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## **Women War Survivors of the 1989-2003 Conflict in Liberia: The Impact of Sexual and Gender-Based Violence**

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## **Abstract**

This article presents a summary of the qualitative data from research carried out in post-conflict Liberia by Isis-WICCE, a women's international non-government organisation, in conjunction with the Ministry of Gender and Development of Liberia and Women in Peace-building Network, WIPNET. Analysis of research findings detail women's experiences of conflict and the serious effects of sexual violence and torture on

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their physical and psychological health. The paper also describes the omission of women from justice and rehabilitation processes. In support of women participants' views, the author's recommend that funding is urgently required for the provision of holistic and sustainable, gender- sensitive services. Additional recommendations are made with respect to health, justice and policy changes in line with enhancing women survivor's roles and utilising their skills and resilience.

*Keywords:* Women, War, Liberia, Sexual, Gender-Based Violence

### **Introduction and Setting of Context**

We must address the social consequences of the war, including gender-based violence, which continues to permeate Liberian society today. (Republic of Liberia, 2008b)

The Liberian conflict descended into civil war by 1989. Without the intervention of Nigerian led forces the Charles Taylor's rebels would have taken Monrovia. Subsequently, however, Taylor won the presidential elections in 1997. Almost immediately other rebel groups formed and closed in on the capital. At the intervention of international community a Comprehensive Peace Agreement was reached in 2003 and the UN organised a Mission to Liberia (UNMIL) to support the peace process, sending 15,000 troops. Presidential elections in November 2005 brought the first ever elected woman head of state in Africa, Ellen Johnson Sirleaf.

The fourteen years of armed conflict saw not only the destruction of Liberia's social and economic infrastructure, but high levels of brutality by all factions. These included widespread killings, rape, sexual assault, abduction, torture, forced labour, recruitment of child soldiers. As a result related of their experiences of violence and torture during the conflict the population is suffering from a wide range of psychological, alcohol /drug related addiction, surgical problems and for women, urgent gynaecological problems. Yet the broken down health system of Liberia struggles to respond to the needs of survivors of sexual abuse. There are few health centres or adequately trained and employed health workers to deal with the overwhelming levels of health needs.

Another major challenge has been to create an environment secure from crime. Gendered crime, such as rape and domestic violence has escalated since the ending of the war and coerced prostitution and trafficking is widespread. This may partly reflect that women are more willing to report crimes. However, by and large Liberia's citizens are not being protected from crime or having it successfully investigated and prosecuted by the state policing agencies.

In 2006, the government of Liberia launched a national action plan to prevent and respond to violence against women. It included plans to strengthen the justice system and facilitate health care for survivors of sexual violence. In terms of legislation, the definition of rape was expanded. Further, the age of consent was raised to 18 years old; nevertheless perpetrators are still hardly ever convicted. Part of the problem is the failure to report incidents due to shame, fear of rejection and lack of confidence that the 'system' will protect the rights of women. The lack of justice structures for dealing with these crimes outside of Monrovia remains very weak and cases tend to be resolved through cultural processes, often to women's disadvantage.

Liberia was the first country to launch its National Action Plan for the implementation of UN Resolution 1325. Its 2009 Plan urges women's equal and full participation as active agents in peace and security (Republic of Liberia, 2009a). Further it calls for the prosecution of people for crimes against women and extra protection of girls and women in war zones. A National GBV Task Force was put in place to implement the Plan of Action. It is chaired by the Ministry of Gender and Development and comprises all stakeholders. The Joint Programme to prevent and Respond to Sexual and Gender-Based Violence (SGBV) Report of June 2008 (Republic of Liberia, 2008b) observes that whilst capacity to respond is slowly improving with various interventions under the plan of action; they are not making meaningful impact as they are fragmented and uncoordinated.

Within this context, Isis-WICCE, an international women's non-government organization based in Kampala, the Ministry for Gender and Development of Liberia, and Women in Peace Network (WIPNET), based in Liberia, carried out a research documentation entitled "*A situation analysis of the women war survivors of the 1989-2003 armed conflict in Liberia*". Since 1998, and in collaboration with medical experts and researchers from Coventry University, Isis-WICCE have carried out documentation and medical interventions in several regions of central, eastern and northern Uganda, aimed at highlighting the plight of women in these conflict areas and campaigning to Government and development agencies to prioritise their health needs. Through these studies Isis-WICCE has been able to offer emergency medical and psychological treatment to war-affected communities, train local health workers, build capacity and highlight the impact of war on women (Isis-WICCE, 1999; 2001; 2002; 2006; Liebling-Kalifani, 2009; 2010; Liebling-Kalifani et al., 2007; 2008; Liebling and Baker, 2010). In 2008, Isis-WICCE moved to Liberia for the same purpose.

The objectives of the research in Liberia were far reaching but this paper focuses on sexual and gender-based violence committed against women during the armed conflict, the impact on women's health, their involvement in the disarmament, demobilization, reintegration and rehabilitation process and the truth and reconciliation commission. It also makes policy recommendations.

## **Methodology**

The research documentation adopted a multi-stage purposive sampling design involving selection of study counties, districts, villages, households and participants. As the 1989–2003 armed conflict affected the whole country, regional balance for representativeness of the research findings was a major consideration. Therefore Bong County represented central Liberia, Lofa County in Foya District represented the far north western border areas with Sierra Leone and Guinea, Maryland County represented the Far East bordering Cote d'Ivoire and Grand Kru County represented the extreme south eastern corner of the country.

Although no single corner of Liberia was saved from the atrocities, Bong and Lofa counties had particularly intensive and protracted fighting. For example Human Rights Watch (2002) reported that the Liberian United for Reconciliation and Democracy (LURD) fighting faction, a Liberian opposition group widely believed to be backed by the government of Guinea, launched an incursion from Guinea into Northern Lofa County in July 2000. This incursion resulted in several more years of civil war. Maryland

and Grand Kru are the most isolated and inaccessible counties due to the very bad state of the roads and communication networks. Hence, they are the most disadvantaged and marginalized counties. The isolation of Grand Kru resulted in this area being nicknamed the “*walking county*” due to the lack of public means of transport and communication.

### **Selection of Participants**

The study adopted a weighted proportional cluster sampling. Hence, the larger the population of the respective county, the higher the number of participants selected for interview. The smallest enumeration unit was the woman head of household or the oldest female member of the household, for those household headed by men. Only one woman was interviewed per household. However, the control group of men comprised 20% of the participants. This helped in highlighting the gender differences between men and women. In this case, the male head of the household was interviewed. Given the nuclear type of settlement, data collection centred on nuclear towns with outreach to identified villages.

The total sample size of individual war survivors was 643 participants of whom 515 (80%) were women and 128 (20%) men. The participants comprised of women and men at and above the age of fifteen years, including war survivors, ex-combatants, market women, women in leadership and peace negotiations, opinion leaders, medical and health practitioners and members of women’s activist groups, government officials, youth, street children and child soldiers. Interviews were also carried out with United Nations agencies, interfaith denominations, human rights organizations, international rescue committee, humanitarian workers, women’s organizations and civil society organizations.

The research aimed to strengthen the capacity of Liberia’s research team to document using a gender-sensitive, feminist and human rights perspective with a mixed methods approach. However, this article focuses on the qualitative data to highlight participant’s views and experiences.

### **Qualitative methods and analysis**

Twenty-four focus group interviews were carried out including twelve with women, three with female youth, six with men and two with male youths. Each focus group comprised 20- 25 persons. The groups were large as it was considered good practice to include all those who volunteered to participate in the study. Key informant interviews and community meetings were also held. In-depth interviews included testimonies of individuals who were subjected to extreme violence and torture and those who sustained injuries. Descriptive analysis of the qualitative data was carried out through analysis of prevalent themes and concepts obtained from a systematic review of international literature as well as thematic analysis of transcripts from focus group discussions, key informants and testimonies from survivors.

### **Research Findings**

#### **Experiences and effects of the conflict**

Charles Taylor's soldiers came here to Todee in 1990 and took our things. We ran into the bush. The ULIMO soldiers came and asked us to come back to the town. When we came back from the bush, my husband was worried too much and that led to his death. I do not have a husband and no-one to help me. I do midwifery for a living. (Woman participant, Todee)

Several groups were named by participants as being the worst perpetrators of torture. These included The National Patriotic Front for Liberia (NPFL), the Liberia Peace Council (LPC), the United Liberian Movement-Kromoh (ULIM-K) and the Liberia United for Reconciliation and Democracy (LURD). Those institutions expected to keep law and order, such as the police and prison officers, were also amongst those named by participants as the perpetrators of torture. In total twelve armed groups indiscriminately traversed the whole of Liberia committing violent kinship systems. These repeated armed engagements led to forced and massive displacement of the population to unknown and undesirable destinations.

The consequences of displacement had devastating effects on women's lives. Their daily routines were completely disrupted and many lived as refugees and internally displaced persons, with a lack of food, inadequate access to health, water, education and shelter. In the absence of household and community protection and support, and the disintegrated social support and kinship systems, women and girls suffered sexual abuse, rape, early forced marriages and pregnancies, all of which exposed them to HIV/AIDS and sexually transmitted diseases, STDs.

Many boys and girls were forcefully recruited to become child soldiers. In addition girl child soldiers were forced to become wives of combatants, exposing them to further sexual and gender-based violence. A woman respondent from Maryland described how she became the wife of a rebel:

In 2001, MODEL came while we were in Pleebo and I left with my children in Grand Kru. Whilst in Grand Kru my husband abandoned me and left. I started loving an LPC rebel. He and I had 4 children and when I was pregnant with the fifth child, my rebel husband got killed. Right now, I am selling fish while my children are selling wood in order to earn a living.

The educational status of women and men was found to be low due to the disruption of educational programmes. The lack of alternative employment opportunities and sources of income pushed many girls into early marriage and commercial sex work. The issue of early marriage raised great concern amongst survivors. As a result of early marriage in a morally eroded society and poverty coupled with high levels of illiteracy, women and girls were highly more vulnerable to commercial sex and sexual and gender-based violence. Adolescent girls were especially susceptible to sexual abuse, rape, recruitment by armed forces, trafficking, HIV/AIDS and complications from pregnancies. These experiences, as international literature has also argued (Donovan, 2002; Liebling-Kalifani et al. 2007; 2008; Sideris, 2003), have long-term and devastating effects on women's lives and those of their children, as many of them are stigmatized, rejected from their communities, unable to marry and forced to live on the streets.

Women and child headed households were the most vulnerable in terms of poverty and human insecurity including sexual abuse and increased male violence. The current research also found many men had left relationships to avoid responsibilities. Widowed, separated/divorced, and single women were more vulnerable than men to

physical and sexual abuse and other forms of discrimination, especially during the armed conflict.

Many schools in Liberia were destroyed during the protracted war years. Thousands were displaced and many schools were closed or used as refugee camps. Many of the girls displaced by the armed conflict were forced to change environment as they relocated to other parts of the country. This disrupted their social networks leading to some of them into early marriage or prostitution. Thousands were unable to continue with their education as they also became heads of households. There were only two women who had reached university level.

A consequence of conflict on Liberian women was to destroy their economic activities. Women's work would normally most frequently take place in the informal sector; including in the townships and markets. However, once violence broke out the livelihoods of the majority of women collapsed. As well as losing their work opportunities many of their houses were burnt. This particularly affected women who had become heads of households.

The lack of control over land and insecurity of tenure by women often put them at high risk to sexual and gender-based violence, especially after losing their rights to land that they had farmed as wives. Even as widows, they can lose the right of access to the former husband's land, unless they accept the land to be inherited by a male relative of the former husband. However, this is also risky as the man's ownership of the land normally extends to include taking over the woman as his wife. Hence, she also becomes his property, which further increases her vulnerability to infectious diseases, particularly due to the high prevalence of HIV/AIDS.

### **Experiences of sexual and gender-based violence**

The war led to breakdown in the social fibre and cohesion of communities. There was disruption and denial of education and health services for many survivors. Children were indoctrinated with violence, leading to moral decadence. Many were exposed to HIV/AIDS and STI's and there was an increase in levels of sexual and gender-based violence. A woman from Maryland County narrated her story:

Four MPFL soldiers raped me...they threatened me that if I refuse, they will kill me with my children. I accepted because I wanted to save my children and I knew they were serious...other women were raped, mutilated and then killed for me to survive together with my children.

Another woman respondent from Foya, Lofa County said:

The ULIMO people also raped my young sister's daughter and she got sick. She died because there was no medicine. My Aunt also got crazy.

Several women and girls were abducted during the war by armed forces. Women participants in the study described how they were abducted and subjected to forced marriages to rebels. They described being systematically raped and tortured. A woman from Pleebo briefly described her experiences:

I was captured in 1992 and raped. I was with the rebels all through the bush until 1994, when I started falling sick and I went to the hospital. I later went to Guinea and returned in 1997 and got very ill again. When I went to hospital I was tested positive, it is only my sister who knows my status.

The violence and torture took place in several locations as this male respondent in Maryland described:

Violations took place in bushes; others took place in homes and houses, by the roadside and in barracks of warring groups. AFL detained people. Some atrocities took place in churches. Violations were committed as a result of the civil war where there was no law and order. War lords saw themselves as their own gods. Power and greed took over their lives. They only looked at what they could do to gain power all costs. Rape and torture were used as a weapon of war to weaken the opponents.

Several participants described the different circumstances of the violence and torture. For instance during a woman's focus group in Pleebo, Maryland one woman said:

MODEL were killing machines, a torture group who used rape as a weapon of war. NPFL used civilians as labourers and used rape as a weapon of war.

Women in Liberia suffered both physically and mentally from the harsh and inhumane treatment they endured. Few had access to appropriate healthcare, particularly where long-term care was required. Women associated with fighting forces faced significant discrimination and carried a burden of shame for being forced to carry out acts that were viewed as 'unacceptable for women' in Liberian society. Often widowed or abandoned, women were left alone to shoulder overwhelming responsibilities with little help to ease the burden. They had full responsibility for their children, some having been born as a result of rape during the conflict. This was particularly distressing and shameful for women to deal with.

Many women and men lost parents, spouses, relatives and children during the conflict. Participants reported that their spouses, 'disappeared, were abducted, died of hunger or were abandoned'. A woman from Todee explains her experience of losing her spouse:

My husband was killed by this same man who cut me when I was going to Sierra Leone. He cut my husband into pieces, so now I do not have anyone to help me. I do not have money to send my children to school nor land to grow food. In this world, if there is no-one to help you, that is a problem.

The substantial loss of children during the war caused participants to 'lose hope' as this woman during a focus group in Todee narrated:

I had six children, I lost all of them as a result of the war, I cannot farm because I have no child and I am unable to ask anyone to farm for me. I have no means of support. I make a very small farm to take care of myself.

As well as suffering the loss of relatives, husbands and children, participants described the torture and violence against women's bodies which took place:

The rebels would start debating whether a pregnant woman was carrying a boy or a girl to show that they had power over life and death and to prove how powerful they were. They would then split the woman's stomach to see what she was carrying. And right there they gave themselves the power to destroy two lives or more in case of twins just to prove a point. (Male Key Informant, Monrovia)

The study revealed that well over half of the women who joined the rebels were frequently subjected to sexual and gender-based violence, particularly if they tried to escape as this woman respondent from Grand Kru explained:

I suffered because my last name was Taylor. When I was escaping from AFL, one soldier asked me to pay money but I did not have any, so I was raped by three men. Later on another man raped me. At last when I was allowed to cross the river to Ivory Coast, my sixteen year old daughter drowned.

Sexual torture was very rampant and occurred in many forms. The study revealed that well over half of the women experienced some form of sexual torture including objects being forcefully inserted in their vagina. A further study undertaken by Johnson et al. (2008) amongst a population sample in Liberia, noted that 9.2% of the women participants and 7.4% of the male participants had suffered some form of sexual violence. The rates of sexual violence were higher amongst former combatants; 42.3%, amongst women combatants and 32.6% amongst male combatants. In this study the rates of psychiatric disorder were; major depressive disorder (40%), post traumatic stress disorder (44%) and social dysfunction (8%) (Johnson et al. 2008).

### **Effects on general health**

The majority of participants interviewed in the current research had at least one surgical complaint. This was highest amongst women. The problems most frequently reported included backache, pains in the joints and swellings of limbs. Backache and pains in the joints were reported more frequently by women than men. In terms of health-seeking behaviour for surgical complaints, the majority of participants had visited clinics others having sought self-medication or attended traditional healers.

### **Effects on reproductive health**

Analysis of research interviews found that the nature of sexual torture experienced by women in Liberia had severe and damaging effects on their sexual and reproductive health. Those who had objects forcefully inserted in their vagina frequently

acquired traumatic vesicle or rectal vaginal fistulae. The level of sexual abuse escalated the prevalence of sexually transmitted infections, including HIV/AIDS.

Women survivors reported their commonest reproductive health problems were; abnormal vaginal bleeding, abnormal vaginal discharge, infertility, leaking urine and chronic abdominal pain. Other gynaecological problems described were leaking of faeces, perineal tears, genital sores, genital prolapse, sexual dysfunction and unwanted pregnancies. Though sexual abuse was common, unwanted pregnancies were rarely reported most likely due to underreporting as a result of stigma and shame

Sixty-eight point five percent of women respondents had at least one gynaecological complaint. Younger women up to the age of 24 years were more likely to have a gynaecological problem. Age at the time of conflict outbreak related to increased vulnerability associated with exposure of the young reproductive system to different sexual abuse and traumas. Women who had been raped or experienced gang rape were more likely to have urinary or faecal fistulae, infertility and/or genital prolapse. Data analysis revealed that women who had gynaecological complaints were also more likely to have other health problems. Psychological problems, attempted suicide and alcohol abuse were significantly associated with chronic gynaecological problems reflecting their debilitating and traumatic nature.

In terms of HIV/AIDS, the research concluded that participants lacked knowledge about how infection is transmitted and there were high levels of stigma. Contraceptive use was also low. There was also an identified lack of awareness of health services and knowledge of preventative measures for HIV/AIDS infection, particularly amongst the women interviewed. The majority of respondents in the study were adolescents during the conflict and engaged in early sex, early marriages and pregnancies and having multiple partners was a high risk factor that exposed them to HIV/AIDS infection. This has been recognized by the Ministry of Health and Social Welfare together with the United Nations (United Nations Theme Group on HIV/AIDS, 2003) who stated.

HIV has the potential to become a national disaster because it effects the most productive, reproductive and vulnerable age group of people (15-49 years) with more females than males affected, and it is not adequately addressed by existing public health laws and regulations.

### **Effects of torture and violence on mental health**

Analysis of the results revealed a considerable proportion of the population in Liberia suffered war-related torture. The physical torture experiences reported by participants included; bayonet/knife/spear/cutlass injures, severe tying (Tibay), burning with molten plastic, gunshot injuries, landmine injury, hanging, being stripped naked, suffocation with red pepper and being denied access to toilet facilities. Significantly more women than men reported being deprived of food, water, medicine and sleep. The most frequently reported experiences of psychological torture cited included being forced to sleep in the bush and witnessing someone being killed. Other psychological torture experiences included witnessing; people being buried alive, splitting open the stomachs of pregnant women, cutting off body parts such as ears, nose and lips, abduction, being forced to join fighting groups and being forced to kill.

Almost two thirds of the women reported a personal experience of sexual torture or physical torture and the majority suffered at least one form of psychological torture.

Previous studies from Liberia indicated a similar pattern (UNFPA, 2007; WHO, 2005). The psychological trauma and physical consequences of the war was considerable. The majority of participants reported that psychological symptoms affected their ability to work. Around half of the participants in the study had significant psychological distress indicating probably psychiatric disorder. There were no significant differences between men and women with respect to psychological distress. Some of the participants reported having attempted suicide in their lifetime. A male key informant and counsellor described the effects of rape on a woman:

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

In terms of gender differences, significantly more men than women reported attempting suicide. When analysed across Counties, homicidal ideation (ideas of wanting to kill others), were reported by a fifth of the participants. Homicidal ideation (wanting to kill others) was significantly higher amongst men than women participants.

Almost half of the participants had psychological distress scores suggestive of a mental disorder. A number had alcoholism. Significantly more males suffered from alcoholism than women. Previous studies undertaken in Liberia also confirm the magnitude of mental health problems (Johnson et al, 2008; WHO, 2005). In the words of Emmanuel Bowler, a former Minister and trauma therapist:

Liberia is a big psychiatric ward because people are really going out of their minds. People are being challenged by trials and tribulations in life but if they have psychosocial counselling they could cope.

War-related physical and psychological trauma was significantly associated with having above threshold distress scores in this study and has also been found in other war-affected regions of the world (Kadenic, 1998; Johnson et al. 2008; Skyly, 1992).

Displacement and change of lifestyle during the conflict pushed a number of women and girls into substance abuse. This included tobacco, alcohol, marijuana, opium, cocaine and petrol. Substance abuse had a negative impact on the sexual and reproductive health of women. Tobacco and alcohol consumed in large amounts in pregnancy can cause miscarriages or lead to delivering a deformed baby. Nicotine is also associated with cancer of the cervix. The research found alcohol and drug use led young women and girls to be vulnerable to illicit sex leading to the acquisition of STDs including HIV/AIDS.

### **Access to health services**

Women were interviewed to determine their health-seeking behaviour. About half of the participants with gynaecological problems either did not seek any care or medicated themselves and few sought treatment from a traditional healer. The most visited health facility for psychological problems and surgical problems related to war were the private run clinics. However, significant numbers utilised self medication, traditional healers, local health centres and district hospitals. A tenth of the participants

had not sought any treatment at all for their psychological problems. Participants described government health facilities as not having the necessary professional expertise to handle the psychosocial consequences of war as well as the emerging epidemic of domestic violence. A previous World Health Organization (2005) study indicated that the majority of survivors treated themselves (92%) or sought treatment from traditional healers (63%) with only 35% seeking treatment from health professionals.

Previous attempts to address the psychological trauma in Liberia by the international community was summarised by a trauma therapist interviewed who revealed:

I came home to help the psychosocial situation...but what I saw was happening made me fold my books and papers..... they (the UN) were training psychosocial helpers in a matter of weeks. How can you have training of people who are going to help de-traumatise others to come back to normal and give them only two-weeks of training? ... the trained people then gave psychological counselling for five days maximum seven days! Then you say people are ready to be integrated in society ...that is a grand fraud.

(Emmanuel Bowier, former minister and trauma therapist)

### **Training and medical intervention**

In line with its research recommendations, Isis-WICCE obtained a European Union grant from the Dutch government of the Millennium Development Goal 3 fund to carry out emergency medical interventions in two of the research study counties. Maryland and Grand Kru were selected due to their remote and under-developed infrastructure, the lack of medical services and the heavy burden of gynaecological and psychological problems revealed during the study. The training and intervention aimed to:

1. Provide specialised health care for women war survivors
2. Provide reproductive health kits to rural health units.
3. Build the capacity of local health workers in the management of reproductive and surgical complications of war through undertaking surgical camps.
4. Train primary health workers to provide psychological support to women, children and men war survivors.
5. Revise and pilot a training manual for health workers in the recognition, assessment and management of the psychological, reproductive and surgical health consequences of war.

The training manual which was originally developed from research carried out in northern Uganda was revised for the Liberia context using a multi-disciplinary team that included health and justice specialists from Liberia, Uganda and Coventry University in the United Kingdom. The training was piloted at a workshop for health workers carried out in Harper, Maryland country from 21<sup>st</sup> - 27<sup>th</sup> May 2009. A total of 49 participants; 24 women and 25 men, attended the training, which emphasised a holistic approach that included counselling and management of psychological trauma, sexual and reproductive

health, gender-based violence, human rights and professional standards in health care. As the trainees were also war survivors, the training included individual and group counselling to model a way of professionals supporting themselves, which they could continue to utilise in their own communities.

Urgently needed drugs and equipment were delivered to twelve health centres and two hospitals. Screening of survivors was carried out by the trained health workers, social workers and community leaders. A total of 1076 survivors; 685 women and 391 men were assessed and received treatment and counselling. A screening questionnaire identified the following conditions; epilepsy, mental health disorders, infertility, pelvic inflammatory diseases, fibroids, vesico-vaginal fistulae, (VVF's), genital prolapses, hernias, hydroceles, enlarged and elongated breasts, swellings, malaria and fevers, malnourishment in children and urinary tract infections.

The surgery focussed mainly on sexual and reproductive health complications including VVF's, uterine fibroids, genital prolapses and infertility problems. Some survivors had more than one surgical condition. A total of 207 survivors; 60 women and 147 men ranging from 1 to 90 years benefitted from the surgical camp. Due to the enormous numbers who accessed the services, the medical consultants, Isis-WICCE and WIPNET staff volunteered extra hours. The heavy rains and the poor road infrastructure were a key challenge. It is also important to note that previous health programmes in this area had focussed on men therefore women assumed this was still the case. With time, and once women saw their fellow women deriving benefit from the programme, they came for treatment. However, due to limited funding at this late stage not much could be done.

An initial evaluation of the intervention revealed a two- fold increased rate of psychological ill-health compared to a non-conflict society. Factors associated with this were high rates of loss and grief, physical, sexual and psychological torture, a high rate of intimate partner violence, surgical and gynaecological problems. Although men were not spared, the majority of those who reported psychological problems were women. However, those women and men who received successful treatment of their physical health problems reported a decrease in stigma and an increase in their quality of life.

### **Women and the Disarmament Demobilisation Re-integration and Rehabilitation programme (DDRR)**

In 2003, following the end of the armed conflict, a DDRR programme was embarked on in Liberia (UNDP, 2003). This was intended to consolidate national security through disarmament and reintegration of all ex-combatants into society (UN, 2003). The intention of the programme was also to ensure women's participation and focus on and address their needs as stipulated by the UN Council resolution 1325 by including reference to women and children as a 'specialized' group (Republic of Liberia, 2008b).

As noted by Amnesty International (2008a) estimates of women associated with fighting forces were in range of 30% to 40% of all fighting forces or approximately 25,000-30,000. According to this report (Amnesty International, 2008a: 5) stated:

Women chose to take up arms to protect themselves from sexual violence, avenge the death of family members, because of peer pressure, for material gain and for survival.

Officially, more than 130,000 ex-combatants, significantly more than the 38,000 originally planned for, had been disarmed and demobilized, and of those approximately 22,000 were women and 2,740, girls. However, this was understood to represent only a fraction of the total number of women and girls that participated in the conflict. It was also observed that the DDRR largely failed to meet a large number of women's and girls' needs compared to men's and boys'. Thousands of women and girls formally associated with the fighting forces did not participate in the DDRR for reasons such as misinformation, lack of knowledge and understanding about the process, manipulation by commanders, lack of funding, lack of political will to ensure a gender-based approach, shame and fear. Some of the women that did participate were said to have been harassed by UN designated officials during the disarmament phase, including being ridiculed or hit whilst trying to disarm. Amnesty International (2008a) reported that some women did not benefit unless they were prepared to have sex with their commander. The programme failed to meet the needs of many women and girl combatants and did not ensure that their participation was proportional to their actual level of involvement. Many women were said to have failed to fully benefit from the rehabilitation and reintegration phase because the programme largely failed to acknowledge and address stigma and shame as a barrier to their participation, as well as taking into account adequate understandings of women's and girl's war experiences (Amnesty International, 2008a).

Failure to participate in the DDRR had significant consequences for former women combatants who were eligible by then for skills training or formal education reintegration packages. With few other opportunities and the challenging post-conflict situation, self demobilisation was not easy because for those who knew about the process, manipulation by commanders discouraged them from getting involved. Either family members or others, who had favourable relationships with a commander, were most likely to be beneficiaries of the DDRR. Consequently many women ex-combatants were excluded (Amnesty International, 2008a). As one key informant from Bong County told us during the research:

Most of the former combatants have been disarmed. Some of the girl's fighters have taken to drinking alcohol and smoking. Because they have not received support during the demobilization, they are demoralised. They have not been rehabilitated and reintegrated into society.

Given the few other opportunities and the biting poverty of the post-conflict period as well as the sexual and gender-based violence which continues, women participants of the Isis-WICCE research in line with the recent Amnesty International report (2008a) recommends extension of the DDRR as a special programme to rectify these anomalies. This would include a thorough gendered needs assessment survey in line with Security Council Resolution 1325, as well as international guidelines, to accurately determine the needs of women and girls affected throughout Liberia. Relevant programmes should then be designed, implemented and properly monitored based on this information.

### **Gaining justice? The Truth and Reconciliation Commission of Liberia (TRC)**

The TRC (2009b) concluded that women have been the most marginalized, economically socially and politically in Liberia and it was only in 1947 they were granted rights of suffrage. It reported that Liberia produced the highest number

of women perpetrators compared to other conflict regions of the world. In terms of the violations reported during the process, men accounted for nearly 50%, whilst women only accounted for 33% of those recorded (Kirsten et al. 2009). The committee noted the under-representation of atrocities against women and provided mechanisms and procedures to pay particular attention to gender-based violations. The TRC met with women's groups and a gender committee was established. However, a review of the TRC process carried out by Amnesty International (2008b) described the activities to support women's participation as fragmented (The Analyst, 2008). Further, although it is acknowledged that the TRC created a space for women to speak, Pietsch (2010: 66) argues that there was a:

Tendency to represent women during the public hearings as limited to victimhood, portraying women mainly as passive victims to physical sexual violence.

Pietsch (2010: 66) also concluded in her study of women's participation in the TRC, that it was 'male perpetrator centric and had excluded women ex-combatants'.

Notwithstanding this, the TRC made several recommendations related to women's rights, protection and empowerment and in summary these include establishing medical, psychological and social programmes, free medical services, ensuring Liberia's compliance with the Convention on the Elimination of All Forms of Discrimination against Women treaty (CEDAW, 1979) including monitoring, mentoring and reporting, advancement of policies and laws that favour education and training through adult-literacy programmes of women and girls, particularly in reproductive health, special programmes to reunite and support women and their children born from sexual slavery, building on women's expertise in conflict resolution and peace building and addressing sexual harassment through enactment of a statute.

Pillay (2009: 99) discussing the TRC concludes:

At the practical level, even though space was created for women to participate, there has not been a significant change in social thinking, attitudes or behaviour. In the Liberian context the best one can hope for now is that {...} the truth-seeking process will work towards significant reform in the months and years to come.

### **Discussion and recommendations**

The fourteen year armed conflict in Liberia and the human rights abuses that were carried out, had devastating effects, not only to individual women and girl survivors but to whole communities. The research concluded that the entire population is suffering from a wide range of psychological, alcohol /drug related addiction and surgical problems related to their war experiences.

The sexual and gender-based violence women and girls survived during the conflict caused extensive damage to their psychological, reproductive and gynaecological health. They have been infected with sexually transmitted diseases, HIV/AIDS, and are

left with serious reproductive health problems. Some of these psychological and reproductive health problems are not treatable within the current Liberian health system and the study found that the majority of women failed to access medical treatment due to a combination of factors including poverty, lack of adequate health care facilities and professionals. Women's experiences were exacerbated by the stigma of rape, which silences many women within this cultural context (Liebling-Kalifani, 2009; Liebling and Baker, 2010; Obbo, 1989). Post-conflict Liberia also faces substantial public health challenges. Although there are considerable efforts to tackle the problems including a recently published mental health plan, Liberia is currently unable to provide adequate health care for the overwhelming needs of the population (IRIN, 2009; Liebling-Kalifani and Baker, 2010; MSF, 2007; Republic of Liberia, 2010).

The majority of participants reported that their psychological problems were continuing to affecting their ability to function, which demonstrates the negative consequences of continuing to neglect this important aspect of rehabilitating women and girl survivors of sexual and domestic violence. However, despite the suffering endured, they have not been passive victims. On the contrary, women in Liberia have engaged as active campaigners for peace, played a key role in the presidential elections and have taken up male roles, becoming heads of households. As Liebling-Kalifani and Baker (2010:195) emphasised:

Liberian women and girls, who were the objects of attack, also resisted the breakdown of their cultural identity, not only physically and militarily, for example as combatants, but also socially, psychologically and culturally.

Although Liberian women groups have been active in the post-conflict recovery processes, their needs have failed to be adequately addressed by rehabilitation and reconciliation processes. Research carried out in Lofa indicated that women ex-combatants are more vulnerable to returning to fighting for several reasons including poverty, stigma and hardship (Hill et al. 2008). As highlighted in the current research as by others (e.g. UNFPA, 2007), women and girls report that they continue to suffer violence in post-conflict Liberia. Previous research has argued that the culture of violence experienced during the conflict period has led to the 'militarization of intimate relations' (Liebling-Kalifani and Baker, 2010: 196). Women cited the perpetrators of the continuing sexual and domestic violence as ex-combatants, community or family members, teachers and husbands/partners. However, in terms of justice, there is a fragile and barely functioning legal system, a lack of correctional facilities, inexperienced newly recruited police force and a lack of logistical necessities.

As an outcome of the research, policy briefs on governance, mental health and reproductive and sexual health were prepared and shared in consultative meetings with policy makers in Liberia. These can be found on the Isis-WICCE website at <http://www.isis-wicce.or.ug/>.

In terms of the outstanding needs of women and girl survivors of conflict sexual and gender-based violence, it is recognised that multiple strategies, working across different sectors at multiple levels are most likely to be effective (Liebling-Kalifani and Baker, 2010; UNIFEM, 2007). Based on the research findings and women's views, we recommend:

1. Training and sensitisation programmes for government, local leaders, policy makers and health care workers in Liberia on the gendered effects of war and the service and policy changes required.

2. That the Government should draw up a multi-sector and multidisciplinary post-conflict recovery plan to address the psychological, social and physical health problems of women and girls in Liberia (Isis-WICCE, 2008; WHO, 2007). As recommended in recent National Health Policy publications (Ministry of Health and Social Welfare, 2007; 2008; Republic of Liberia, 2010) there should be a long-term programme that includes a gender-balanced health workforce with the skill mix needed by different levels of health services.

3. Establishment of mobile and survivor-informed mental health services to address the massive psychological problems of the population including war trauma and alcohol and drug use. These services should be fully integrated into the existing primary health care system, in line with the mental health plan for Liberia. It could helpfully include peer to peer training of survivors to counsel each other as well as training of health and operational level workers on the gendered effects of trauma (Liebling-Kalifani, 2009; 2010; Republic of Liberia, 2010). Any such programme must seriously take account of the reality of the Liberian situation; a Country which lacks trained mental health professionals. Failure to account for this lack of infrastructure is a fate that has befallen previous psychosocial programmes.

4. There should be a holistic and accessible gender-sensitive public health intervention to address the reproductive health needs of women and girl war-survivors. The Department for International Development included 'universal access to reproductive health services by 2017' as a priority area for action. As has been emphasised worldwide, particularly in conflict and post-conflict settings, urgent resources are required if this target is to become a reality (DFID, 2000; Doyal, 2000; Jewkes, 2007; Liebling-Kalifani et al. 2008; WHO, 2007).

5. Income-generating activities, vocational training and micro-finance schemes would empower women and girls economically to enable them to access health services. Education for girls should be addressed in line with the Education Sector Recovery Plan (Ministry of Education, 2007). Poverty reduction strategies in conjunction with specialist health care programmes would improve the health outcomes for women and girl war survivors (OCED, 2003; Isis-WICCE, 2006; Liebling-Kalifani et al. 2007; 2008; 2009; Republic of Liberia, 2005; 2008a).

6. Women survivors should act as advisors to the peace building processes in Liberia. The Disarmament Demobilisation Re-integration and Rehabilitation should be extended to all those women and girl war survivors who were eligible but missed out. Lessons should be learnt from the failure of the DDDR programme to account for their neglected needs. Sufficient funding is required in order that civil society organizations can monitor all the post-conflict processes and ensure that a gender-sensitive, holistic and

empowerment approach is taken (Amnesty International, 2008a; 2008b; Koen, 2006; Liebling-Kalifani and Baker.2010; UNDP, 2006).

7. Evaluation of the effectiveness of the government and UN Joint Programme to prevent and respond to Sexual Gender Based Violence (Republic of Liberia, 2008b) as well as monitoring of the implementation of Security Council Resolution 1325 and the National Gender Policy of Liberia (Ministry of Gender and Development, 2009a), aimed at achieving gender equity and equality. The latter requires gender responsive budgeting for all ministries and agencies (Ministry of Gender and Development, 2009b). Legal and governance systems need sufficient funding and rehabilitation with reform of the security, army and police sector as outlined in the report 'Liberia: Uneven Progress in Security Sector Reform and the national security strategy of Liberia (International Crisis Group, 2009).

In summary, and as argued by Liebling-Kalifani and Baker (2010: 1); in order to be successful services:

Have to be gendered, culturally sensitive, address justice as well as health needs and build upon the resilience of women war survivors and their communities.

### **Bibliography**

- Amnesty International. 2008a. Liberia: A flawed post-war Process discriminates against Women and Girls. March 2008.
- Amnesty International. 2008b. Liberia: Towards the final phase of the Truth and Reconciliation Commission.
- Convention on the Elimination of All Forms of Discrimination against Women.1979.
- Department for International Development, DFID. 2000. Halving World Poverty by 2015: economic growth, equity and security. Strategies for achieving the international development targets. Department for International Development.
- Donovan, P. 2002 Rape and HIV/AIDS in Rwanda. *The Lancet*, 360, 17-18.
- Doyal, L. 2000. Gender equity in health: debates and dilemmas. *Social Science and Medicine*, 51, 6, 931-939.
- Hill, R., Taylor, G. and Temin, J. 2008. Would you fight again? Understanding Liberian Ex-Combatant Reintegration. United States Institute of Peace. Special Report 211. September 2008.
- Human Rights Watch.2002. Back to the Brink war crimes by Liberia Government and Rebels.
- Integrated Regional Information Networks, IRIN. 2009. Liberia: War Wounds Left to Fester. 12th January 2009. Accessed on 10<sup>th</sup> September 2009 at: <http://www.unhcr.org/refworld/docid/496c5c.htm>
- International Crisis Group. 2009. Liberia: Uneven Progress in Security Sector Reform. Africa Report No: 148.13<sup>th</sup> January 2009.
- Isis-WICCE. 1999. The short-term intervention of the psychological and gynaecological consequences of armed conflict, in Luwero district, Uganda. An Isis-WICCE Report, Kampala, Uganda.
- Isis-WICCE. 2001. Medical Interventional Study of war affected Gulu district, Uganda. An Isis-WICCE Report, Kampala, Uganda.

- Isis-WICCE. 2002. Medical Interventional study of war affected Teso Region, Uganda. An Isis-WICCE Report, Kampala, Uganda.
- Isis-WICCE. 2006. Medical interventional study of war affected Kitgum district, Uganda. An Isis-WICCE Publication.
- Isis-WICCE. 2008. A Situation Analysis of the Women Survivors of the 1989-2003 Armed Conflict in Liberia: An Isis-WICCE Research Report, in collaboration with Ministry of Gender and Development, Liberia and WANEP/WIPNET, Liberia.
- Jewkes, R. 2007. Comprehensive response to rape needed in conflict settings. *The Lancet*, 369, 9580, 2140-2141.
- Johnson, K., Asher, J., Rosborough, S., Raja, A., Panjabi, R., Beadling, C., and Lawry L. 2008. Association of combatant status and sexual violence with health and mental health outcomes in post conflict Liberia. *JAMA* 300, 6: 676-90.
- Kirsten, C., Hoover, A. and Kruger, J. 2009. Statistics from Statements to the Liberian Truth and Reconciliation Commission. Bentech Human Rights Program.
- Liebling-Kalifani, H. 2009. A gendered analysis of the experiences of Ugandan women war survivors. VDM Verlag Dr. Muller.
- Liebling-Kalifani, H. 2010. 'Research and Intervention with Women War Survivors in Uganda: Resilience and Suffering as the Consequences of War,' in *War, Medicine and Gender: The Sociology and Anthropology of Structural Suffering*, H. Bradby. and G. Lewando-Hundt. (Eds.). Ashgate Books.
- Liebling-Kalifani, H. and Baker, B. 2010. Women War Survivors of Sexual Violence in Liberia: Inequalities in Health, Resilience and Justice. *Journal of International and Social Research: Woman Studies (Special Issue)*, 3, 13, 188-199.
- Liebling, H. and Baker, B. 2010. Justice and Health Provision for Survivors of Sexual Violence: a case study of Kitgum, northern Uganda. LAP Lambert Academic Publishing AG & Co. Germany.
- Liebling-Kalifani, H., Marshall, A., Ojiambo-Ochieng, R. and Nassozi, M. 2007. Experiences of Women War-Torture Survivors in Uganda: Implications for Health and Human Rights. *Journal of International Women's Studies*. May, 1-17.
- Liebling-Kalifani, H., Ojiambo-Ochieng, R., Marshall, A., Were-Oguttu, J., Musisi, S. and Kinyanda, E. 2008. Violence against Women in Northern Uganda: The Neglected Health Consequences of War. *Journal of International Women's Studies*, 9, 3, 174-192.
- Liebling-Kalifani, H., Marshall, A., Ojiambo-Ochieng, R. and Nassozi, M. 2009. Experiences of Women War-Torture Survivors in Uganda: Implications for Health and Human Rights. In, *Women and Armed Conflicts: Consequences and Coping Mechanisms*. India.
- Medecins Sans Frontieres, MSF. 2007. From Emergency Relief to Development: no cheap solution for health care in Liberia. Brussels.
- Ministry of Education. 2007. Priorities of Education Sector Recovery in Post-Conflict Liberia: Building a Solid Foundation for future growth. Outline for the partner's Forum. February 13-15 2007. Washington DC. Government of Liberia.
- Ministry of Gender and Development. (2009a) Liberia National Gender Policy. Republic of Liberia 2010-2015.

- Ministry of Gender and Development. (2009b) Liberia National Gender Policy. National Gender Policy Strategic Results Framework and Plan. Republic of Liberia 2010-2015.
- Ministry of Health and Social Welfare. 2003. United Nations Theme Group on HIV/AIDS. RC Annual Report for 1003 Liberia. Accessed on 7th September 2009 at [http://www.cfapp2.undp.org/dgo\\_unct\\_report/.../annex\\_LIR\\_380075557.doc](http://www.cfapp2.undp.org/dgo_unct_report/.../annex_LIR_380075557.doc)
- Ministry of Health and Social Welfare, Republic of Liberia. 2007. National Health Policy National Health Plan 2007- 2011. Monrovia, Liberia. [http:// MOH.GOV.LR](http://MOH.GOV.LR)
- Ministry of Health and Social Welfare, Republic of Liberia. 2008. Basic package of health and social welfare services for Liberia. Ministry of Health and Social Welfare, Publication.
- Obbo, C. 1989. Sexuality and Economic Domination in Uganda. In. F. Anthias and N. Yuval-Davis. (Eds.). Woman-Nation-State. The Macmillan Press Ltd. Cambridge.
- Organisation for Economic Co-operation and Development, OCED. 2003. Poverty and Health in Developing Countries: Key actions. Policy Brief. November.
- Pietsch, S. 2010. Women's Participation and Benefit of the Liberian Truth and Reconciliation Commission-Voices from the Field. Unpublished Master's Thesis. Philipps University, Marburg.
- Pillay, A. 2009. Truth and gender: The Liberian experience. In, African Journal on Conflict Resolution. Special Issue on Gender and Transitional Justice in Africa, 9, 2.
- Republic of Liberia. 2005. A National Youth Policy for Liberia: A Framework for Setting Priorities and Executive Actions: Placing the Youth on the National Agenda of Liberia. December 2005.
- Republic of Liberia. 2008a. Poverty Reduction Strategy. April 2008.
- Republic of Liberia. 2008b. Government and UN Joint Programme to Prevent and Respond to Sexual Gender Based Violence. 13 June 2008.
- Republic of Liberia. 2009a. The Liberia National Action Plan for the Implementation of United Nations Resolution 1325. March 2009.
- Republic of Liberia. 2009b. Truth and Reconciliation Commission Volume 11: Consolidated Final Report. June 30<sup>th</sup> 2009.
- Republic of Liberia.2010. Ministry of Health and Social Welfare National Mental Health Strategic Plan 2010-2015.
- Sideris, T. 2003. War, gender and culture: Mozambican women refugees. Social Science & Medicine, 56, 4, 713-724.
- Skylv, G. 1992. The physical sequellae of torture. In Torture and its consequences – current treatment approaches. M. Basoglu. (Ed.) Cambridge University Press, United Kingdom.
- The Analyst. 2008. 73 Witnesses Testify in Montserrado County, 10 February 2008.
- UNDP. 2003. UNDP Liberia programme, Disarmament Rehabilitation and Reintegration. UN DOC.S/2003/1509, 19<sup>th</sup> September, 2003 Resolution 1509/2003.
- UNDP. 2006. National Human Development Report, Liberia, Mobilizing Capacity for

- reconstruction and Development for Human Development Indicators for Liberia.
- UNFPA/USAID/JSI/CDC. 2007. Women's reproductive health in Liberia: The Lofa county reproductive health survey.
- United Nations. 2002. Report of the Secretary General on Women, Peace and Security. United Nations Security Council s/2002/1154 October 2002.
- United Nations. 2004. Report of the Secretary General on ways to Combat Sub Regional and Cross Border Problems in West Africa. S/2004/200. United Nations New York 12 March 2004.
- United Nations. 2006. Ending Violence against women: From words to Action-Study of the Secretary General. Violence against women: Unmet needs broken promises. United Nations Fact sheet dated 9<sup>th</sup> October 2006.
- United Nations Assistance Framework for Liberia. 2008-2012. Consolidating Peace and National Recovery for Sustainable Development.
- United Nations. 2007. United Nations Assistance framework for Liberia. 2008 2011. Consolidating Peace and National Recovery for Sustainable Development.
- United Nations Report of the Secretary General on Women, Peace and Security-s/2002/1154. Ibid.
- WHO/UNICEF/UNFPA. 2000. Maternal mortality in 2000. Estimates developed by WHO, UNICEF and UNFPA.
- World Health Organisation. 2005. Sexual gender-based violence and health facility needs assessment (Lofa, Nimba, Grand Gedeh and Grand Bassa counties). WHO publication. Geneva.
- World Health Organisation. 2007. Health Action in Crises: UGANDA. June 2007.