also had a key role in supporting women and their organizations, most notably through the United Nations Development Program's (UNDP) Trust Fund for Women; the U.S. Agency for International Development's (USAID) Women in Development Program; and the United Nations High Commissioner for Refugees' (UNHCR) Rwanda Women's Initiative (RWI). In terms of genocide-related violence, the RWI in particular provided direct funding to local women's programs providing psychosocial assistance. Several of these local NGOs, as well as MIGEPROFE and a few international NGOs, have led efforts to address the effects of GBV perpetrated during the genocide.

Gender-based Violence

During the Genocide

In a glaring conflation of gender and ethnic biases, the first three of the Hutu "Ten Commandments," which reportedly circulated widely before the genocide, exhort Hutu men to avoid the seduction of Tutsi women, and accord favor to Hutu women, who are "more dignified and more conscientious in their roles as woman, wife, and mother" than their Tutsi counterparts, and "pretty, good secretaries, and more honest."[11] Such propaganda illustrates and reinforces some of the gender issues at play in the atrocities committed by both male and female *genocidaires*: by specifically raising the specter of Tutsi women's enticing sexuality, the commandments simultaneously promote and devalue the Tutsi woman in terms of her sexuality, laying the groundwork for violence that targeted that image. Although exact numbers of victims are unknown, it is estimated that a quarter- to a half-million women and girls of all ages *survived* rape. (The figures, loosely extrapolated from the estimates of the two to five thousand babies reportedly born of genocide sexual violence, assume a 1 to 4 percent chance of pregnancy with every sexual encounter.[12]) It is impossible to account for the numbers of women who were raped and then murdered. In a 1999 research initiative undertaken by the local Rwandan NGO Association of Widows of the Genocide (Avega), 39 percent of women interviewed acknowledged being raped, and 74 percent stated they knew women who were raped. Given the cultural stigma associated with rape and the subsequent isolation of victims—a stunningly low 6 percent of women interviewed had sought medical care since the genocide—it is likely that the actual number of rape survivors lies somewhere between these percentages. Avega's findings of types of genocidal sexual violence reinforce earlier findings of human rights investigators: atrocities included sexual slavery, gang rape, forced incest, purposeful HIV transmission and impregnation, and genital mutilation.[13]

Beyond the Genocide

According to the Avega report, GBV is not a new phenomenon in Rwanda. "Violence in everyday life is deeply rooted in the memory and habits" of the Rwandese, finding its expression in traditions such as the dowry, polygamy (illegal but condoned), forced marriage (illegal but prosecutable only by the victim's

family, who may often be complicit), and forced sex in marriage.[14] The genocide, directly and indirectly, further engendered violence against women and girls. For example, Hutu refugees were exposed to sexual violence in their camps in Tanzania and Zaire.[15]

Domestic violence—claimed in a Rwandan proverb to be a necessary precursor to achieving womanhood—was estimated at 20 percent in the 1995 Rwandan National Report to the Beijing Fourth World Conference on Women.[16] Women's representatives believe that this number is low and that, in any case, domestic violence increased in the genocide's trail of tension and despair. Prostitution, though officially illegal, has reportedly risen dramatically. Even more alarmingly, in a nationwide government survey of prostitutes, 76 percent of those interviewed who had undergone HIV testing were seropositive.[17] A spate of rapes of young children by adult males was also a post-genocide phenomenon, attributed on the one hand to misperceptions that having sex with young children cured HIV/AIDS, and on the other hand to the "near impunity enjoyed by those people responsible for violence during the genocide."[18]

Impunity has been a feature of rape-related genocide crimes, in part because the judicial response has been extremely slow. The success of international and Rwandan women's advocates in obtaining a "category 1" classification (punishable by death) for genocidal rapes involving "sexual torture" has heightened public awareness of the severity of rape, which was previously categorized as a misdemeanor, traditionally requiring reparations provided by the perpetrator to the victim's family. Yet few convictions have been levied by the International Criminal Tribunal for Rwanda, and women's organizations have complained that lack of security and confidentiality for survivors has discouraged them from speaking with tribunal investigators about their assaults.[19] The traditional *gacaca* system of community-based courts, reformulated by the Rwandan government as a way to expedite the thousands of accused awaiting trial for genocide crimes, will when implemented exclude category 1 offenses and thus further limit the prosecution of genocidal rapists.

However, several post-genocide rape cases have received judicial attention—due in large part to the advocacy of MIGEPROFE and local human rights and women's organizations. Some recent cases are reportedly being prosecuted to the full extent of existing laws, with punishments ranging from five to twenty years.[20] The Ministry of Justice (MINIJUST) has also facilitated short sensitization trainings on violence against women to the newly installed and overwhelmingly male national police force, but women's representatives suggest that police response to rape victims is still inconsistent and reflective of long-standing gender discriminatory practices. Response to most other non-genocide crimes against women, such as domestic violence, generally remains the domain of the family and the community; they have not yet achieved the same nationwide attention as rape.

Current GBV-related Programming

Compared to resources that flooded Rwanda after the genocide, the contributions of the international community to address genocide-related sexual assault were limited and belated. In her report following a visit to Rwanda in 1998, the United Nations Special Rapporteur on Violence Against Women expressed concern "at the incomprehensible absence of any programs supporting women victims of violence by any United Nations agencies and operations present in Rwanda."[21] A notable exception to this absence was the World Health Organization's (WHO) project to address the health needs of women and girls who survived violence. WHO's initiative began in 1997 with national education campaigns and continued until 1999 to provide medical supplies and basic psychosocial training to health care and social service providers.[22] Even so, WHO's brief trainings were admittedly introductory, and funding is not yet secured to implement the evaluation phase of their project. RWI also has GBV as one component of its mandate, yet only a few of the RWI-funded women's organizations have targeted issues related to violence against women. Plagued by dramatic shifts in funding, RWI has not been sufficiently consistent and/or strategic in its outreach to rural women affected by the genocide, thus limiting its overall "empowerment" objective.[23] In fact, all of RWI implementing partners are Kigali-based.[24]

More recently, several United Nations agencies, including UNDP, the United Nations Population Fund (UNFPA), and the United Nations Development Fund for Women (UNIFEM), have undertaken efforts to address GBV. With support from UNIFEM, for example, the Minister for Gender participated in a

1999 global videoconference on violence against women, and on International Women's Day in March 2000 MIGEPROFE initiated a year-long media campaign to Stop Violence Against Women and the Girl Child. The Minister for Gender continues to be a staunch proponent of the importance of addressing GBV, and has worked together with the Ministry of Health (MINISANTE) on HIV/AIDS and prostitution, with MINIJUST on GBV prosecution issues, and with the Ministry of Social Affairs on providing social assistance to victims of genocide-related sexual violence. MINISANTE has included sexual violence as a component of its national reproductive health policy, but protocols for response have not been standardized or implemented.

MIGEPROFE's Secretariat for Women's Organizations has been charged with coordinating the large numbers of women's NGOs and emerging government-supported local women's councils in order to enlarge the capacity to prevent and respond systematically to GBV countrywide. The Secretariat's effort will be considerably enhanced by UNIFEM's current national mapping project of all women's NGOs. At the moment, however, no consolidated umbrella project exists for GBV. Most direct services to GBV victims are the purview of a small number of Kigali-based women's NGOs, whose financial and technical support comes from a similarly small number of international donors and NGOs, and whose field outreach is limited by their lack of funding and administrative capacity.

Kigali

Pro-Femmes/Twese Hamwe is the Kigali-based umbrella organization for local women's NGOs; it has grown from thirteen to thirty-eight organizations since its 1994 inception. In spite of its size, the umbrella does not yet serve a coordinating function, particularly with regard to GBV programming. Of participating NGOs, six have developed the capacity to provide services to survivors of GBV. Among them is Haguruka, a legal advocacy NGO whose 330 paralegals, working nationwide, accompany rape victims to doctors and police, provide legal counsel, and attempt to facilitate the prosecutory process. Last year Haguruka also received over 1,500 domestic violence complaints, though women rarely sought prosecution of their husbands because of economic constraints, social stigma, and fear of family and partner retribution. A model former employee of Haguruka now works as a consultant to several women's organizations to conduct field-based advocacy efforts, most notably convincing the police and judiciary to attend to GBV cases. Another Pro-Femmes member active in GBV response is Avega. In addition to their research initiative on genocide violence mentioned above, Avega provides rape survivor counseling to widows of the genocide.

Avega and three other women's organizations providing GBV counseling and case management services—Barakabaho, Icyuzuzo, and Clinique de L'espoir—are currently receiving assistance from Médecins Sans Frontières (MSF) to further improve their clinical capacities to respond to survivors and to develop an inter-agency clinical supervisory and support network. MSF's capacity-building project will enhance the earlier efforts of the Irish NGO Trocaire. Although Trocaire's commitment to long-term counselor training of select members of these NGOs was a positive departure from the more usual short-term trauma training models that overwhelmed Rwanda following the genocide, Trocaire's objectives did not include, as do MSF's, oversight and assistance with administration and coordination of counseling services among local women's NGOs.

Another reputable and long-standing Kigali organization working with female survivors of the genocide is the Polyclinic of Hope. Started by Church World Service in 1995, the Polyclinic is now operating under the umbrella of the local Rwanda Women's Network. Polyclinic services to over five hundred registered members include free medical care, psychosocial counseling and support activities, income generation support, and shelter assistance. The Rwanda Women's Network's overall orientation toward women's empowerment informs the strategies of Polyclinic, so that women are encouraged to develop community networks of mutual assistance and support. Like most local NGOs, Polyclinic is continually confronted with challenges of obtaining ongoing funding. In order to ensure that their model program continues, they are considering joining with MINISANTE to replicate their services within hospitals nationwide.

As yet, MINISANTE has no national program to address GBV. Select hospitals have social workers and health care providers trained in trauma counseling by WHO and the Trocaire-supported organization Association Rwandaise des Conseillers en

Traumatisme (ARCT). With rare exceptions rape victims continue to be required to pay for forensic exams, for which there are no special protocols or specially trained doctors available. Association Rwandaise Pour le Bien-Etre Familial (ARBEF), the long-standing local arm of the International Planned Parenthood Federation, also has no specific services targeting victims. When a survivor requests rape treatment, ARBEF will provide reduced-fee medical treatment for sexually transmitted infections as well as general emotional support. ARBEF workers acknowledge they are not trained to provide counseling for GBV. They have instead tried to adapt their methods of HIV/AIDS counseling, "telling her to avoid such conditions so as not to be raped again." Although formal records of domestic violence reports are not kept, the clinical director of ARBEF reported that large numbers of clients reveal histories of domestic violence.

Byumba Refugee Camp

This camp in northern Rwanda is one of three in Rwanda serving Congolese and Burundian refugees. The American Refugee Committee (ARC), alarmed by reports of domestic violence, forced marriage, and sexual violence against Congolese women within the Byumba camp, facilitated a community education series on violence prevention and response. Although the sensitization was short term, representatives of the camp committee feel that the trainings significantly reduced incidents of violence, particularly the high rates of forced marriage. Even without methods for measuring the impact of the program, the camp representatives credited the sensitization's "success" to the involvement of MIGEPROFE, the local government, and UNHCR in educating the camp population that rape and forced marriage are illegal and ensuring that reported cases were brought to trial. Representatives of the camp committee also attributed the sensitization's success to the broad-based community education approach: teachers instructed children; representatives of each of the seventy-two camp sections educated their section leaders; and health care providers educated patients.

In spite of the reported achievements of the project, several Byumba camp representatives alluded to ongoing problems, such as coerced sex and prostitution of young girls outside the camp, and ongoing though less frequent incidents of domestic violence within the camps. A UNHCR protection representative paints a much more sober picture; she feels that non-reporting of many types of violence remains commonplace. In an example of the perils of reporting, one camp community ostracized a sixteen-year-old impregnated by a well-liked camp leader after she identified her rapist to UNHRC. At the behest of the community, UNHCR released the leader back to his camp after a brief detention. It is impossible to determine the current rates of refugee violence, as there are no ongoing prevention or response programs specifically addressing GBV within the camps.

Summary

More than seven years have passed since Rwanda's genocide, and yet most existing GBV programs have not advanced beyond addressing the victimizations perpetrated during the genocide. This lack of progress reflects the profound destruction brought about by those few months in 1994. It also reflects the failure of the international community to respond to the issue of genocide-related GBV efficiently and effectively. Until the last two years, almost all GBV initiatives were delivered at the local level, primarily in Kigali, with the assistance of international NGOs operating largely independent of one another. Furthermore, all of the NGOs providing services have GBV as only one component of usually extensive programming, a probable response to the donor-driven necessity to diversify services in order to obtain sufficient operational funds. The need to generalize organizational mandates has undermined NGOs' abilities to evolve specialized, comprehensive, or in-depth skills in the area of GBV.

Certainly the environmental challenges to the international and local organizations cannot be underestimated. In the early post-genocide period, national government was overwhelmed, civil sector organizations were extremely weak, and ongoing conflict and population movements complicated efforts to coordinate and strengthen community-based initiatives. Even so, early post-genocide GBV programming in Rwanda may provide a case study for the outcomes of humanitarian projects that are primarily curative with limited or no preventive components, that are small in scale, and that do not place conflict-related violence in the broader context of gender inequities. The results appear to be that post-conflict violence has escalated, and that few women

are seeking and few organizations are offering assistance for GBV outside the realm of sexual assault.

Nevertheless, promising shifts have taken place in Rwanda within the last two years that may change the landscape of future efforts to address GBV. Most importantly, MIGEPROFE and the Secretariat for Women's Organizations are vocal advocates for confronting violence against women. All Ministries—notably Gender, Justice, Social Affairs and Health—appear to be committed to coordinating with each other regarding GBV, as well as to coordinating the activities of NGOs. MINIJUST has shown a commitment to expediting judicial response to rape cases. MINISANTE has similarly embraced the importance of addressing GBV by including it within their national reproductive health policy, though implementation of the policy has not been initiated. The relatively new locally based and nationally supported women's councils may, with technical assistance, be a resource for facilitating coordination of GBV prevention and response activities, especially if they are not viewed competitively by local women's NGOs as attempting to usurp precarious NGO funding. The success of local NGOs in providing services, even in the face of challenges such as short-term funding, limited technical assistance, and administrative inexperience, is a testament to the capacity and commitment of Rwandan women, and it speaks to the potential that women's organizations offer in the reconstruction of the country's social infrastructure.

Recommendations

1. International donors must consider prevention of GBV an integral activity of long-term development and fund accordingly. Models of short-term, curative services funded during the emergency phase are no longer suitable to the society's needs. Priority should be given to supporting the government's institutionalization of GBV prevention and response activities through the design and implementation of GBV-related policy, as well as through support to government and civil sector actors at the national and local levels. In order to facilitate this, local NGOs with experience in GBV must be financially and technically assisted to provide training and consultation.

2. An interagency working group should be established, led by MIGEPROFE, including representatives of relevant ministries, U.N. bodies, and international and local NGOS. The interagency working group should monitor the progressive efforts by the national and local governments to institute prevention and response activities.

3. MIGEPROFE should be fully supported with technical assistance and funding by international donors and the Rwandan government to continue its ongoing efforts to address GBV. The Ministry must receive particular assistance in developing the skills and mandate of locally based women's councils, so that the councils can serve their communities by enhancing existing NGO accessibility and coordination. The Ministry should also receive assistance necessary to coordinate the activities of the NGOs so that they may work cooperatively toward common goals rather than exclusively and competitively. The Ministry's proven success in changing discriminatory inheritance laws against women should be utilized in addressing laws related to violence against women and girls. MIGEPROFE should also ensure that all other ministries have policies relevant to GBV.

4. MINSANTE should require that their implementing partners institute supportive protocols to respond to women seeking medical exams for sexual and physical assault. Women should be encouraged to pursue treatment through broad-based media campaigns and through the provision of free services for providers. Model NGOs already experienced in the provision of health services to survivors, such as the Polyclinic of Hope, should be consulted for program design, and accessed for trainers and service providers. MINISANTE should endorse Polyclinic's proposal to create centers within hospitals where women can access services similar to those currently provided by the Polyclinic's Kigali-based center. Data should be collected at all health centers and submitted to MINISANTE for regular monitoring and evaluation of health response mechanisms.

5. MINIJUST should provide important advocacy regarding the necessity for police forces and judiciary to respond appropriately to cases of GBV.

MINIJUST should continue to facilitate trainings for police officers and create specialized units in the police forces to monitor cases and maintain data systems on case reports, with the requirement that data be regularly submitted for review by MINIJUST. Efforts should be made to recruit more women into the police forces. MINIJUST should also ensure that the judiciary receives ongoing education about laws affecting GBV survivors, so that cases are tried according to statutory rather than customary law.

6. International NGOs should create GBV programs in close collaboration with local initiatives, with the goal of strengthening established programs through capacity building and technical assistance. Such collaboration will require a respect for NGOs' existing management structures and commitment to long-term yet flexible support.

7. Local NGOs addressing GBV should incorporate preventive activities in all areas of programming, with particular attention to empowering women and girls through community organizing and self-help programming. Increased specialization in GBV prevention and response will surely lead to expanded services addressing a spectrum of survivor needs, such as psychosocial centers, women's resource centers, safe houses, and increased community outreach and involvement. Local NGOs should also recognize the benefits of collaboration with other NGOs through their Pro-Femmes umbrella, women's councils, and MIGEPROFE. The successful advocacy activities of Pro-Femmes members illustrate the potential impact of cooperation among NGOs, especially if Pro-Femmes can further develop its coordination, networking, and fundraising strategies.

8. Men, who are notably absent from GBV initiatives, should be encouraged to offer their support and expertise in addressing gender violence, and should also be considered as potential service recipients.

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Internally Displaced in *Sierra Leone*

February 5-15, 2001

Background

Historical Context

Since gaining independence from British rule in 1961, resource-rich Sierra Leone has been characterized by economic exploitation, public unrest, and political instability. During its first thirty years of self-rule, a series of governments, often established by way of coups rather than elections, was unsuccessful in containing the growing discontent and divisiveness of Sierra Leone's ethnic and political factions. By the early 1990s the Revolutionary United Front (RUF) manifested a powerful rebel alliance with neighboring Liberia and succeeded, after five years of devastating civil war, to wrest control of much of Sierra Leone's diamond producing regions. The RUF's trademark mutilation, as well as forced induction, abduction, rape, and execution of civilians, also succeeded in terrorizing and dislocating over half of the country's five million inhabitants. Many civilians crossed the border into Guinea and Liberia, and others fled to Sierra Leone's capital city of Freetown or were otherwise internally displaced.

The promising multiparty elections in 1996 that popularly voted Ahmad Tejan Kabbah and his Sierra Leone People's Party into power resulted in a short-lived peace agreement with the RUF. In the face of resumed RUF hostilities, Kabbah fatefully designated a Civil Defense Force (CDF) to assist the Sierra Leone Army (SLA) in defeating the RUF. Breakaway leaders of SLA responded to this insult by staging a coup, driving Kabbah into exile, establishing a junta with RUF, and inciting looting and a murderous rampage in Freetown. In 1998 the Economic Organization of West African States Monitoring Group (ECOMOG) deployed Nigerian forces to drive the junta out of Freetown and restore Kabbah to power. The RUF leader, Foday Sankoh, was jailed and sentenced to death, thus instigating a January 1999 rebel advance on Freetown that resulted in the further maiming, rape, and murder of thousands of civilians and the eventual release of Sankoh to United Nations monitors.

The heralded July 1999 Lomé Peace Accords included in its Disarmament, Demobilization, and Reintegration (DDR) plan a power-sharing agreement between RUF and the Kabbah government, notably designating Sankoh as chairman of the government commission responsible for diamond mining. The U.N. Security Council then introduced a peacekeeping force, the U.N. Mission in Sierra Leone (UNAMSIL), and by April 2000 ECOMOG troops were withdrawn and humanitarian organizations established or reestablished basic relief programs in areas occupied by RUF. A National Commission for Reconstruction, Resettlement, and Rehabilitation (NCRRR) was created to coordinate assistance to the internally displaced (IDPs), returning refugees, and ex-combatants. Even so, rebel violence sparked by Sankoh and led by RUF and the Westside Boys, an ex-SLA faction, once again flared—targeting civilians, UNAMSIL, and humanitarian workers, and further increasing the ranks of IDPs. The Lomé Accords' power-sharing agreement collapsed, Sankoh was once again detained, and the RUF resumed exclusive and hostile control of its

diamond fiefdoms. SLA and CDF militia rearmed, humanitarian workers were evacuated from rebel territories, and the government of Sierra Leone launched military attacks in RUF locations using helicopter gunships. Meanwhile, regional tensions escalated along the Guinean and Liberian borders, such that by early 2001 Sierra Leone's internal crises were further exacerbated by a swell of repatriating refugees unable to return to their homes in eastern and northern provinces.

Current Situation

At present, the cease-fire brokered by Kabbah in late 2000 remains tentative and rebel forces continue an only slightly mitigated reign of terror. Nevertheless, the U.N.-assisted government is moving forward in regions not held by RUF with its DDR plan, and the NCRRR is similarly advancing disarmament incentives. Humanitarian aid agencies are operating in about half the country, trying to address some of the effects of Sierra Leone's protracted conflict. Their task overwhelms, given that Sierra Leone is at the bottom of the Human Development Index: life expectancy—at thirty-seven years in 2000—continues to decline; child and maternal mortality rates are at record international highs; per capita income stands at about $150 per year.[1] Malaria, pneumonia, tuberculosis, bloody diarrhea, and HIV/AIDS are common,[2] and severe food shortages are resulting in an estimated one hundred starvation deaths per day.[3] Against this alarming backdrop of social ills, women and girls continue to suffer the additional spectrum of violent gender-based abuses and their consequences.

Gender-based Violence

During Conflict

Throughout Sierra Leone's ten-year war, the RUF systematically used the bodies of civilian women and girls to advance their brutal agenda of terrorizing, demoralizing, and destroying communities. In a comprehensive prevalence survey of 991 IDP women and their family members conducted by Physicians for Human Rights (PHR) in 2001, almost all households (94 percent) reported some exposure to war-related violence and 13 percent reported incidents of war-related sexual assault. Extrapolating from their findings, PHR estimates that approximately 50,000 to 64,000 IDP women may have histories of war-related assault.[4] Médecins Sans Frontières (MSF), in collaboration with the local NGO Forum for Women Educationalists (FAWE), treated approximately two thousand women victims of rapes that occurred in and around Freetown during the January 1999 rebel incursion, and another two thousand victims, mostly IDPs, living in camps in the Bo and Kenema regions. Some survivors had severe gynecological problems, the majority had sexually transmitted diseases, and at least ten percent were pregnant.[5] The tradition of excising all or part of the clitoris and labia, which ceremoniously ushers an estimated 80 to 90 percent of Sierra Leonean girls into womanhood,[6] may also introduce among sexual assault survivors—particularly virgin girls—increased rates of genital trauma, HIV/AIDS, and other sexually transmitted infections.

Testimony taken by Human Rights Watch, Amnesty International, and PHR indicate that the RUF raped as a matter of course, often in gangs, often in front of family members. They forced boys and men to rape their mothers and wives. They abducted women and girls—reportedly targeting virgins—and compelled them into sexual and domestic slavery. They mutilated women's genitals with knives, burning wood, and gun barrels. They sexually assaulted and then disemboweled pregnant women. They rounded up girls and repeatedly raped and then abandoned them. And in the 1999 Lomé Accords they were given blanket amnesty for their abuses.[7]

The amnesty provision, which was presumably designed to facilitate reintegration, may have instead contributed to, or at the very least did not deter, further sexual abuses. In its year 2000 report, Human Rights Watch suggested that even after the signing of the Lomé Accords, a "hellish cycle of rape, sexual assault, and mutilation" of women and girls continued to be perpetrated by "all sides," including pro-government forces.[8]

Beyond Conflict

It is perhaps not surprising that a culture that has spawned such apparently high rates of war-related sexual violence also suffers from high rates of domestic partner abuse. In a national report to the 1995 Beijing Conference on Women, violence against women was identified as a "long-standing problem."[9] More recently, cross-sectional research undertaken in Freetown in 1998 found that 66.7 percent of 144 women surveyed had been beaten by an intimate

partner—of whom 60 percent required medical treatment for injuries. Of the 50.7 percent who acknowledged having been forced to have sex, boyfriends and husbands ranked in the ninetieth percentile as the perpetrators.[10] In the PHR 2001 population-based research of IDP women, more than half of those surveyed believed their husbands had the right to beat them.[11]

Prostitution is also on the rise as a result of the increased presence of international peacekeepers, as well as Sierra Leone's economic collapse and population dislocation. A 1999 national government survey of over two thousand prostitutes found that 37 percent were less than fifteen years of age; more than 80 percent were unaccompanied or displaced children; and all declared an intention to stop engaging in prostitution once alternative work became available.[12] However, the opportunity for reasonably remunerative work is slim: literacy rates among women are around 23 percent to men's 36 percent, so that women predominate in petty businesses and agriculture; in formal sector employment, women constitute only 8 percent of administrative and managerial positions.[13] This inability to escape from commercial sex work has even more dire consequences when weighed against the growing HIV crisis in Sierra Leone: a 1997 survey of Freetown prostitutes found that 70 percent were HIV-positive, as compared to 26 percent in 1995.[14]

Although Sierra Leone ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1998, and the national constitution provides for equal rights for both sexes, there are few specific laws that protect women against GBV.[15] Rape is punishable by up to fourteen years' imprisonment, but domestic violence is not recognized as a crime, nor is prostitution or sex solicitation.[16] Even though the national age of consent is sixteen, girls in villages may be forced or encouraged into earlier sexual relationships or marriages, reflecting the implementation of local customary law and practice in cases where national law is not enforced. Female genital excision prevails, as does polygamy. Customary inheritance laws often discriminate against women, and women are disproportionately excluded from education, professional employment, and community leadership. Women are also underrepresented in senior government: only two of eighteen cabinet members and only seven of eighty legislators are women.[17]

Current GBV-related Programming

In spite of Sierra Leone's evident history of gender discrimination and abuse, recent activities at the international, national, and local level show promise in addressing and improving the rights of Sierra Leonean women and girls. International human rights organizations have called for the recognition of sexual atrocities perpetrated against Sierra Leonean women as a crime against humanity, punishable by an international tribunal. The government has designed national policies on gender mainstreaming and the advancement of women that include provisions for improving protections for women against violence, and has designated the Ministry of Social Welfare, Gender, and Children's Affairs (MSWGCA) to monitor the implementation of those policies. Most significantly, efforts at the local level have resulted in increased awareness of and response to survivors of GBV.

Freetown

Sierra Leone, or at least Freetown, has an impressive number of local NGOs. In the face of the country's violent history and extreme poverty, civil sector initiatives have surfaced as an antidote to the lack of government-supported programming. This is especially true with regard to women's issues, which have until recently been virtually absent from the national agenda. Sierra Leone's Women's Forum—organized in 1994 as an NGO coordinating body—is comprised, for example, of over forty local women's organizations variously seeking to advance the education, welfare, and general status of women and girls. Following the 1999 rebel incursion into Freetown, several of these organizations incorporated GBV prevention and response activities into their programming. A brief description of some of the more prominent initiatives is provided below. In large part, local NGOs are operating with volunteer staff and limited financial resources. Their reach and impact are directly related to the extent they are able to obtain ongoing international financing and technical support.

According to a representative of the Sierra Leone Women's Forum, supportive counseling, previously unavailable, became popular during the war. Western therapeutic models have been adapted to local traditions by including storytelling, proverbs, and singing in the treatment process. One of the most well-organized and well-supported GBV counseling

programs was undertaken by FAWE, a member organization of the Women's Forum. Although FAWE's original purpose, when conceived in 1995, was to promote education among girls, the organization developed supportive programming for GBV victims following the January 1999 Freetown invasion because they perceived that GBV victims were especially vulnerable to exclusion from education as a result of their social stigmatization and related isolation, medical problems, and lack of financial resources. With support from MSF and in collaboration with MSF, MSWGCA, and the Sierra Leone Association of University Women (SLAUW), FAWE developed a team of counselors trained to provide brief counseling, case management, and referrals for free medical services to victims. They also provided micro-enterprise support and education assistance. They worked with collaborating organizations to raise awareness of their services and the availability of free medical treatment, and to conduct sensitization campaigns aimed at decreasing the social stigma of rape.

Despite success in accessing approximately two thousand victims in the first year of FAWE's Freetown project, MSF funding was short-lived (though MSF continues to invest their resources in an independent MSF-run counseling center for trauma survivors). The United Nations High Commissioner for Refugees (UNHCR) offered extension funding that allowed the program to continue for another two months, but services and staff have since been curtailed and prospects for future GBV funding are uncertain. Other organizations face similar limits: the local arm of the international NGO Christian Children's Fund, for example, had a community-based initiative to train health care workers, teachers (in collaboration with SLAUW), and community representatives on basic therapeutic responses to girl victims of violence, but did not receive ongoing funding to continue community organizing and capacity building of the six hundred trainees. The locally run and well-respected Marie Stopes Clinics likewise report a lack of financing required to expand outreach to rape victims—perhaps through mobile clinics—to areas in which there is identified need. The National Association on Violence Against Women (NAVAW) has worked through its volunteers to provide education to police on issues of violence against women, but they too have not received sufficient funds to continue their efforts or to expand their outreach beyond Freetown.

Funding issues represent one limitation in locally based GBV prevention and response. Other limitations are related to the reporting procedures for victims seeking legal recourse. The Council of Churches of Sierra Leone (CCSL)—which, like the Campaign for Good Governance and Democracy (CGG), has attempted to provide advocacy and legal support to victims—stresses that the legal process is structured so as to discourage reporting: police officers are generally not sympathetic to victims; those who have been raped must pay for the requisite medical examination; there is no standard exam process, and often reports reflect a preoccupation with determining virginity status; the doctor is not obligated to appear in court; court cases may be lengthy and are not necessarily *in camera* (private); and the application of laws, if not the laws themselves, often discriminates against survivors. Domestic violence cases are even more difficult to prosecute than rape cases. CCSL and CGG are working to improve the prosecutory process by variously providing case management to survivors and their families, sensitizing lawyers and members of the judiciary about GBV, and advocating for improved legislation.

Another significant local initiative aimed at addressing some of the reporting challenges facing GBV victims has been undertaken—almost single-handedly—by a senior female officer within the Sierra Leone police force. With support and guidance from an equally committed British officer of UNAMSIL, she has established a domestic violence police unit, created protocols and trainings for responding to victims of rape and domestic violence, and is instituting data collection of police reports relating to violence against women. The UNAMSIL representative is attempting to recruit trainers from Britain to lend technical assistance to the design of a hospital-based exam and counseling room for survivors. Both officers are soliciting funding to establish a safe house for victims, and both are working to create a collaborative relationship between health services, counseling programs, and police so that survivors can be more effectively and efficiently treated.

The United Nations Children's Fund (UNICEF) and the MSWGCA have assumed coordination for programming related to violence, and they have undertaken several media campaigns—with posters, radio jingles, etc.—to sensitize the community about sexual violence. Given the scope of their responsibilities, their oversight regarding GBV initiatives is

limited and the predominant focus of their coordination is children and adolescents; programs targeting victims over eighteen have no special coordinating body. In fact, there appear to be few projects aimed at adult women survivors. Long-standing organizations such as the Italian NGO Cooperazione Internationale and Planned Parenthood Association of Sierra Leone (PPASL) have devised specific programs—assisted living, community activity centers, health awareness, and school fees—for child and adolescent survivors. The Irish NGO GOAL, whose project focusing on the welfare of street children and commercial sex workers provides outreach, sex education, transit shelters, and reintegration support to prostitutes, also reportedly works primarily with adolescents. None of these programs excludes women, but their emphases are nevertheless on younger populations.

This emphasis on children may in part reflect available funding streams. UNHCR recently retained a consultant to explore the possibility of developing a Sierra Leone Women's Initiative (SLWI), led by the Women's Forum and facilitated by UNHCR and the Brookings Initiative, to support and coordinate women's development projects. In her preliminary assessment, the consultant identified the lack of rehabilitation for survivors as an important gap to be rectified by the activities of the proposed SLWI. The consultant also identified the dearth of services outside of Freetown as a major limitation to addressing women's development in general and GBV specifically.[18]

Kenema

As in Freetown, the Kenema branch of FAWE was supported by MSF to work in collaboration with MSF, the International Committee of the Red Cross, the local branch of the MSWGCA, and Kenema hospital in the provision of medical triage and psychosocial services to approximately two thousand survivors of rape and domestic violence, mostly from the IDP camps in the Kenema area. Services were curtailed when MSF ceased to provide free medical services to victims in 2000, presumably in a strategy to support local fee-based treatment. FAWE representatives believe that the motivation for victims to come forward was stimulated by the availability of free medical care and that numbers will significantly decline without such an incentive. More recently, with assistance from the International Rescue Committee (IRC), FAWE formalized GBV data collection and advocacy efforts, and has assumed the lead in consulting with elders, the police, lawyers, and the judiciary to develop GBV prevention and response protocols.

IRC's GBV program operates in three camps and two towns in the Kenema region. Its activities include case management, and health and counseling services for survivors; training for community-based counseling; data collection of GBV incidents; and basic GBV-related sensitization among local men and women leaders and community groups. They also facilitate leadership training and the development of women's camp councils; support construction of camp buildings for council meetings and survivor counseling; and provide coordination and resources for women's income-generating initiatives. The underlying goal of the IRC program has been to facilitate the development of local efforts to respond to the needs of survivors. Local women, including those living within the IDP camps, have been mobilized to provide supportive services. They have also been assisted in developing their advocacy skills, which enable them to raise awareness of and combat ongoing incidents of GBV. Many IDP women have not only experienced violence by the RUF or Westside Boys, they are additionally vulnerable to ongoing domestic violence as well as sexual abuse by men in their host community and within the camps. Notably, there were no reports of prostitution among the IDPs, though women's representatives in Freetown assert that prostitution is an inevitable outcome of impoverished camp conditions.

FAWE's and IRC's work is especially critical given the lack of GBV awareness among leaders in the Kenema area. Neither the local MSWGCA nor NCRRR representatives highlighted GBV as an area of concern. One representative even suggested that women coming forward to report rape were shaming themselves. Local police, as well, lack sensitivity to the issue and are generally not called upon to respond to incidents. There is currently no GBV coordination between local and international NGOs and local government officials. However, IRC and a local FAWE lawyer have taken steps to begin prosecution of rape cases. They have received initial support from local and national representatives, to the extent that a judge will be fielded from Freetown to preside locally over the cases. (Previously all cases had to be tried in Freetown.)

Summary

As is the case in many conflict and post-conflict settings, war-related GBV in Sierra Leone has necessitated programmatic responses that have in turn raised awareness of GBV and strengthened local capacities to address the issue. Perhaps unique to Sierra Leone is the sheer number of local organizations interested in promoting women's development. During Sierra Leone's latest transition to peace, some of these organizations have been crucial in mobilizing communities and the government to recognize the rights and needs of survivors. In order to continue efforts to reduce violence against women, local NGOs will require increased technical and financial support. A consistent complaint from local NGO representatives is that international NGOs often create independent programs rather than partner with local organizations to provide services—such as the stand-alone trauma counseling program created by MSF and the street children program established by GOAL. The UNHCR-supported SLWI will presumably redress this problem by providing financing necessary to launch or continue local programming.

Even so, Sierra Leone women's organizations cannot operate effectively without a national infrastructure that supports the prevention of and response to GBV. The government's national plans for gender mainstreaming and the advancement of women represent an unprecedented effort in this direction, particularly to the extent that they call for the revision and expansion of laws relating to GBV. However, nationally supported collaboration related to GBV issues is an ongoing struggle. There have been no provisions instituted by the government to collect statistics from GBV service providers, though such statistics could clarify the maze of programming by identifying the populations currently receiving or requiring services as well as the nature of those services. Similarly, there is no national health policy mandating standard treatment protocols for survivors or exempting them from medical fees, in spite of clear indications from the FAWE/MSF collaborations that free services encourage survivors to seek medical treatment.

National programs, in turn, cannot be developed without international financial aid. In her recent visit to Sierra Leone, the U.N. Special Rapporteur on Violence Against Women concluded that the donor community is not responding appropriately to the needs of Sierra Leonean women. Freetown programs have generally focused on the needs of adolescent victims, specifically regarding war-related sexual abuse. Adult women have received less focused attention. Domestic violence, prostitution, and civilian rape are also lesser concerns, and though there are a few notable Sierra Leonean women advocating to reduce the practice of female genital excision, no programming currently exists. Populations outside of Freetown are reportedly not receiving GBV services, though there are organizations such as the Network Development for Justice and Rural Aid Sierra Leone which are interested in and prepared for fieldwork. Kenema and nearby Bo are exceptions given the presence of FAWE and IRC; their success may be a model for programming in other regions. In all programs, counseling services, though a popular intervention, tend to be the result of brief trainings and are themselves short term and informal. There are no provisions for counselor supervision or the ongoing development of treatment skills. Most projects, in fact, are based on short-term objectives. As Sierra Leone looks forward to transitioning from crisis to development strategies, GBV programming should evolve accordingly.

Recommendations

1. International donors and NGOs must seek to provide support to national structures such as NCRRR and the government to address GBV on a broad scale. They should facilitate the MSWGCA's capacity to coordinate GBV prevention and response by participating in and, in some cases, leading coordination activities. Donors and NGOs must also provide local organizations with the financing and ability to address GBV at the community level, as well as to create a GBV advocacy base.

2. MSWGCA, responsible for implementing government polices on gender, must be supported to achieve the objectives outlined in the national plan. Local women's organizations should be solicited to participate in oversight and implementation. Service statistics on GBV should be submitted to relevant ministries and monitored and analyzed by MSWGCA. Nationwide media campaigns should educate the public regarding government policy and changing legislation.

3. The Ministry of the Interior must support the further sensitization of the police forces so that the activities already underway in Freetown can be implemented nationwide. Police must be held accountable for appropriate interventions and for the application of statutory laws. The judiciary must similarly be held accountable for upholding existing and evolving protections for survivors of GBV.

4. The Ministry of Health must remove obstacles to reporting violence by allowing no-fee rape exams, creating standard forensic reports, training forensic doctors in appropriate response, and supporting doctors' participation in court proceedings. All hospitals should be equipped with examination rooms and relevant medical equipment.

5. The NCRRR, if it is to fulfill its rehabilitation responsibilities, must include in its community-based projects objectives related to the prevention of and response to GBV. Similarly, the DDR policies, which currently do not acknowledge the needs of survivors of sexual assault, should introduce strategies for medical and psychosocial care.

6. International and local organizations—whether working in the community or in camps for the IDPs—should extend their programming to include GBV issues beyond war-related sexual assault, including domestic violence, prostitution, and harmful traditional practices. Local organizations should include men in their target population, whether as survivors of violence or as advocates for its reduction.

7. Respective ministries should sensitize local leaders about the necessity to address GBV, as well as about government policies. Local leaders should support the application of government polices in the prevention of GBV, so that the basic right to protection from GBV is not relative to local tradition.

Notes

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2 UNOCHA, *Consolidated Inter-Agency Appeal for Sierra Leone*, 13.

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5 Amnesty International, *Rape and Other Form of Sexual Violence Against Girls and Women* (New York, 2000), 10.

6 U.S. Department of State, Bureau of Democracy, Human Rights, and Labor, *Female Genital Mutilation Background Paper* (Washington, D.C., 1997), 12.

7 Amnesty International, *Sierra Leone: Rape and Other Forms of Sexual Violence against Girls and Women* (Boston, 2000). See also: PHR, "Preliminary Findings and Recommendations," March 2000 Delegation to Sierra Leone, unpublished report.

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12 Government of Sierra Leone, *Situation Analysis of Women and Children in Sierra Leone*, 121.

13 Ministry of Social Welfare, Gender, and Children's Affairs (MSWGCA), *National Policy on Gender Mainstreaming* (Freetown, 2001), 3.

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16 U.S. Department of State, *Sierra Leone Country Report on Human Rights Practices* (Washington, D.C., 2000), 8.

17 U.S. Department of State, *Sierra Leone Country Report on Human Rights Practices*, 7.

18 United Nations High Commissioner for Refugees, *Mission Report on Sexual and Gender-based Violence Programming Support to Sierra Leone: Reintegration with Equality* (Geneva, 2000), 19.