TOUCHING THE UNREACHED

A
Medical Intervention
In Liberia

Touching the Unreached:

A Medical Intervention in Liberia

A report prepared by

Isis-WICCE

In conjunction with

Ministry of Health and Social Welfare, Liberia
Ministry of Gender and Development, Liberia
WANEP/WIPNET, Liberia

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrom
BPHS	Basic Package of Health Service
HIV	Human Immuno Virus
IDPS	Internally Displaced Persons
Isis-WICCE	Isis Women's International Cross Cultural
MHSW	Minisrty of Health and Social Welfare
RVF	Recto Varginal Fistulae
PTSD	Post Traumatic Stress Disorder
SPSS	Statistical Package for Social Science
STATA	Statistical Package by Statacorp
STIs	Sexually Transitted Infections
VVF	Vesico Varginal Fistulae
WANEP	West Africa Network for Peacebuilding
WIPNET	Women in Peacebuilding Network

Foreword

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

As a result of their experiences of violence and torture, the population of Liberia is suffering from a wide range of psychological, alcohol/drug related addictions, surgical problems, and for women, serious gynaecological problems. The dilapidated health system of Liberia is still struggling on to respond to the needs of survivors of sexual violence. There are few health centres or adequately trained and employed health workers. The extensive physical and psychological outcomes of armed conflict inhibit women's capacity, not only as individuals, but also in their relationship with their families, households and communities. This affects their roles of production and reproduction.

In line with its previous research recommendations, (Isis-WICCE, 2008), Isis-WICCE obtained a grant from the Millennium Development Goal 3 Fund of the Dutch government to carry out an emergency medical intervention in Maryland and Grand Kru counties in 2009. These counties were selected due to their remote and under-developed infrastructure, the lack of medical services and the heavy burden of gynaecological and psychological problems. The intervention aimed at:

1. Providing specialised health care for women war survivors.

2. Providing reproductive health kits to rural health units.
3. Building the capacity of local health workers in the management of reproductive and surgical complications of war through undertaking surgical camps.
4. Training primary health workers to provide psychological support to women, children and men war survivors.
5. Revising and piloting a training manual for health workers in the recognition, assessment and management of the psychological, reproductive and surgical health consequences of war.

The first stage of the intervention involved training of health workers, social workers and community leaders at a workshop that was carried out in Harper, Maryland Country from 21st - 27th May 2009. A total of 49 participants; 24 women and 25 men, attended the training, which utilised a holistic approach and 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 1158 survivors; 744 women and 414 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 ranging from 1 to 90 years benefitted from the surgical camp. Due to the ernomous numbers who accessed the services, the medical consultants, Isis-WICCE and WANEP/WIPNETstaff 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 had focussed mainly on men. Most women therefore assumed this was still the case. With time, and once women saw their fellow women deriving benefit from the programme, they came for treatment. 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.

We extend our sincere congratulations to Isis-WICCE together with their partners in the Ministry of Gender and Development and West Africa Network for Peace building (WANEP) for having successfully been part of this well conceived and executed Short Term Medical Intervention, which will make a real difference to the medical and psychological health of Liberia's war-affected communities.

As Ministry of Health and Social Welfare, we were delighted to have been part of this innovative model of providing quality health care in a friendly environment for the benefit of women, men and children in Maryland and GrandKru.

Dr. Bernice T. Dahn
Deputy Minister/Chief Medical Officer
Ministry of Health and Social Welfare,
Republic of Liberia

Preface

Nothing was as challenging, but at the same time so fulfilling as going into Liberia in 2008 after the 14 years long atrocious conflict, to document the experiences of the survivors, especially women and girls. Thanks to the skilled and well prepared Isis-WICCE institute alumni who passionately sat for long hours to document the experiences of survivors, whose outcome pointed to the neglected reproductive health complications that women and men still faced even after the guns went silent. We thank our traditional partners who enabled us to start this journey[1].

The enthusiasm of the leadership at different levels of governance in Liberia; the technical teams we interacted with, including the ordinary women, men and youth, provided a conducive platform for Isis-WICCE to practice her action oriented approach to documentation, by responding to the major findings that emphasised the pathetic state of women's health.

Our thanks and honour goes to the Dutch Government for providing the grant through the Millennium Development Goal 3 Fund, and to put trust in Isis-WICCE to mobilise experts to immediately respond to the reproductive health complications of the population especially women that went unattended to for over a decade. For Isis-WICCE, this has remained a memorable activity that put long forgotten smiles on the faces of the women and men war survivors, and provided a sigh of relief. Following our dream of making change in the lives of women and girls; we found ourselves thumbing up to Albert Einstein's famous quote; *"Only a life lived by serving others is worthwhile"*.

Touching the Unreached: A Medical Intervention in Liberia gives a story about the medical intervention that Isis-WICCE with her partners carried out in the two counties of Maryland and Grand Kru in Liberia, in 2009. Amidst difficulties of infrastructure, lack of medical personnel and means of communication including high level of poverty among most patients, Isis-WICCE provided the required quality health

[1] Evangelischer Entwicklungsdienst (EED), HIVOS, ICCO en Kerkinactie, NORAD/ Norwegian Council for Afrika/Fokus, Open Society Institute, Sigrid Rausing Trust

services to over 1158 survivors in response to their gynaecological and psychological needs due to sexual violence and neglect. The process included the training of health workers; distribution of drugs and medical equipment to 12 health centres and clinics, and 2 hospitals; screening and treatment of survivors, and surgery for the various identified cases.

Isis-WICCE's feminist transformative approach to restoring bodily integrity did not only address reproductive health complications amongst women but went further to address the reproductive health ailments presented by men and some chronic ailments found in children, in an effort of bringing peace to the affected households. With the in-built post surgical care, patients fully recovered and went back home with smiles.

The magnitude of the health problems the team experienced on the ground necessitated an impromptu engagement with policy makers particularly those from Grand Kru and Maryland to provide them with an informed opinion on the long term strategies for addressing the reproductive health needs of survivors

The intervention was of course a drop in the ocean given the magnitude of the problem. However, Isis-WICCE is proud to have touched the bodies, minds and the souls of the unreached. Isis-WICCE therefore challenges others with the capability and capacity to follow suit because the reproductive health problems amongst women and men in Liberia is still enormous.

Isis-WICCE's sincere appreciation goes to our partners in Liberia; the Ministry of Gender and Development, Ministry of Health and Social Welfare, and West Africa Network for Peace Building (WANEP), for willingly moving on this journey with us in giving a new beginning to some of those who had given up.

Ruth Ojiambo Ochieng
Executive Director
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Acknowledgement and Authorship

Isis-WICCE, Ministry of Gender and Development, MOHSW and WANEP/WIPNET are indebted to the entire team that participated in the medical intervention for the hardwork, enthusiasm and dedication during the entire period. We acknowledge the expertise and time the different consultants put in the analysis of the data collected and the compilation of this report.

All the theatre and surgical ward staff, laboratory and pharmacy staff; laundry and cleaning team and the kitchen staff.

Leadership in Maryland and Grand Kru counties, and Liberia in general.

And to all the women, children and men who benefitted from the medical intervention, we are glad that you found relief yuo were seeking.

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Chapter One

BACKGROUND

1. Introduction

This report presents the process leading up to and the analysis of the major findings of the short term medical intervention that was undertaken by Isis-WICCE in the two counties of Maryland and GrandKru in Liberia. The medical intervention was prompted by the findings from the Isis-WICCE report, *'A situational analysis of the women survivors of the 1989-2003 conflict in Liberia,'* where the four counties of Lofa, Bong, Maryland and GrandKru were studied. The study findings reported grave instances of war torture violations committed against women, children and men. Examples of war torture reported included; 66.2% of the respondents had witnessed the killing of someone; 27% of the respondents reported losing a spouse as a result of war; 62.5% of the women interviewed reported having suffered some form of sexual violation that included single episode rape, gang rape, sexual comforting, forceful insertion of objects in the vagina, abduction with sex, attempted rape and forced incest.

The study findings indicate that these incidents of war torture have left the population with both psychological and physical scars. For example, 69% of the women reported at least one gynaecological complaint; 43% of the respondents had significant psychological problems; 12% of the respondents were psychologically dependant on alcohol; and 61.4% had at least one surgical complaint. From the study, it was also established that 69% of those with significant psychological problems were impaired in their ability to work.

Isis-WICCE action oriented approach demanded that these psychological and physical health problems be addressed for there to be complete rehabilitation, healing and recovery of the dignity

of the population. Against this background, Isis-WICCE undertook a fundraising drive to mobilize resources to undertake a short term medical intervention in the 4 study counties. Through the Dutch MDG3 Fund, Isis-WICCE was able to secure resources to undertake a short term medical intervention in two of the study counties.

The two counties consciously selected for the short term medical intervention were Maryland and GrandKru for the following reasons:

i) Maryland and GrandKru are some of Liberia's remotest counties having the least developed infrastructure including the health system
ii) Maryland and GrandKru are often 'left out' when medical interventions are planned in the country.
iii) The Isis-WICCE study findings found the two counties as the most affected by the war with the resultant heavy burden of gynaecological and psychological problems.

1.1 The state of the health system in Liberia

The 14 year Liberian civil war led to severe disruption of health services: where health workers were forced to flee into IDPs or to go to neighbouring countries; health facilities were looted and vandalized; medical supplies becoming unavailable; and eventually government funding run out leading to the total collapse of the country's health service system. Against such a background, it is no surprise that Liberia has some of the world's worst indicators of health; infant mortality rate of 157/1000 (sub-Saharan Africa average is 171/1000; UNICEF, 2008) maternal mortality rate of 580/100,000 (one of the worst in the world); HIV prevalence of 5.2% (UNDP, 2008); moderate and severe underweight rates among under fives of 27% and 7% respectively (UNICEF, 2008).

Although there has been a revitalization of health services following the end of the conflict, the health situation remains poor. In addition, the heath sector suffers from a lack of accurate data on access and utilization of health services, with the available estimates often unreliable. The Interim Poverty Reduction Strategy (2006) estimates that only 49% of the population has access to health services.

1.1.1 Policy framework

To address this state of affairs, the Liberian National Health Plan 2007-2011 has as it's mission, the reform of the health care sector to effectively deliver quality health and social welfare services in an equitable manner to the people of Liberia. The Liberian health policy and plan were prepared with the themes of decentralization and a public health model of service provision. As a cornerstone of it's national healthcare delivery strategy, Liberia has developed a Basic Package of Health Services(BPHS) which includes essential preventive and curative care services to be provided at every level of the health system from the village health worker to the major referral hospital. The five priority areas of the BPHS include maternal and new born health, child health, reproductive and adolescent health, communicable disease control, mental health and emergency care.

While acknowledging the need for the BPHS to be delivered in an integrated manner, the National Health Policy (2007) is cognizant of the fact that it currently faces practical limitations with regard to limited human and financial resources (e.g. Liberia a country of 3.5 million people at the time of the medical intervention had only one psychiatrist who is not employed in the public sector). Thus the mental health component was not initially operationalised. However, with the recent government approval of both the mental health policy and

the mental health strategic plan, this component too is slowly being operationalised starting with the opening of four *'Wellness Clinics'* at county hospitals.

1.1.2 The three tier system of health care delivery

The national healthcare system of Liberia is based on three levels of care; primary, secondary and tertiary.

Primary level of Care :This includes basic health care services delivered through clinics and small health centres. The health clinic is a small facility with no more than 5 beds and providing basic preventive and curative care. The package at this level includes promotional health, basic mental health services and the management of common conditions of children and adults. These primary health facilities also support environmental health (water and sanitation) in the surrounding community.

Secondary level of Care: This encompasses large health centres and county hospitals. The health centre is a primary care and referral facility with up to 40 beds; providing a wide range of curative and preventive services supported by a small laboratory. Basic emergency and in-patient care is provided. The county referral hospital has more than 50 beds and a permanent capacity to manage common surgical conditions including basic intensive care.

Tertiary level Care: is represented by John Fitzgerald Kennedy Medical Centre (JFK-MC) with the only psychiatric facility in Liberia (the Grant Clinic in Monrovia) which is soon to be incorporated to other regional referral hospitals (150 beds) to be established countrywide. These units will provide tertiary care including having mental health facilities. JFK-MC also has a specialised unit that addresses women's gynaecological problems especially fistulae and cancer.

1.1.3 State of the health infrastructure

The health infrastructure of Liberia suffered considerably under the 14 year civil war, where many of the health facilities were looted, vandalized or virtually destroyed. Those that survived the on slaughter lacked medical supplies and were abandoned when government funding finally dried up. After the war, most of them continued to suffer from persistent under funding and are in urgent need of rehabilitation. The uneven population distribution where four counties Montserrado, Nimba, Bong and Lofa host 70% of the total Liberian population puts added pressure on health facilities in these over populated counties. In addition, the massive population displacement from the rural areas to cities during the war has led to artificially accelerated urbanization that has resulted in severe overcrowding in towns and cities; thus putting immense pressure on health facilities in these places. A 2006, Ministry of Health and Social Welfare (MHSW) Rapid Assessment identified 354 functional health facilities in the country including 286 clinics, 50 health centres and 18 hospitals. An additional 200 health facilities were found to be nonfunctional, with access to health services estimated to be 41%.

The 2006 Ministry of Health and Social Welfare Rapid assessment observed that many of the health facilities struggle to attain acceptable performance levels and are in urgent need of robust infrastructural interventions to become truly functional. That report further observed that the hospital component of the health sector was undersized and it's technical capacity grossly inadequate and in need of major investment. The projected requirement for Liberia indicates the need for 500-550 health facilities to make primary health care (PHC) geographically accessible. As proposed, this would increase the number of functional health facilities from 354 to 550. This process

would require minor to major rehabilitation of 110 existing facilities. In addition, 30 facilities would need to be reconstructed and 30 new health clinics constructed in the remote not easily accessible and underserved areas.

1.2 Isis-WICCE's short term medical interventions

1.2.1 Introduction

Since 1997, when Isis-WICCE undertook a program to document women's experiences in war situations with Uganda as a starting point, it quickly realized that many of the women survivors still had many unattended health problems, often many years after the war. Working with in-country and out-of-country professional groups, Isis-WICCE developed a programme to undertake short term medical interventions, not only to provide medical and psychological relief to the suffering of women war survivors but also to raise awareness among policy makers and implementers about these unmet health needs of women war survivors. This model of short term medical interventions has since then been utilized by Isis-WICCE to provide emergency medical assistance to four conflict and post-conflict communities in Uganda, namely: Luweero district (Central Uganda, in 1998/99), Gulu district (Northern Uganda, in 2001), Teso region (North-Eastern Uganda, in 2002) and Kitgum district (Northern Uganda, in 2006).

Luweero medical intervention (1998/99)

Luweero district in central Uganda went through a devastating war between 1980-1986 leading to more than 100,000 deaths with many atrocities committed against the population including maiming and displacement. In 1997, Isis-WICCE undertook a project to document

the women's experiences of armed conflict and observed that 13 years after the conflict, many of the women still had unattended psychological and gynaecological problems. Many women suffered loss of family members (40%), physical torture (50%) and sexual torture (60%). The most common mental disorders reported included post traumatic stress disorder (PTSD; 55%), depression and generalized anxiety disorders (80%), and diffuse chronic aches and pains i.e. somatisations (81%). Over half (55.5%) of the assessed women had gynaecological problems including sexually transmitted infections (64.7%), urinary tract infections (7.8%), vesico-vaginal fistulae (6.0%), infertility (4.3%), fibroids (3.4%), uterine prolapse (4.3%) and cancer of the cervix (3.4%). All the women respondents had never accessed medical care prior to the Isis-WICCE medical intervention in 1998.

Gulu Medical Intervention (2001)

Gulu district in northern Uganda has been at the centre of the northern Uganda armed conflict that lasted more than 18 years and saw more than 35,000 children abducted, 2 million people displaced into IDP camps and many thousands killed. In July 2001, when the war was still on-going Isis-WICCE working with the medical professional team in Uganda undertook a short term medical intervention in Awer internally displaced persons camp, where the organisation had earlier documented the women's experiences of war (Isis-WICCE, 2001). The research findings of that study were similar to those reported in the Luweero medical intervention. The population had suffered significant war traumatisation including physical, psychological and sexual torture. The main psychological problems reported included PTSD, depression, alcohol abuse and suicide attempt. The population also had significant gynaecological problems.

Teso medical intervention (2002)

In August 2002, in her desire to highlight the women's sufferings in war affected Teso region, Isis-WICCE undertook a documentation of the women's experiences in armed conflict that focused on investigating what had happened to the women as a result of the 1987-1992 'Teso insurgency' which was complicated by a century's old cattle rustling perpetrated by the Karamajong. The cattle rustling by the Karamojong had particularly become vicious due to the commercialization of the raids and the entry of small arms. In the subsequent short medical intervention, that followed that research, respondents who were reviewed during the process presented considerable psychological distress, suicidal ideation and homicidal ideation. Gynaecological problems identified included: chronic pelvic pain, abnormal vaginal discharge, infertility, vaginal/perineal tears and urinary /rectal fistulae. Surgical problems identified included: complications of amputations, chronic wounds, complicated scars, various disfigurements and disabilities. Although many of these people had tried to seek medical treatment from health facilities in the region, there were no specialised services to help them.

Kitgum medical intervention (2006)

In October 2005, Isis-WICCE undertook a short term medical intervention in Kitgum district, a district that had suffered for 18 years as a result of the northern Uganda armed conflict. The medical intervention was undertaken in two internally displaced persons camps (IDPs) of Mucwini and Padibe. As in previous projects, survivors accessing the Isis-WICCE medical intervention reported experiences of severe war torture and the consequent psychological, gynaecological and surgical complications. This time round, Isis-WICCE included the

experiences of the young. More than a quarter of both the girl and boy children treated had suffered physical torture. The number of children with significant psychological problems was high. There was however lack of facilities that would address the childhood psychological trauma.

1.2.2 Achievements from the Uganda medical interventions

For the past 11 years that Isis-WICCE has collaborated with the medical professionals, it has been possible for the coalition to utilize the documented data to develop and produce the first ever comprehensive training manual for health workers in the management of medical and psychological effects of war trauma[1]. The manual was adopted by the Uganda Ministry of Health – Mental health section as its standard training manual. In addition, Isis-WICCE contributed to the Uganda Ministry of Health 5-year strategic plan (2001-2005) in which mental health was incorporated as a priority area.

Furtherstill, the World Health Organisation – Uganda has since 2007 utilised the training manual "*Management of Medical and Psychological Effects of War Trauma*" to train over 300 health workers in Northern Uganda.

The emergency interventions enabled 1,340 women to receive gynaecological treatment, 500 women, men and children to get surgery, 2000 to receive counselling and trauma therapy and 1500 to receive general treatment. The research reports produced from these interventions have strengthened Isis-WICCE's research with scientific data and the evidence from the actual survivors thus linking research with activism.

1 The training manual was launched in Kampala, Uganda, in June 2006. Two government Ministers, 10 MPs, and many researchers and activists attended the function.

Using the data generated, Isis-WICCE opened the way for setting up of longer term trauma treatment services with organizations such as the Peter C Alderman Foundation, which has set up two clinics in the Northern Uganda towns of Gulu and Kitgum, and in Tororo in Eastern Uganda.

In addition, through participating in Isis-WICCE medical interventions, Ugandan health workers have enhanced their expertise in managing medical effects amongst survivors in communities affected by conflict, and have been able to take on new assignments in the Ministry of Health.

Chapter Two

METHODOLOGY OF THE LIBERIA MEDICAL INTERVENTION

2.1 Introduction

Earlier in 2008, Isis-WICCE in collaboration with the Ministry of Gender and Development and WANEP undertook a study[2] which provided valuable data and information, to facilitate and enable decision and policy makers, planners, activists and humanitarian agencies to respond more appropriately to the practical and strategic needs of women survivors of the armed conflict. The analysis of the study findings, recommended that:

..." there was urgent need to establish psychological treatment centres in all areas of war-torn Liberia to address the massive psychological problems of the population. International NGOs were called upon to provide the medical treatment for the survivors of war trauma and those with reproductive health problems, as a component of their rehabilitation programmes. It was also recommended that psychological services should be integrated within the Primary Mental and Maternal Health Service of Liberia"...

In partial fulfillment of this recommendation, Isis-WICCE and her partners[3] in 2009 undertook a short term medical intervention in the counties of Maryland and GrandKru in Liberia. The process and major findings of that medical intervention are described in subsequent chapters of this report.

2 A Situational Analysis of the women survivors of the 1989-2003 armed conflict in Liberia

3 WANEP, Ministry of Gender and Development, and Ministry of Health and Social Welfare

2.2 Study Site

The short term medical intervention was carried out in Maryland and Grnad Kru counties in Liberia.

2.3 Overall Objective

The overall objective was to implement a participatory medical intervention to address the reproductive and mental health needs of women war survivors including men in most need in the two counties of Maryland and GrandKru.

2.4 Specific Objectives

a) To provide specialized reproductive, mental, surgical and medical health care to women war survivors

b) To provide reproductive health kits to rural health units to facilitate their provision of reproductive services to the population

c) To revise and pilot a training manual for health workers in Liberia as a training guide in the recognition, assessment and management of the mental, reproductive and surgical health consequences of war trauma.

d) To build the capacity of local health workers in the management of reproductive and surgical complications of war trauma through jointly undertaking surgical camps in the two counties with a selected national and international team of health professionals

e) Train primary health workers to offer psychological support to women war survivors including children and men

f) To document the general characteristics, war torture experiences, and mental and reproductive health problems of women war survivors accessing the medical intervention.

2.5 Intervention Method and Design

This medical intervention was undertaken through a number of stages:

2.5.1 Planning meetings

Isis-WICCE organised a series of planning meetings in Kampala with the Ugandan based medical professionals, and deliberated on the methodology of the medical intervention, reviewed the screening instruments, drafted the communications strategy and the concept for the in-country planning meeting in Liberia.

A consultative meeting was then held in Monrovia, Liberia from 16th - 17th April 2009. The meeting was attended by 38 persons including health workers from Maryland, Grand Kru, Bong and Lofa counties, and the Ministry of Health and Social Welfare in Monrovia. The meeting also included officials from the Ministry of Gender and Development, women NGOs, Isis-WICCE and the media.

At this meeting the draft plan of the medical intervention was presented by Isis-WICCE, discussed, modified and adapted for implementation.

2.5.2 Reconnaissance visits to the study counties

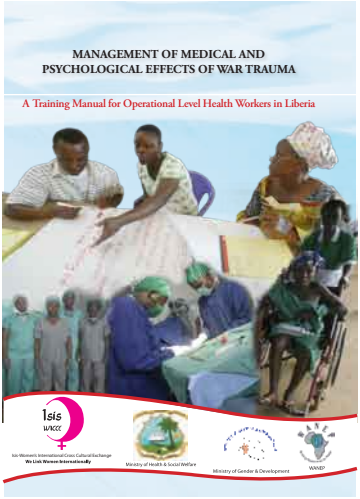
An advance team composed of WIPNET staff was dispatched to Maryland and Grand Kru by the Liberia National Coordinator. The purpose was for the team to assess the state of the health centres, identify additional drugs and equipment needed for the medical intervention, identify health workers and community leaders who would attend the training, identify training venue and accommodation facilities for the training, and related logistical needs.

2.5.3 Revision of the training manual

The highly successful Ugandan training manual for health workers in the recognition, assessment and management of mental health, reproductive health and surgical problems in post confict situation was revised and adapted for use in Liberia. Isis-WICCE's previous experience has showed that the often isolated health workers working in conflict and post-conflict situations in sub-Saharan Africa are not always aware of the psychological and medical consequences of war trauma. This negatively impacts on their ability to help their clients recover from the health and psychological sequel of war trauma. Isis-WICCE therefore undertook the development of a training manual based on the 11-point Harvard Programme for treatment of Refugee Trauma.

When Isis-WICCE completed the study in 2008 it was clear that general health workers and other carers in Liberia urgently needed a tool that could be used to train them in the recognition, assessment and management of the psychological and medical effects of war trauma. As a build up to undertaking the medical intervention, the first Uganda edition of the training manual (Isis-WICCE, 2006) was revised by a multi-disciplinary team that included health specialists from Liberia's MHSW, and an international team of consultants from the Ministry of Health Uganda, Makerere University Training Hospital and the University of Coventry, United Kingdom. This training manual was adapted for use in Liberia and subsequently piloted and tested at a training workshop for health workers who were to participate in the Isis-WICCE medical intervention.

The Liberian training manual compared to the Ugandan manual had



additional chapters on the human rights approach to health care; community psychosocial services in post conflict situations; sexual and gender based violence; and communication in conflict and post-conflict situations. The 11 chapters of the revised Liberian training manual highlight major issues like torture during war, professional and ethical standards in health care, psychological consequences of war trauma, management of gynaecological consequences of war and counselling of survivors of trauma. It further includes management of trauma in children, Sexual and Gender Based Violence in post conflict situations, HIV and AIDS, community psychosocial services, approaches to communication and a detailed screenning tool.

2.5.4 Authorisation for the foreign medical consultants

The team of medical consultants from Uganda were required to meet the required standards as per the Liberian National Medical Board.

Procedures for authorisation of foreign medical practitioners in Liberia were thus acquired from the Liberian Medical Board to facilitate the licensing of the Ugandan medical doctors to participate in the intervention. They consequently submitted the required documentation which was vetted by the Liberia Medical Board and the doctors were authorized to practice in Liberia for the specified period of the medical intervention.

2.5.5 Training workshop for health workers, community resource persons and women leaders

The mobilisation of health workers, community resource persons and women leaders was done by Ministry of Health and Social Welfare, Ministry of Gender and Women in Peace Building Network (WIPNET). This was done through telephone calls and the advance team of WIPNET staff to Maryland and Grand Kru, to ensure that the message reached the appropriate people.

The criteria of selection was based on the fact that the health workers were practising in the identified health centres and hospitals on a full time basis. Community social workers and leaders were required to be resident in the identified localities and thus had a direct contact with the population. This was important because Isis-WICCE's approach emphasises building the skills of the community, as well as ownership. In addition, the identified team would be instrumental in identifying, reaching out and encouraging the intended beneficiaries to access the medical services, and post recovery follow up.

The training was conducted in Harper, Maryland county from the 21st - 27th May 2009. It aimed at building the capacity of the health workers, social workers and community leaders in the management and identification of physical and mental health related complications in post conflict settings.

A total of 49 (24 women and 25 men) participants attended the training. Of these 16 were from Grand Kru, 29 from Maryland, 2 from Lofa and 2 from Bong counties. It must be noted that the number of trained personnel among women in Liberia is still very low. The objectives of the training were:

i) To equip the trainees with skills in the recognition, assessment and

Dr. Nakku facilitating on mental health during the training in Harper Town, Maryland County

management of mental, reproductive and surgical complications of war trauma

ii) To pilot the draft training manual

iii) To standardize practice and procedure for the medical intervention

iv) To train health workers and WIPNET field staff in the use of the medical intervention data collection tools

v) To investigate the war trauma experiences of the participating health workers

vi) To investigate the nature of reproductive and maternal health, and mental health services offered by the parent facilities of the health workers

The participants were trained in counselling and medical management of war trauma problems, sexual and reproductive health, Gender Based Violence, management of the psychological health consequences of survivors, human rights and professional standards in health care and communication. The training emphasized a holistic approach especially in addressing the trauma that affected most of the survivors of the conflict. Given that most of the trainees were also survivors, the

training had a special session on individual and group counselling to help them come to terms with their own past traumatic experiences.

The trained health workers, social workers and leaders were immediately deployed after the training (28th May to 1st June) to go out in the communities to inform the women and men about the plans for the screening, treatment and surgery.

2.5.6 Purchase drugs and equipment for the medical intervention

The purchase of drugs were based on Liberia's Ministry of Health procedures and regulations. Majority of the drugs were purchased from the National Drug Service, B-Kay Pharmacy Inc, and Abeer Pharmaceuticals in Liberia. Drugs that were not available on the Liberia market were purchased from Pharmatech Limited in Uganda.

The assortment of drugs and medical equipment purchased included blood pressure machines, thermometers, stethoscopes, fetoscopes, spinal needles, pulsemeters, glucometre strips, syringes; medical sundries like surgical gowns and caps, linen, hospital mattresses, gloves; and drugs like anti-malarials, pain killers, antibiotics and iv-injectables.

The drugs were transported by road and air depending on their state of fragility. The Ministry of Health and Ministry of Gender availed a truck to transport drugs from Monrovia to Maryland in order to reduce on the high cost of transportation. In addition, two vehicles were hired to distribute the drugs and equipment to the 12 health centres and 2 hospitals from 1st – 8th June 2009.

Isis-WICCE staff with a team of health workers delivering large quantities of medical drugs and equipments to over 14 health centres in the two counties of Maryland and GrandKru

In Maryland County, drugs and equipment were provided to health centres and clinics that included Pleebo, CRC, Kaloken, Cavalla, Ferloken, Glofaken, Fish town and J.J Dossen hospital.

In Grand Kru County, drugs and equipment were delivered to Newaken, Behwen, Barclayville, Garraway and Sass town health centres as well as Rally Time hospital.

Kits were then delivered to each of the participating health units and for the hospital level facilities included:

Health Centre Packs

No.	*Name*	*Quantity*
1.	Paracetamol tabs	8 x 1000
2.	Cotrimoxazole tabs	1 x 1000
3.	Amoxicilin tabs	2 x 1000
4.	Folic acid tabs	5 x 1000
5.	Doxycycline tabs	6 x 1000
6.	Ferrous Sulphate tabs	10 x 1000
7.	Paracetamol syrup	50x 60ml
8.	Diclofenac tabs	8 x 100
9.	Metronidazole tabs	30 x 100
10.	Oxytocin inj.10IU	2 x 100
11.	Exam gloves	1 x 50
12.	ORS	2 x 100
13.	Cloxip Caps	2 x 100
14.	Quinasol tabs	1 x 100
15.	Ciplox	1 x 500
16.	Syringes 10cc	1 x 100
17.	Plaster	20
18.	Povidine 20ml.	20
19.	Clinical Thermometer	3
20.	BP Machine	1
21.	Stethoscope	1
22.	Fetoscope	2
23.	Urine sticks	2 packets
24.	Syringes 10ml	1 x 100
25.	Syringes 5ml WNDL	1 x 100
26.	Needles	1 x 100
27.	5% Dextrose (500ml)	1 x 24
28.	Ringers Lactate (1000ml)	1 x 12
29.	Normal Saline (500ml)	1 x 24

Hospital Packs

	ITEM	QUANTITY
1	Plaster rolls	70
2	Povidine 2ml	70
3	Endotracheal tube	
4	Pulseoximeter	1
5	Neostigmine	150 ampoules
6	Propofol	25 ampoules
7	Bupivacaine	25 ampoules
8	Spinal needles	50
9	Syringes 10ml	4 x 100
10	Syringes 5ml WNDL	3 x 100
11	Needles	4 x 100
12	5% dextrose	15x 24
13	Ringers lactate	6 x 24
14	Normal saline	14 x 24
15	50%dextrose	24 bottles
16	Urine bags	30 pieces
17	Cotton wool	25rolls
18	Gentamycin	10 x 100
19	Iv sets	240
20	Blood giving set	40
21	Mattresses	20
22	Surgical Gowns	
23	Surgical Linen	

2.5.7 Coordination of the project

The coordination was done at two levels.

i) Medical

The overall coordinator was Dr. Otim Tom Charles (a Ugandan consultant gynaecologist) whose role was to ensure that all medical procedures were handled as per the professional ethics. He was on ground for three months (May – July 2009) overseeing the exercise. He was supported by Dr. Jallah Wilhemina (a Liberian consultant gynaecologist at JFK Hospital).

ii) Logistical

The entire coordination was headed by the Executive Director, Isis-WICCE; and the Liberian partners, the National Coordinator, WANEP/WIPNET; the Assistant Minister of Social Welfare, Ministry of Health; and the Minister of Gender and Development ; with the support of staff [4] who were in the field. The team ensured that the drugs were transported to the locations on time, the participating teams were motivated, the screening instruments utilized in the right manner, the mobilization and awareness raising was on course and that the beneficiaries were attended to.

2.5.8 Mobilisation of survivors

A communications strategy was developed using various approaches to mobilise survivors for the medical intervention. These included announcements through faith based institutions, schools and at community meetings; posters informing survivors about the medical interventions, door to door messaging, and town cryers (making public

[4] Bedha Balikudembe, Juliet Were Oguttu, Cecilia Danuweli, Philip Kollie

announcements using loud speakers), were also utilised in order to encourage everyone with any ailment to visit the health centres. In Maryland where a community radio existed, spot announcements were aired on a daily basis to ensure that the community remained informed about the progress of the intervention. These communication strategies complemented the announcements that were occasionally aired on the Monrovia based ELBC, United Nations Mission in Liberia (UNMIL) radio, JAM Star and Sky FM radios.

In addition, a total of 1500 t-shirts and 6 banners with messages "*Health is Wealth*", "*No Good Health No Development*", "*A Healthy Body, Mind and Soul is Key to Development*", and "*Access to Health Care for Women is a Right*", were produced and disseminated.

Radio and television talk shows were also organised in Monrovia. They featured the Uganda and Liberia medical consultants and Isis-WICCE staff, who discussed the process of the medical intervention and the need to have more actors to support similar initiatives. Dialogues were also utilised to sensitise the general populace about the effects of the conflict on sexual and reproductive health and psychosocial well being of women war survivors in Liberia.

Among the intervention team was the media proffessionals who kept relaying new stories and press releases on the progress of the training of health workers, screening, treatment and surgery. The following newspapers were used;The Analyst, The Informer, Public Agenda, Renaissance, Inquirer. Radio stations included UNMIL Radio, ELBC Radio, Jam F.M, Sky F.M and Star Radio. In addition, all the stages were video recorded and interviews with health workers and beneficiaries captured. This video and pictorial footage has been utilised to develop two video documentaries"*Touching the Unreached*" (13 mins.) and *"Giving Hope: the Case of Ozata"* (8 mins. 30 secs).

2.5.9 Screening and treatment phase

The screening of survivors was done by the trained health workers, social workers and community leaders. A total of 1158 (741 women and 413 men) survivors were assessed and received treatment and counselling. This process was done at all the health centres and the two hospitals in the two counties. (See table 15 on Pg. 57). A screening questionnaire was used to capture data and assess the state of health as presented by women and men who came to the health centres. (see appendix 2)

Mr. Durbor (standing) screening women at Rally Time Hospital before they were operated

Dr. Otim Tom carried out screening of children and women alike during the process

The key conditions presented included infertility, pelvic inflammatory diseases, fibroids, VVFs, genital prolapse, enlarged and elongated breasts, urinary tract infections, hernias, hydroceles, epilepsy, mental health disorders, swellings, malaria & fever, malnourishment in children, among others.

The medical doctors from Uganda and Liberia including two Isis-WICCE and two WIPNET staff supported the screening process. Patients with complications were identified and reviewed by the medical consultants to confirm whether they required surgery.

Dr. Otim Tom (Uganda) and Mr. Samuel J. Jee (Liberia) making a critical appreciation of the list of patients that were due for medical operation

2.5.10 Surgical camp

The surgery was conducted from 29th June to 10th July 2009 at J.J Dossen Hospital and Cavalla Rubber Corporation health centre in Maryland county, and Rally Time Hospital in Grand Kru County. All those identified for surgery were gathered at an agreed location and transported to the hospitals where they were admitted and availed pre-surgical counselling and preparation.

The surgical team composed of 10 medical consultants (gynaecologists, surgeons, and anaethesists) from Uganda and Liberia, and a support team of nurses and anaethesist assistants.

The surgery focussed mainly on sexual and reproductive health complications. These included 17 with vesicle vaginal fistulae (VVF), 9 uterine fibroids, 6 with genital prolapse, 6 with infertility, 109 with

hernia, 40 with hydroceles, 10 with Lipoma and 1 with elephantiasis of the scrotum. Some survivors had more than one surgical condition. One case of a young girl with enlarged and elongated breasts had to be transported to JF Kennedy Hospital due to its complexity where the surgical operation was successfully undertaken. A total of 207 survivors ranging from 1 to 90 years benefitted from the surgical camp. Due to the ernomous number of women and men who wanted to access the service, the medical consultants, Isis-WICCE and WIPNET staff had to volunteer extra hours to handle the cases presented.

All those who underwent surgery were offered appropriate post surgical care and treatment that included food, medication and a gift. Some of the patients stayed in the hospital for three months due to the complexity of their surgery which required close monitoring. In addition, all the women and men had to be transported back to their homes after being discharged, given their inability to access resources due to poverty, and also lack of public transport in some communities.

2.5.11 Data entry and analysis

Three sets of questionnaires were transported to Uganda for data entry and analysis. These were: *questionnaires on the screening interview of persons accessing the medical intervention (1158); questionnaires on the psychological wellbeing of the health workers (50); and questionnaires on reproductive and maternal health, and mental health service provision by the health facilities where health workers who participated in the intervention worked on a day to day basis (17).* These questionnaires were examined for completeness and any queries forwarded back to Liberia for clarification. They were then entered using SPSS version 11 and analysed using both SPSS and STATA to generate frequencies, bi-variable associations and multivariable associations.

2.5.12 Engagement with Policy Makers

In July 2009, Isis-WICCE and her Liberian partners organized a roundtable dialogue to provide Senators from Maryland and Grand Kru with a preliminary report of the medical intervention giving details about the conditions of women in the two counties, and Liberia in general, and proposed policy actions that needed to be enhanced. Issues highlighted included absence of mental health care service, few health workers, high number of young women with infertility and Vesco Vaginal Fistulae, lack of medical equipment e.g. x-ray and anaesthetic machines, poor road conditions, inadequate drug supply, lack of running water in the hospitals and no constant electric power supply in the hospitals. The senators were shocked to recieve such revealing data and committed to hasten efforts to respond to the health issues. Policy Briefs on Governance, Mental Health, and Reproductive and Sexual Health were developed and shared in consultative meetings with policy makers in Monrovia, Liberia.

Dr. Otim Tom the lead senior consultant handing over the preliminary report of the Medical Intevention to the President Pro-Tempore of the Liberian Senate Hon. Cletus S. Wotorson at the Capitol Hill in Monrovia

As a result WIPNET was invited for a follow up engagement during a caucus meeting to address county development concerns in Grand Kru. The meeting which included county legislators, local administrative authorities, community leaders and WIPNET took place in September 2009. Consequently, it was resolved that the County Development Fund increases its allocation to health and road construction.

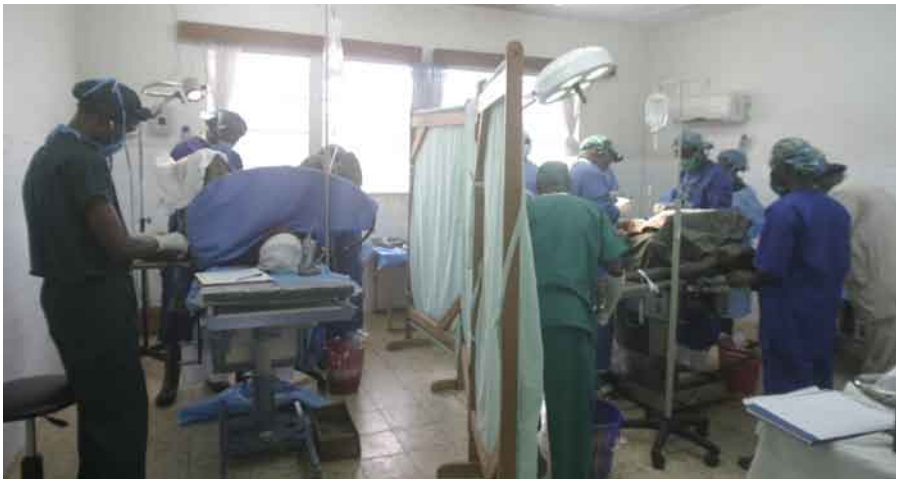
A follow up mission by WIPNET and Isis-WICCE to the counties in April 2010, observed that the county development administration had embarked on the rehabilitation of roads.

2.5.13 Challenges

The heavy rains and the poor road infrastructure were a key challenge. This made the movement from one location to another difficult, costly and delayed the distribution of the drugs and equipment to some health centres.

The intervention team was bogged down by poor road infrastructure, often with broken down bridges

Hospitals like JJ Dossen and Rally Time lack crucial medical equipments like Xray machines that are necessary for screening and assessing the extent and nature of the problems. This to some extent affected the perfomance of the medical team.



Two surgical tables had to be squeezed in one room

It was further noticed that due to gender insensitivity of service provision prior to this medical intervention, majority of women were not vigilant on coming for the service. It took a lot of sensitisation and house to house mobilisation to build the confidence of women on the value of the intervention to women's reproductive health.

Due to poverty and lack of specialised medical facilities, women and men had lived for a long period of time ranging from 1 to 10 years with medical conditions that were manageable. It was therefore important to open doors for men who also had sexual and reproductive health complications to access surgery. In addition, such reproductive health problems have an impact on gender relations within the household and could affect the women negatively, especially with regard to her triple role and power relations.

Chapter Three

MATERNAL, REPRODUCTIVE AND MENTAL HEALTH SERVICES IN MARYLAND AND GRAND KRU COUNTIES

3.1 Introduction

With the background of severe disruption of health services during the conflict, many of the health facilities in Liberia are still unable to deliver key components of the Liberian Basic Package of Health Services. Yet this is occurring in the context of increased burden of both reproductive and mental health problems as shown by the recent Isis-WICCE report and by previous authors. To document how the health facilities in the counties of Grand Kru and Maryland were performing in terms of delivery of both maternal and reproductive health and mental health services, health workers from the two counties who had been identified and trained to participate in the medical intervention were asked to fill out a questionnaire that assessed the nature of maternal and reproductive health, and mental health services offered by their parent health units. (See appendix I)

3.2 Results

In total, 17 health workers were interviewed for this sub-study, where majority (64.7%) were from Maryland and Bong (17.6%). Table 1, shows that the majority (47.1%) of respondents worked in health centres, while other health professionals such as physician assistants, nurses and clinical supervisors were equally represented at about a quarter each.

Table 1: County, nature of facility, position of the respondent (N=17)

County	**n**	**%**
Maryland	11	64.7
Bong	3	17.6
Lofa	1	5.9
Grand Kru	2	11.8
Nature of Facility		
Referral hospital	5	29.4
Health centre	8	47.1
Clinics	4	23.5
Position of the Respondent		
Physician Assistant	4	23.5
Nurse	5	29.4
Screener	2	11.8
Clinical Supervisor	4	23.5
Midwife	2	11.8

3.2.1 Maternal and Reproductive health services

Most of the respondents (94.1%) reported that their health units provided maternal and reproductive health services.

Table 2: Health units providing reproductive health services

Provision of reproductive health services offered	**n**	**%**
Providers of service	16	94.1
Do not provide service	1	5.9

The services reported to be offered included the entire range of maternal and reproductive health services (Table 3) although from a physical inspection of many of these health facilities, many lacked adequate drugs, equipment and even space.

Table 3: Reproductive health services provided by the health units

- Antenatal care
- Family planning services
- Expanded programme for immunization
- Health education on reproductive health
- Delivery services
- Post natal care
- Pre natal care
- Vaccination services
- Malaria treatment
- Health education on MCH
- Treatment of STDs
- Health talks

Indeed when asked what the challenges experienced in the delivery of maternal and reproductive health services were, majority of respondents reported lack of equipment (88.2%), lack of adequate knowledge and skills to manage reproductive health problems (47.1%), lack of clinic space (41.2%) and a heavy work load among health workers (41.2%) as presented in Table 4.

Table 4: Problems faced by reproductive health services as reported by the different respondents

Problem faced	Total (N= 14)	
	n	%
Lack of adequate knowledge about reproductive health	8	47.1
Lack of clinic space to treat reproductive health problems	7	41.2
Lack of drugs to treat reproductive health problems	12	70.6
Lack of skills in the assessment of patients with reproductive health problems	7	41.2
Lack of equipment to treat reproductive health problems	15	88.2
Lack of support by the hospital/health centre administration	8	47.1
A heavy work load	7	41.2
Lack of interest	2	11.8

Poor transportation system of patients was a common feature in Liberia. A woman in labour being carried in a hammock to the nearest health centre from a distance of about 20 kilometres

On **recommendations** on how to improve maternal and reproductive health services, the respondents suggested the need for training (adequate training of health workers, frequent refresher workshops in maternal and reproductive health and better training and supervision of traditional midwives), need for support supervision, need to train more health workers, need for better equipping of health facilities to deliver maternal and reproductive health, and a need for adequate supplies of drugs, as well as adequate transport facilities

3.2.2 Mental health services

On the nature of mental health services offered, majority (82.4%) of respondents reported that their health units did not offer any form of mental health services while only 17.6% reported that their health units offered only counseling services.

Table 5: Nature of mental health services offered

Nature of mental health services offered	n	%
None	14	82.4
Counselling	3	17.6

On the problems experienced in providing mental health services, it was reported that they stem from two main areas; lack of adequate knowledge about mental health (88.2%) and lack of drugs (94.1%) and skills in providing psychotherapies including counselling (76.5%). Also reported was lack of administrative support to initiate mental health programs (76.5%), as shown in Table 6.

Table 6: Problems experienced in providing mental health Services

Problem experienced	Total (N= 14)	
	N	%
No sufficient time for patients	1	5.9
Lack of adequate knowledge about mental health	15	88.2
Lack of drugs to treat mental illness	16	94.1
Lack of skills in the assessment of patients with mental illness	13	76.5
Lack of counseling skills	13	76.5
Lack of support by the hospital/health centre administration	13	76.5
Heavy work load	7	41.2
Lack of interest	4	23.5

Recommendations on how to improve mental health services revolved around three main areas: training in mental health (in-service training of serving health workers), the strengthening of the mental health curriculum of the different health professionals and the need to train specialized mental health workers (psychiatrists, psychologists, psychiatric nurses, specialized physician assistants in mental health, psychiatric social workers); improving the provision of mental health and antiepileptic drugs; and need to raise community awareness about mental health issues. Other recommendations included need to improve transport, strengthening the entire health system including referral, as well as stocking reference materials on mental for health workers continued learning.

Conclusion

Although these results are based on a very small sample of the health units in the two counties of Maryland and Grand Kru, they reflect the general picture in many rural areas of Liberia. In general, it can be said that the war had very devastating effects on the health system of Liberia. The two key areas in the rehabilitation of women survivors of maternal and reproductive health and mental health have not been spared either. While the results of this study show that attempts are being made to offer some maternal and reproductive health services, the situation for mental health is still very poor with most facilities still not offering any such services. It is hoped that the recent assent by Parliament of Liberia of the Mental Health Policy and the development of a Mental Health Strategic Plan by the MHSW will pave the way for the eventual delivery of a package of mental health services to the population.

Chapter Four

HUMAN RESOURCE FOR HEALTH SERVICE DELIVERY IN POST CONFLICT LIBERIA

4.1 Introduction

During the Liberian armed conflict, health workers were not spared from the war trauma. Many of them were subjected to torture which resulted into death forcing many survivor health workers to flee into IDP camps or to neigbouring countries. Previous Isis-WICCE studies and interventions in both Uganda and Sudan presented similar war torture experiences among health workers as illustrated by this account by a health worker from Eastern Uganda:

> *"at the height of the civil war in Teso, we were at a funeral vigil of someone who had been killed by rebels ,... when all of a sudden rebels came into our midst... They ordered us to cook the corpse and forced us to eat it. This affected me greatly but as a health worker, I had to continue caring for others. Each time a client came to hospital and shared their encounter, I would gape. I could no longer cope and for a while stopped working."*

This health worker from Eastern Uganda shared this experience with the Isis-WICCE research team just a few days to winding up a medical intervention that had involved her station of work. She had never shared this highly traumatic experience with anyone, but only felt sufficiently safe to share it with Isis-WICCE team towards the end of the medical intervention in her region. This experience and many others compelled Isis-WICCE to begin looking at the psychological wellbeing of health workers in all its interventions.

Sadly, in most post-conflict countries in Africa, the psychological wellbeing of the health workers who have lived through the conflict situation is never addressed. The few health workers who continue to work in the post-conflict situations often under extreme working conditions are often not only disadvantaged in terms of training opportunities and promotion, but are also often left to deal with

their trauma alone in addition to the burden in post war times . As a result many end up adopting maladaptive strategies including abuse of alcohol and other substances, absenteeism and in the extreme, engaging in suicidal behaviour which all impair their ability to deliver quality health services to the population.

4.2 Liberian MHSW policies on health workers

The Liberia National Health Policy and Plan (2007) recognizes that a trained, educated and skillful workforce must be the foundation for increasing access to quality health services. The MHSW further observes that the human resources are it's most valuable asset in the health sector. It recognizes that in rural and poor urban areas, building the human capacity of the health sector at the community and county levels is an essential component of the national health reform process and policy implementation.

According to the Rapid Assessment of the Health Situation in Liberia 2006, the workforce is composed of approximately 4000 full-time and 1000 part-time staff. The distribution of trained health workers is grossly imbalanced in favour of urban areas and qualified professionals are scarce. It observed that many health workers hold substandard qualifications whose actual value needs to be evaluated. Numerically, the workforce appears adequate for the size of the health sector and the population to be served, however analysis indicates that 36% of the total workforce are made up of traditional midwives and health aides. The report concludes by observing that the human resource sector of MHSW requires strengthening in terms of skills appropriateness and productivity.

The National Health Plan has set itself a target to ensure that the right number of health workers are in the right places at the appropriate time and with the right skills. Such a workforce is then anticipated to ensure delivery of the BPHS to meet client and community needs.

What both the policy and strategic plan are silent about is the need to rehabilitate both psychologically and medically the war traumatized health workforce, in order to realize it's full potential. As will be observed in the next chapter, health workers who experienced the conflict are psychologically traumatized and need urgent redress if they are to effectively help others.

4.3 Psychological wellbeing of health workers

4.3.1 Introduction

As part of preparations for the medical intervention, 50 health workers from the intervention sites of Maryland and GrandKru filled out a structured questionnaire that contained a number of assessment tools, including the following: socio-demographics, work experience, war torture experiences, and tools to assess their psychological wellbeing (Hopkin's depression Inventory (to screen for depression), the Harvard Trauma Questionnaire (to screen for PTSD), the C.A.G.E (to assess for alcohol dependency) and two questions on previous suicide attempt (both life-time and in the last 12 months).

4.3.2 Results

Fifty health workers of whom 28% were female were interviewed for this study. Maryland presented 40.0% and GrandKru 54.0%. Those who worked in clinics were 46.9% and health centres were 38.8%. On age, most respondents were in the 26-35 years (40.0%) and the +46 years (32.0%) age groups. On tribe, the majority (72.0%) belonged to the Grebo, as shown in Table 7.

Table 7: Characteristics of the health workers (N= 50)

	Total (N= 50)		Females (n=14)		Males (n=36)	
Characteristics	**n**	**%**	**n**	**%**	**n**	**%**
Type of health centre						
Clinic	23	46.9	5	35.7	18	51.4
Health centre	19	38.8	5	35.7	14	40.0
Government Hospital	6	12.2	3	21.4	3	8.6
Private Hospital	1	2.0	1	7.1	0	0.0
County						
Maryland	20	40.0	6	42.9	14	38.9
Grand Kru	27	54.0	6	42.9	21	58.3
Lofa	1	2.0	1	7.1	0	0.0
Bong	2	4.0	1	7.1	1	2.8
Age groups						
26-35 yrs	20	40.0	5	35.7	15	41.7
36-45 yrs	14	28.0	5	35.7	9	25.0
+46 yrs	16	32.0	4	28.6	12	33.3
Tribe						
Kpelle	1	2.0	1	7.1	0	0.0
Bassa	1	2.0	0	0.0	1	2.8
Kru	3	6.0	2	14.3	1	2.8
Grebo	36	72.0	9	64.3	27	75.0
Mano	1	2.0	0	0.0	1	2.8
Mandingo	1	2.0	1	7.1	0	0.0
Lorma	1	2.0	0	0.0	1	2.8
Kissi	2	4.0	1	7.1	1	2.8
Krahn	1	2.0	0	0.0	1	2.8
Other	3	6.0	0	0.0	3	8.3

Other tribes: Bakrobo (1), Bandi (1), Vai (1)

On religion, majority (60.0%) belonged to the Christian 'saved sect' while on marital status, most (40.0%) were in monogamous married/ cohabiting relationships. On highest educational attainment most health workers in this study had either a senior 5-6 level (40.0%) or

a tertiary/university level (38.0%) educational attainment, as given in Table 8.

Table 8: Religion, marital status, highest level of education of health workers (N=50)

	Total (N=50)		Females (n=14)		Males (n=36)	
Characteristics	**n**	**%**	**n**	**%**	**N**	**%**
Religion						
Protestant	7	14.0	1	7.1	6	16.7
Catholic	11	22.0	4	28.6	7	19.4
Christian saved sect	30	60.0	8	57.1	22	61.1
Moslem	1	2.0	1	7.1	0	0.0
Other	1	2.0	0	0.0	1	2.8
Marital status						
Never married	13	26.0	5	35.7	8	22.2
Married/cohabiting (Monogamous relationship)	23	46.0	5	35.7	18	50.0
Married cohabiting (polygamous relationship)	8	16.0	1	7.1	7	19.4
Widowed	3	6.0	3	21.4		
Divorced/Separated	3	6.0	0	0.0	3	8.3
Highest level of education						
Primary level	5	10.0	1	7.1	4	11.1
Senior 1-4	6	12.0	2	14.3	4	11.1
Senior 5-6	20	40.0	3	21.4	17	47.2
Tertiary/University	19	38.0	8	57.1	11	30.6

** Statistically significant association*

With regard to duration of work, most (70.0%) had been working at their job for more than 3 years (+36 months). On salary, most respondents earned Liberian dollars, between 2001-5000 (44.0%) and 5001-15,000 (34.0%) with nearly all (96.0%) of them reporting that the salary they were getting was not sufficient to meet their basic requirements, as reflected in Table 9.

Table 9: Duration of work(months) and salary (N= 50)

Characteristics	Total (N= 50)		Females (n=14)		Males (n=36)	
	n	%	n	%	N	%
Duration of work						
≤ 12 months	6	12.0	2	14.3	4	11.1
13-24 months	6	12.0	2	14.3	4	11.1
25-36 months	3	6.0	3	21.4	0	0.0
+37 months	35	70.0	7	50.0	28	77.8
Salary(Liberian Dollars)						
≤ 2000	4	8.0	1	7.1	3	8.3
2001-5000	22	44.0	5	35.7	17	47.2
5001-15000	17	34.0	7	50.0	10	27.8
Missing	7	14.0	1	7.1	6	16.7
Salary sufficient to meet my basic needs						
Yes	2	4.0	1	7.1	1	2.8
No	48	96.0	13	92.9	35	97.2

On war torture experience most respondents (68.0%) reported that they had lost at least one close relative as a result of war, 10.0% had lost a spouse (more among female than male respondents) and 16.0% had lost a child/children, as shown in Table 10.

Table 10: Relatives who died in the war (N=50)

Characteristics	Total (N= 50)		Females (n=14)		Males (n=36)	
	n	%	n	%	N	%
Lost spouse	5	10.0	3	21.4	2	5.6
Lost child/children	8	16.0	3	21.4	5	13.9
Lost other relatives	34	68.0	10	71.4	24	66.7

The most reported physical torture experiences included: beating/ kicking (52.0%), deprivation of food/water (48.0%) and forced hard labour (42.0%) all reported more by males than females.

The most reported psychological methods of war torture included: loss of property/livestock through destruction and looting (84.0%), detention by the army (68.0%), and forced to sleep in the bush/swamps (70.0%). All these psychological methods of torture were reported by both females and males in equal proportions, as reflected in Table 11.

Table 11: Experience of war torture (N=50)

Characteristics	Total (N= 50)		Females (n=14)		Males (n=36)	
	N	%	n	%	n	%
War experience						
Beating/Kicking	26	52.0	2	14.3	24	66.7
Bayonet/Knife/Panga/Spear injuries	5	10.0	0	0.0	5	13.9
Forced hard labour	21	42.0	3	21.4	18	50.0
Severe tying(Kandoya)	9	18.0	1	7.1	8	22.2
Deprivation of food/water	24	48.0	4	28.6	20	55.6
Deprivation of medicine	20	40.0	3	21.4	17	47.2
Cutting of body parts	4	8.0	1	7.1	3	8.3
Gunshot/landmine injury	10	20.0	2	14.3	8	22.2
Burning	5	10.0	1	7.1	4	11.1
Detained by the army	34	68.0	9	64.3	25	69.4
Forced to sleep in the bush/swamp	35	70.0	10	71.4	25	69.4
Abduction	9	18.0	3	21.4	6	16.7
Losing property/livestock through destruction and looting	42	84.0	12	85.7	30	83.3
Forced to join the arm or rebel ranks against your will	6	12.0	0	0.0	6	16.7
Being forced to kill someone against your will	1	2.0	0	0.0	1	2.8

** Statistically significant associations*

The main perpetrators of war torture among this group were the rebel groups (68.0%) and government soldiers (44.0%). Both groups were equally reported by both gender, according to Table 12.

Table 12: Perpetrators of war torture(N=50)

Characteristics	Total (N= 50)		Females (n=14)		Males (n=36)	
	n	%	n	%	N	%
War perpetrator						
Government soldiers	22	44.0	6	42.9	16	44.4
Rebel groups	34	68.0	10	71.4	24	66.7
Police	5	10.0	0	0.0	5	13.9
Local militia	12	24.0	1	7.1	11	30.6
Prison officers	3	6.0	0	0.0	3	8.3

On physical wellbeing and psychological health, most respondents (72.0%) reported that their health was good to very good with more females (85.7%) than males (66.7%) reporting this. On psychological problems, 26.0% had scores suggestive of depression more among females (28.6%) than males (25.0%), while 14.0% of respondents had scores suggestive of PTSD that was significantly more among females (21.4%) than males (11.1%). Other psychological problems reported mainly among males were alcohol dependency (8.2%) and attempted suicide (2.0%), reflected in Table 13.

Table 13: Psychological problems(N=50)

Characteristics	Total (N= 50)		Females (n=14)		Males (n=36)	
	n	%	N	%	n	%
General health						
Excellent	3	6.0	0	0.0	3	8.3
Very good	15	30.0	5	35.7	10	27.8
Good	21	42.0	7	50.0	14	38.9
Fair	8	16.0	1	7.1	7	19.4
Poor	3	6.0	1	7.1	2	5.6
Psychological problems						
Have depression (Hopkins scale score of least 31)	13	26.0	4	28.6	9	25.0
Have PTSD (HTQ) (score of at least xx)	7	14.0	3	21.4	4	11.1
Alcohol dependency (CAGE positive)	4	8.2	0	0.0	4	11.4
Attempted suicide (last 12 months)	1	2.0	1	7.1	0	0.0

About one tenth of the health workers reported that they were impaired in their physical (14.0%) and in their professional work (16.0%) as a result of the psychological symptoms they were experiencing. The impairment in physical work was reported more by females (28.6%) than males (8.3%), with no gender differences observed on impairment of professional work, as shown below Table 14.

Table 14: Impairment problems(N=50)

Impairment in:	Total (N= 50)		Females (n=14)		Males (n=36)	
	n	%	N	%	n	%
Vigorous activity (digging in the garden, lifting heavy objects)	7	14.0	4	28.6	3	8.3
Professional work (helping and treating patients)	8	16.0	2	14.3	6	16.7

Discussion/Recommendations

Like in previous Isis-WICCE studies undertaken in other societies emerging from conflict in Africa, many health workers assessed in this study reported that they had suffered various forms of torture. The torture experiences included both physical and psychological. The main perpetrators of these abuses on the health workers were the primary protagonists of the Liberian civil war, the rebels and government soldiers. These war tortures have left psychological scars on the health workers as reflected by those who had depression, PTSD, alcohol dependency and attempted suicide. These psychological scars were among 16% of cases impairing the professional functioning of the health workers.

Indeed, significant amount of training time during the Isis-WICCE medical intervention was spent trying to help the attending health workers psychologically come to terms with their war torture experiences. Therefore for the MHSW of Liberia to fully realize the full potential of it's human resource, it has to put in place programs to address the psychological health of it's health workers. There is also need for a larger study to investigate the actual extent of this problem in Liberia as this data was from only 50 respondents who were drawn from 2 counties in Liberia.

Chapter Five

THE GENERAL CHARACTERISTICS OF THE PARTICIPANTS WHO ACCESSED THE MEDICAL INTERVENTION

5.1 Introduction

This section of the report presents an analysis of the demographic and socio economic characteristics of the men and women who attended the screening for medical and psychological effects of the 1989-2003 armed conflict in Liberia. Analysis of the demographic and socio-economic status of women and men, and trends in their livelihoods was based on the premise that demographic and social economic factors can affect and impact on the health, medical and psychological situation of women as well as their health seeking behaviour. Therefore, an analysis and understanding of the socio-economic and demographic characteristics of the women and men who underwent the screening was a pre-requisite to the understanding of the underlying causes of the medical, mental, psycho-social and, traumatic situations of the women and men, and the need for redress.

5.2 The Socio-demographic characteristics

5.2.1 Participation in the screening

A total of 1158 respondents were screened of whom 64.2% were females and 35.8% were male. Maryland contributed 58.1% while Grand Kru contributed 41.9% of the screened patients. In both counties more females than males accessed the medical intervention. With regard to tribe, the Grebo (65.5%), and Kru (25.4%) constituted the largest percentage of those who turned up for the medical intervention. The dominance of the Grebo and the Kru is not surprising as Maryland and Grand Kru are their tribal homes.

Table 15: County, health centre and tribes (N= 1158)

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	n	%	N	%	n	%	χ^2	P-value
County (n= 1154)								
Maryland	673	58.1	442	59.4	231	55.8	1.59	0.207
Grand Kru	485	41.9	302	40.6	183	44.2		
Health facilities (n=13)								
Pleebo	268	23.1	187	25.1	81	19.1		
Garraway	65	5.6	38	5.1	27	6.5		
Karloken	22	1.9	14	1.9	8	1.9		
Sass Town	38	3.3	35	4.7	3	0.7		
Fish Town	40	3.5	13	1.7	27	6.5		
Barclayville	96	8.3	74	9.9	22	5.3		
Bewehn	78	6.7	52	7.0	26	6.3	156.22	<0.001*
J.J.Dossen	192	16.6	143	19.2	49	11.8		
Rally Time Hospital	73	6.3	58	7.8	15	3.6		
Newaken	106	9.2	26	3.5	80	19.3		
Glofaken	36	3.1	26	3.5	10	2.4		
CRC	68	5.9	49	6.6	19	4.6		
Cavalla	76	6.6	29	3.9	47	11.4		
Tribe								
Kpelle	9	0.8	5	0.7	4	1.0	41.37	<0.001*
Bassa	19	1.6	12	1.6	7	1.7		
Gio	25	2.2	16	2.2	9	2.2		
Kru	294	25.4	224	30.1	70	16.9		
Grebo	758	65.5	446	59.9	312	75.4		
Others	53	4.7	41	5.5	12	2.7		

** Statistically significant association*
Other tribes: Mano, Mende, Mandingo, Lorma, Kissi, Krahn, Sapo.

A total of 13 health facilities participated in this intervention, with the most represented health facilities being Pleebo (23.1%) and J.J Dossen (16.6%). Most female were treated at Pleebo (25.1%), J.J Dossen (19.2%) and Barclayville (9.9%), while most male were treated at Newaken (19.3%), Pleebo (19.1%), and J.J Dossen (11.8%) and this difference was statistically significant. Reasons for these differences are not immediately clear but may reflect regional differences among the different gender in health seeking behaviour or differences in how

the medical intervention was perceived by the community. Where, it was perceived that the intervention mainly targeted women, there was proportionally a greater female turn-up than in communities where the intervention was perceived as targeting both gender.

Table 16: Age groups, religion, highest level of education and employment (N= 1158)

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	N	%	N	%	N	%	χ^2	P-value
Age groups								
< or equal to 18 yrs	80	7.0	25	3.4	55	13.3		
19-24 yrs	98	8.6	74	10.1	24	5.8		
25-34 yrs	279	24.4	219	29.9	60	14.5		
35-44 yrs	329	28.7	248	33.9	81	19.6	164.20	<0.001*
45-64 yrs	268	23.4	145	19.8	123	29.8		
+65 yrs	91	7.9	21	2.9	70	16.9		
Religion								
Christian	1103	95.3	710	95.4	393	94.9		
Islam	21	1.8	12	1.6	9	2.2	2.66	0.447
African Traditional Faith	25	2.2	18	2.4	7	1.7		
Other	9	0.8	4	0.5	5	1.2		
Highest level of Education								
No formal education	324	28.0	258	34.7	66	15.9		
Elementary	425	36.7	273	36.7	152	36.7		
Junior high	198	17.1	120	16.2	78	18.8		
Senior high	171	14.8	79	10.6	92	22.2	77.00	<0.001*
Vocational school	15	1.3	3	0.4	12	2.9		
Polytechnic	4	0.3	2	0.3	2	0.5		
University	20	1.7	8	1.1	12	2.9		
Employment								
Farmer	575	49.7	367	49.3	208	50.2	0.09	0.766
Pastoralist	74	6.4	50	6.7	24	5.8	0.38	0.538
Fisherwoman/Man	62	5.4	29	3.9	33	8.0	8.71	0.003*
Professional	97	8.4	54	7.3	43	10.4	3.39	0.066
Petty business/Yanajus	298	25.7	251	33.7	47	11.4	69.73	<0.001*
Marketeer/Craft person	56	4.8	47	6.3	9	2.2	9.92	0.002*
Driver/Carboys	25	2.2	18	2.4	7	1.7	0.67	0.414
Unemployment	34	2.9	19	2.6	15	3.6	1.07	0.302

** Statistically significant association*

Table 16 shows the age groups, religion, highest level of education attained, and employment of the respondents who turned up for the medical and psychological screening and treatment.

Majority of female respondents were in the 35-44 years age group (34%) compared to the males (20%). There were also more females in the 25-34 years category (30%) compared to the males (14.5%) as well as in the 19-24 years age group (10% females, 6% males). However, there were more males in the 45-64 years category (30%) compared to the females (20%), and more males above 65 years (17% males, 3% females). This implies that majority of female (77.3%) were in the reproductive age of between 18-44 years compared to the males (53.2%) in the same age group. However, there were more males (47%) in the older age group of above 45 years compared to the females (22.7%).

While men went for psychological and surgical treatment of injuries, women equally accessed the same treatment in addition to gynaecological and obstetric (reproductive health) treatment. Therefore, predominance of women in reproductive age turning up for treatment is not a surprising pattern. Also, dominance of older men than women above 45 years may not be surprising as there is a possibility of more women than men dying early because of high maternal death rate.

As observed in the Isis-WICCE study (2008), understanding the age categories of women and men, especially the women in reproductive age and the adolescents (below 25 years), would help in the identification of target groups for designing and implementing relevant and appropriate interventions especially those related to chronic abdominal pain, fistulae, HIV, AIDS and STIs.

The majority of respondents (95.3%) were Christians, only 1.8% were of the Islamic Faith, and 2.2% were of the African traditional faiths. The Isis-WICCE, (2008) study noted that the non-Christian respondents who were interviewed revealed that they were sidelined in employment, education and political appointments, and that discrimination was a cause of discontent among minority groups.

The level of educational attainment of women and men, who participated in the screening for medical and psychological treatment, is given in Table 16. More females (34.7%) compared to 15.9% of the males had no formal education. The same percentage of women and men (36.7%) had elementary training while more men (22.2%) reached senior high compared to only 10.6% of the women. Those who attained vocational training, polytechnic and University were very few; 1.1% females and 2.9% males.

Causative factors of the low educational attainment, especially of the women include: infrastructural destruction and disruption of educational programmes in communities; increased number of school drop-outs among primary and secondary students; poverty and inability of parents to meet school requirements, change of environment and displacement due to armed conflict, including disruption of social networks leading the majority of girls into early marriage and prostitution. The boys also did not have opportunity of formal education as they were forcefully conscripted to become child soldiers. The low level of education makes it difficult for women and men to take care of their lives including health care. (Isis-WICCE, 2008)

The statistics in table 16 show that farming is the dominant form of employment/economic activity and source of livelihood (50%), with women (49%) and men (50%) equally being engaged in the activity.

The second source of income is petty business (Yanajus) dominated by women (33.7%) compared to the men (11.4%). Very few, both women (7.3%) and men (10.4%) are engaged in professional work. Other forms of employment such as pastoralism, fish mongering, marketeering and working as drivers/crafts persons all employ negligible numbers. There were more unemployed men 3.6% than women 2.6%.

The Isis-WICCE study (2008) revealed that the armed conflict in Liberia seriously eroded the population's ability to rehabilitate their livelihoods. With farming as the only form of occupation for most of the population and given the inadequacy of supply of agricultural inputs, there has been a rise in unemployment for many people and shifting of the production burden to women. The rubber, cocoa and oil palm plantations used to employ many people, but currently, such plantations are not fully rejuvenated. With unemployment rate of 85% in Liberia, a poorly facilitated agricultural sector, dominance of the informal sector, lack of cash crop economy, and lack of alternative sources of livelihood; all have compounded the poverty and food insecurity problem resulting in famine, ill health and malnutrition, which mainly affect the health of women and children.

Table 17: Marital status, age at first marriage, and headship of households of the participants by gender

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	n	%	N	%	N	%	χ^2	P-value
Marital status								
Married-monogamous	523	45.3	321	43.8	197	48.0		
Married-polygamous	151	13.1	79	10.6	72	17.6		
Divorced/separated	37	3.2	27	3.6	10	2.4		
Cohabiting(woman friend/man friend	89	7.7	75	10.1	14	3.4	56.79	<0.001*
Widowed	60	5.2	57	7.7	3	0.7		
Single	273	23.7	163	21.9	110	26.8		
Remarried	21	1.8	17	2.3	4	1.0		
Age at first marriage								
≤ 18yrs	267	35.4	246	50.7	21	7.8		
19-24 yrs	236	31.3	145	29.9	91	33.8	171.69	<0.001*
25-30 yrs	177	23.5	71	14.6	106	39.4		
31+ yrs	24	9.8	23	4.7	51	19.0		
Head of household								
Woman	254	24.9	228	33.3	26	7.7		
Man	740	72.4	438	63.9	302	89.6		
Girl child	17	1.7	17	2.5	0.0	.0	100.22	<0.001*
Boy child	11	1.1	2	0.3	9	2.7		

As shown in table 17, majority of the respondents (43.8% of the women and 48% of the men) were in monogamous marital union. However, more men (17.6%) than women (10.6%) were in polygamous marriage, while more women (10%) than men (3.4%) said they were just living together as man and woman friend (co-habiting). Very few women (3.6%) and men (2.4%) said they had divorced or separated. Quite a reasonable number of both men (26.8%) and women (22%) said they were single (not yet married) and only 7.7% of the women and 0.7% of the men said they were widowed.

In all, it implies that 33% of the women (widowed 7.7%, divorced/ separated 3.6% or single 22%) were living on their own without a permanent male partner.

It is important to understand the type of marital union men and women in Liberia are in. Biological factors and societal/conjugal roles

of women and girls especially adolescents, render them more exposed and therefore more susceptible to reproductive health problems such as STIs and HIV and AIDS infections. These are especially precipitated and reinforced by sexual and gender based violence (SGBV) during armed conflict situations.

The widowed, separated/divorced, and single women are more vulnerable than men to physical and sexual abuse and other forms of discrimination during situations of armed conflict. During these periods, nearly the whole male community attack women and girls because of their sexuality (Isis-WICCE, 2008).

5.2.2 Age at first marriage

It is also important to understand the age at which men and women enter into marital union and therefore the inception of their reproductive life. The statistics as shown in table 17 show that far much more women (50.7%) than men (7.8%) entered into marital union when they were less than 18 years of age. However, more men (33.8%) than women (29.9%) got married when they were in the 19-24 years age group. Again, more men (39.4%) than women (14.6%) were married at the age of 25-30 years. Only 4.7% of the women got married at the age of 31 years and above compared to 19% of the men. It is worth noting that 80.6% of the women were already in marital union by the age of 24 years compared to 41.6% of the men. On the other hand, 58.4% of the men got married after the age of 30 years and above compared to only 19.3% of the women who got married when they are 30 years of age and above.

Having 80.6% of the women in the age group of 18-24 years engaged in early marriage and therefore early sex and child birth as well as having multiple partners, put such women at a higher risk factor than men that expose them to HIV and AIDS, STIs and other reproductive

health complications. This risk factor was identified and recognized by the Ministry of Health and Social Welfare together with the United Nations (United Nations Theme Group on HIV and AIDS 2003).

> *"HIV has the potential to become a national disaster because it affects 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"…*

Given the culture of early marriage, girls and boys might be dropping out of school in favour of marriage and sexual relationship. However, on the other hand, due to limited educational opportunities during the conflict, girls and boys may have opted into early marriage which was perceived as a source of protection and survival.

Either way, once in early marriage, the issue of adolescent pregnancy emerges, resulting in a large number of child mothers with no social and economic support and thus the feminisation of poverty, poor health, and all the other reproductive and social problems.

5.2.3 Head of household

Table 17 also shows headship of households. Majority of households of respondents were headed by men (72.4%) and only 24.9% were headed by women. Very few households were headed by girls (1.7%) and by boys (1.1%). Of the females who were screened, 33% said they headed their households while 89.6% of the males said they headed their households. Looking at earlier studies (Isis-WICCE, 2008), there has been a reduction in the number of households headed by women since 2008 as current statistics show that 72.4% of the households are headed by men.

Earlier studies showed that 43% of the households were headed by women and 60% were headed by men. Women and child headed households are said to be more vulnerable than those headed by men in terms of poverty levels, human insecurity, and physical and sexual abuse. They are said to be more prone to increased gender based and domestic violence and such violence forces many women to remain single. With improved security and end of the armed conflict, females who head households may be more independent to engage in petty trade to earn income. However, those women who depend on agriculture may continue to depend on their spouses for livelihood support and access to land.

5.2.4 Household property ownership

Table 18: Household property ownership

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	n	%	N	%	n	%	χ^2	P-value
Household property currently owned								
Mobile phone	418	36.1	276	37.1	142	34.3	0.902	0.342
Radio	451	38.9	284	38.2	167	40.3	0.525	0.469
Television	27	2.3	18	2.4	9	2.2	0.070	0.791
Motorcycle	38	3.3	23	3.1	15	3.6	0.237	0.626
Car	16	1.4	8	1.1	8	1.9	1.459	0.227
Trucks/Lorry	8	0.7	3	0.4	5	1.2	2.521	0.112
Foam Mattress	45	3.9	29	3.9	16	3.9	0.001	0.978
Blanket	631	54.4	405	54.4	226	54.6	0.003	0.960
Cooking Utensils								
Saucepans	601	51.9	378	50.8	223	53.9	0.997	0.318
Iron pots	430	37.1	275	37.0	155	37.4	0.026	0.872
Clay pots	487	42.1	325	43.7	162	39.1	2.262	0.133
Plates	329	28.4	208	28.0	121	29.2	0.211	0.646
Agricultural implements								
Hoe	491	42.4	336	45.2	155	37.4	7.151	0.028*
Cutlass	615	53.1	421	56.6	194	46.9	10.104	0.001*
Axe	510	44.0	334	44.9	176	42.5	0.612	0.434
Furniture	224	19.3	155	20.8	69	16.7	2.960	0.085

** Statistically significant association*

Table 18 shows household property owned by the respondents. It is evident that the situation is improving as women and men currently own more property than immediately after the war (Isis-WICCE, 2008). However, there is very little difference between household property owned by men and by women. For example 54.4% of the women owned a blanket compared to 54.6% of the men; 37.1% of the women owned a mobile phone compared to 34.3% of the men; 38.2% of the women owned a radio compared to 40.3% of the men. The same pattern is repeated for cooking utensils. However, with regard to agricultural implements, women owned more agricultural implements than men. For example, 45% of the women owned a hand hoe compared to 37.4% of the men; 57% of the women owned a cutlass compared to 47% of the men. This implies that more women may be involved in agricultural activities than the men. Earlier research (Isis-WICCE, 2008) showed that more women (48%) than men (45%) carried out agriculture as the major occupation and main source of income although on a minimal scale.

Deeper analysis and cross tabulation of the data between socio-economic and demographic characteristic and psychological problems, surgical complaints, HIV and AIDS status and personal risk assessment, medical complaints and treatment addressed during the intervention, may reveal more and deeper gender differences and associations.

5.2.5 The War Experience

This section deals briefly with the experiences of women and men during the armed conflict.

Table 19 shows that 50.3% of the women and 30% of the men experienced armed conflict when they were less than 18 years of age; 22% of the women and 12.4% of the men experienced armed conflict when they were between 19-24 years of age and 28% of the women and 57.5% of the men experienced conflict by the age of 25 years. More women (22%) than men (12.4%) had experienced war at the age of 19-24 years. Most of the respondents especially women and girls were therefore adolescents during the time of the conflict implying disruption of their reproductive life and possible exposure to HIV, AIDS and STIs, resulting from increased sexual gender based violence.

Table 19: Age at which women and men experienced conflict

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	N	%	N	%	n	%	χ^2	P-value
Age								
≤18 years	465	43.3	353	50.3	112	30.1		
19 - 24 years	201	18.7	155	22.1	46	12.4	92.314	<0.001*
25 years	408	38.0	194	27.6	214	57.5		

* *Statistically significant association*

In table 20, of the 77 women who indicated that they lost a husband 52% of the husbands died of natural causes, 30% were killed, 7.8% disappeared, 6.5% died of hunger and 3.9% died of abandonment.

Table 20: Loss of husband as a result of war (N= 77)

Characteristics	n	%
Nature of Loss		
Natural causes	40	51.9
Killed	23	29.9
Disappeared/Unknown	6	7.8
Hunger	5	6.5
Abandonment	3	3.9

In table 21, of the 37 men who lost a wife, 68% said the death was from natural causes, 16.2% said wives were killed, 2.7% were abducted, 11% died of hunger and 2.7% were abandoned.

Table 21: Loss of wife as a result of war (N= 37)

Characteristics	n	%
Nature of Loss		
Natural cause	25	67.6
Killed	6	16.2
Abducted	1	2.7
Hunger	4	10.8
Abandonment	1	2.7

In table 22, of the 391 men and women who lost a parent as a result of armed conflict, 63% of the women lost a parent due to the armed conflict compared to 69% of the men; 30% of the women's parents were killed compared to 19% for the men. Ten percent (10%) of the men lost parents due to hunger compared to 3.5% of women.

Table 22: Loss of parents as a result of war (N= 391)

Characteristics	Total (N= 391)		Female (n= 254)		Male n=137)			
	N	%	N	%	n	%	χ^2	P-value
Nature of Loss								
Natural cause	256	65.5	161	63.4	95	69.3		
Killed	102	26.1	76	29.9	26	19.0		
Disappeared/unknown	6	1.5	6	2.4	0	0.0	16.404	0.006*
Abducted	1	0.3	0	0.0	1	0.7		
Hunger	23	5.9	9	3.5	14	10.2		
Abandonment	3	0.8	2	0.8	1	0.7		

** Statistically significant association*

Of the 310 respondents who lost a child, seventy one percent (71%) of the women and 65.5% of the men lost a child due to natural causes while 14.4% of the women and 15.5% of the men had a child killed during the armed conflict. Ten percent (10%) of the women and 15.5% of the men lost a child due to hunger.

The respondents were required to indicate the number of live children they had. Results in Table 23 show that 53.7% of the female respondents had children who were 1-3 years of age compared to 29.3% of the men, and 32.2% of the women and 35.4% of men indicated that they equally had live children who were 4-6 years of age. 2.5% of women indicated having children with more than 7 years of age compared to 25% of the men. More men (29%) had no children at all compared to 25% of the women. More women (66.7%) had children ranging between 1-6 years compared to men (50%) who had children ranging between 1-6 years of age. Generally, more women had younger children and men had older children above 7 years of age. This may be an indication that women get married early and start bearing children while men start late and continue producing children at an older age.

Both majority of women (79.6%) and men (68%) indicated having lost children ranging between 1-3 years of age, compared to 17.9% of the

women and 21% of the men who had lost children ranging between 4-6 years of age. However, more men (52%) indicated having lost no child compared to 47% of the women who said they had lost no child.

Table 23: Loss of children as a result of war (N= 310)

Characteristics	Total (N= 310)		Female (n= 194)		Male (n=116)			
	n	%	N	%	n	%	χ^2	P-value
Nature of Loss								
Natural cause	214	69.0	138	71.1	76	65.5		
Killed	46	14.8	28	14.4	18	15.5		
Disappeared/unknown	7	2.3	7	3.6	0	0.0		
Abducted	1	0.3	0	0.0	1	0.9	9.328	0.097
Hunger	37	11.9	19	9.8	18	15.5		
Abandonment	5	1.6	2	1.0	3	2.6		
Number of live children n=871)								
1-3 yrs	396	45.5	310	53.7	86	29.3		
4-6 yrs	290	33.3	186	32.2	104	35.4	67.98	<0.001*
+7 yrs	185	21.2	81	14.0	104	35.4		
Number of dead children (n=597)								
1-3 yrs	452	75.7	316	79.6	136	68.0		
4-6 yrs	113	18.9	71	17.9	42	21.0	20.89	<0.001*
+7 yrs	32	5.4	10	2.5	22	11.0		

** Statistically significant association*

It is important to know the birth rate, death rate and household/ family size for proper planning and resource allocation especially to the education and health sectors. Given a total fertility rate of 6.2 children per woman in reproductive age and a child mortality rate of 189 per 1000 children born alive (LDHS, 2007), implies that in Liberia, women on average may lose at least two children during their life time. The situation is worsened by armed conflict when health services are disrupted and food security is at stake. Such circumstances may cause women to produce more children as replacement of the dead (Isis-WICCE, 2008). This calls for programmes geared towards family planning, maternal and child mortality reduction, increased food production and nutrition.

In conclusion, forty one percent (41%) of the women lost a close relative compared to 42% of the men; 43.3% of the women had a relative killed as compared to 44.3% of the men. Hunger killed 7% of the women's relatives and 10% of the men's.

Generally respondents lost relatives due to natural causes, being killed, abducted, dying of hunger, disappearing, and being abandoned. Natural causes may have constituted a larger percentage of the deaths due to dilapidation of the health service system and lack of access to the medical facilities in good time to handle minor as well as major injuries and ailments. Displacement and change of environment disrupted the livelihood support systems such that vulnerable groups of women like the elderly and the disabled could not fend for themselves in the absence of their next of kin.

5.1.7 Perpetrators of wars

Table 24, indicates that the worst perpetrators of war were Movement for Democracy in Liberia (MODEL) (66.5%); Liberia Peace Council (66%), National Patriotic Front for Liberia (NPFL) (65%); Armed Forces of Liberia (AFL) 41.6%); and the Independent National Patriotic Front for Liberia (UNPFL) 13%. It should also be noted that institutions such as the police (6.7%), the prisons (6.2%) and the militia (9%) which were expected to maintain law and order were instead involved in torture activities and were also named as perpetrators of torture.

Other fighting groups included United Liberation Movement Johnson (ULIMO-J) (11%); United Liberation Movement - Kromoh (ULIMO-K) 9.7%; Liberian United for Reconstruction and Development (LURD) 9.3%.

In all, eleven fighting groups were involved in the armed conflict. With impunity, violations took place any where in bushes, homes, abandoned homes and houses by the road side, in public places and in barracks of the warring groups. Rape and torture were used as weapons of war to weaken the opponent and to extract information from the civilians.

Table 24: Perpetrators of wars (N= 1158)

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
War perpetrators	n	%	n	%	n	%	χ^2	P-value
Armed Forces of Liberia (AFL)	481	41.6	296	39.8	185	44.7	2.572	0.109
Movement for Democracy in Liberia (MODEL)	769	66.5	485	65.3	284	68.6	2.299	0.317
National Patriotic Front for Liberia (NPFL)	749	64.7	464	62.4	285	68.8	4.757	0.029*
Independent National Patriotic Front for Liberia (INPFL)	150	13.0	87	11.7	63	15.2	2.900	0.089
Liberia Peace Council (LPC)	762	65.9	475	63.9	287	69.3	3.440	0.064
United Liberation Movement-Johnson (ULIMO-J)	129	11.1	79	10.6	50	12.1	0.560	0.454
United Liberation Movement-Kromoh (ULIMO-K)	112	9.7	64	8.6	48	11.6	2.701	0.100
Liberia United for Reconciliation and Democracy (LURD)	108	9.3	60	8.1	48	11.6	3.890	0.049*
Police	78	6.7	35	4.7	43	10.4	13.623	<0.001*
Militia	103	8.9	50	6.7	53	12.8	12.089	0.001*
Prisons	72	6.2	41	5.5	31	7.5	1.768	0.184

** Statistically significant association*

Conclusion

Many women and men suffered both physically and mentally from the harsh and inhuman treatment they and their families endured during the conflict. Few had access to appropriate treatment and health care, and women were often widowed or abandoned, and were left to fend for themselves with no systematic support. They also shouldered overwhelming conditions and responsibilities. Many women are still uneducated, and therefore jobless, with no life and survival skills, while many girls especially young mothers are still vulnerable and without any livelihood support. The medical and psychological screening and treatment undertaken by Isis-WICCE were among the needed interventions to redress the consequences of armed conflict in Liberia.

Chapter Six

WAR TRAUMA EXPERIENCES AND MENTAL HEALTH CONSEQUENCES

6.1 Introduction

Mental health was one of the key components assessed during the screening and treatment of beneficiaries of the medical intervention. A mental health questionnaire was filled to assess the experience of war trauma and torture as well as current psychological distress. Presented in this section is an analysis of the results of the mental health assessment.

6.2 General characteristics

The majority of respondents were from Maryland (671) vis a vis 483 from Grand Kru and were female (744, 64.2% vs. 414, 38.8%) respectively. Most were in the age groups of 24 -64 years (76.5%) with a small percentage (7%) of children under 18 years. Nearly 2/3 (64.7%) of the participants had no formal or at most had elementary education. Only 3% had gone beyond senior high school while nearly half (47.9%) were farmers, and a quarter did petty business (yanajus). Over one half (60.2%) were still married while 23.7% were single. The rest were divorced, separated or widowed. About 35.4% of respondents were married for the first time in their childhood (18 years or under) and the majority of these were women (92%) which implies that some men were married as children. Although the majority of respondents indicated that in their families the head of the household was a man, in about a quarter (25.9%) of cases, it was a woman, and in a small proportion it was a child (girl 1.7%, boy 1.1%). Over half of respondents (54.5%) had large families of more than 3 children. On household property, less than 40% had a radio or mobile telephone. Only 19.3% had some furniture.

The general picture emerging about this population is that this is a predominantly peasant community with very low or no level of education, with large family sizes, high level of material poverty and poor means of communication. Such features are common in post conflict situations due to a break down of community and social services and structures as well as the displacement of populations. Such a prevailing situation increases the day to day life difficulties and determines high rates of mental/psychological distress. The majority of survivors tend to be women and children who are therefore likely to bear the brunt of this distress.

According to Mirandi et al (2002)

"...these factors put populations at a higher risk of developing a mental disorder. When people develop mental disorders they are likely to descend further into poverty, both because of increased health care costs as well as decreased productivity and loss of opportunities for employment. Yet when mental health services are available, people who might otherwise be economically dependent on family members are more likely to recover, find employment and provide for their families thus facilitating the conditions necessary to rise out of poverty. Treating of mental disorders therefore can contribute to meeting the first Millenium Development Goal, the eradication of extreme poverty and hunger"

According to the WHO, MIND project

"Mental health is integral to achieving many development priorities. Ignoring this fact will impede the capacity of countries to reduce poverty and achieve better health and development outcomes"

Table 25: Psychological problems (N= 1158)

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	N	%	n	%	n	%	χ^2	P-value
Has psychological distress scores suggestive of mental health problem	582	50.3	397	53.4	185	44.7	8.006	0.005*
Feel like killing someone	80	6.9	60	8.1	20	4.8	4.325	0.038*

** Statistically significant association*

Clients at health facilities were screened with the Self Report Questionnaire (SRQ) to identify psychological distress and probable psychiatric illness. Half the respondents (582, 50.3%) reported signs of psychological distress with high scores on the SRQ.

This means that half the population would need to be assessed further to identify mental illness that requires expert medical intervention and those with distress who would need at least a community counsellor to deal with their concerns. This magnitude of psychological distress is higher than what you would expect in a normal primary care setting where it is estimated that one in four patients visiting a health service has at least one mental, neurological or behavioural disorder but most of these disorders are neither diagnosed nor treated (Mental Health Gap Action Programme; MHGAP, WHO October 2008). It is, however, not surprising for a population affected by war or disaster where it is estimated that mental ill health may nearly double (IASC guidelines on Mental Health and Psychosocial support in Emergencies, 2007).

Of the 582 respondents with high scores of psychological distress, 68% (397) were female. Also significantly more females (278, 59.4%,) reported mental health as their primary complaints at the clinics ($P<0.001$). This may mean that more females are experiencing such problems or that they find it easier to communicate such problems. Also as a consequence of war trauma, 6.9% of the population 'felt

like killing someone', which was significantly more common among women (8.1%) than males (4.8%). This is indicative of unresolved psychological issues related to the experience of war. Such feelings if not addressed by adequate psychological healing mechanisms in many post-conflict societies provide ready fuel for the next cycles of violence.

6.3 Experience of war and mental health

6.3.1 Grief and loss

This survey showed that over 40% of the respondents first experienced war as children (< 18 years). Of these three quarters are women. Many respondents lost their parents (33.8%) and close relatives (51.8%). Nearly 10% lost a spouse while (26.8%) lost a child during the conflict. This shows that the situation of war caused a rather higher than usual exposure to grief and loss of one's significant people in the counties of Maryland and Grand Kru. While many of these deaths were due to killings, most were due to natural causes such as illness which often are on the increase in times of conflict. Women and men sleep in bushes, lack food, water and medicine and therefore experience increased exposure to life threatening physical conditions. While some women and men can deal with grief and loss, a small proportion of women and men may suffer abnormal bereavement and therefore need professional support to deal with it. In case of mass violence, deliberately organised community mourning may quicken the healing process.

6.3.2 Sexual torture

Sexual torture was part of the experience of armed conflict in (628/744) 84% of the respondents. Many forms of torture were reported which included, gang rape, attempted rape, defilement, sex in exchange

for food and insertion of objects in the vagina among others. Of the 744 female respondents, 628 (84%) reported one or more forms of sexual torture. Among the female respondents, 18% experienced rape or attempted rape, 19% reported defilement/child molestation while 1.6% reported having had objects forcefully inserted in their vagina.

Table 26: Personal experience of sexual torture (N= 1158)

Characteristics	Total (N= 1158)		Females$^{\Sigma}$ (n=744)		Males (n= 414)	
	n	%	n	%	n	%
Personal experience of sexual torture						
Rape single episode	-	-	50	6.7	-	-
Gang rape	-	-	30	4.0	-	-
Homosexual rape(man raping man)	-	-	-	-	4	1.0
Attempted rape	78	6.7	57	7.7	21	5.1
Forced marriage	69	6.0	46	6.2	23	5.6
Sexual comforting	50	4.3	35	4.7	15	3.6
Defilement	201	17.4	148	19.9	53	12.8
Sex in exchange for food etc	70	6.0	47	6.3	23	5.6
Forced incest	15	1.3	9	1.2	6	1.4
Abduction with sex	38	3.3	28	3.8	10	2.4
Child molestation	76	6.6	51	6.9	25	6.0
Widow inheritance	48	4.1	32	4.3	16	3.9
Grabbing property of deceased spouse	47	4.1	32	4.3	15	3.6
Inserting objects in vagina/rectum	20	1.7	12	1.6	8	1.9

$^{\Sigma}$*They may have been under reporting of sexual torture among female respondents*

Sexual torture is one of the most psychologically damaging violations meted out on women and girls during conflict situations. It is often associated with very high rates of psychological distress in the survivors. In this study, having suffered sexual torture was not significantly associated with having high rates of psychological distress on the SRQ in women (Table 27), although it was significantly associated with psychological distress among men. This was an unusual and surprising result. It however probably reflects the amount of stigma associated with this problem among women which led many women to under report about this experience. Women who were interviewed by health workers living in their community were probably reluctant to report this experience for fear of it being spread around the community and negatively impacting on them through the associated stigma. This further highlights the need for sensitivity in planning services to address sexual violence among women.

Table 27: Logistic regression for factors associated with significant psychological distress by gender

Predictor	Female		Male	
	Unadjusted OR (95%CI)	§Adjusted OR (95%CI)	Unadjusted OR (95%CI)	§Adjusted OR (95%CI)
Pastoralist	1	1	1	1
Not pastoralist	0.97 (0.55-1.73)	0.99 (0.56-1.77)	0.25 (0.10-0.64)*	0.26 (0.10-0.68)*
Fisherwomen/men	1	1	1	1
Not fisherwoman/man	0.59 (0.27-1.29)	0.60 (0.27-1.31)	0.37 (0.18-0.79)*	0.39 (0.18-0.83)*
professional	1	1	1	1
None professional	1.36 (0.78-2.36)	1.30 (0.74-2.30)	1.41 (0.74-2.71)	1.51 (0.78-2.94)
Petty business	1	1	1	1
Not in petty business	0.68 (0.50-0.92)*	0.67 (0.49-0.92)*	1.10 (0.60-2.04)	1.30 (0.69-2.45)
Unemployed	1	1	1	1
Employed	1.28 (0.51-3.19)	1.40 (0.56-3.52)	2.28 (0.71-7.29)	2.41 (0.75-7.77)
Marital Status				
Single	1	1	1	1
Married-monogamous,cohabit	1.25 (0.87-1.79)	1.33 (0.91-1.94)	1.49 (0.93-2.37)	1.33 (0.75-2.37)
Married-polygamous	1.69 (0.98-2.93)	1.92 (1.09-3.36)	1.05 (0.57-1.93)	0.92 (0.48-1.77)
Divorced/separated/widowed	0.94 (0.56-1.60)	1.03 (0.59-1.81)	2.49 (0.77-8.12)	2.21 (0.65-7.57)
Number of times married				
1	1	1	1	1
2	1.05 (0.72-1.54)	1.08 (0.74-1.58)	1.08 (0.62-1.87)	0.96 (0.55-1.70)
3+	1.13 (0.56-2.27)	1.17 (0.58-2.37)	1.18 (0.56-2.48)	1.06 (0.49-2.30)
Suffered sexual torture				
No sexual torture	1	1	1	1
Sexual torture	1.34 (0.99-1.82)	1.29 (0.95-1.75)	1.76 (1.14-2.72)*	1.62 (1.04-2.53)*
Physical Torture				
No physical torture	1	1	1	1
Physical torture	2.27 (1.66-3.09)*	2.21 (1.61-3.02)*	2.37 (1.52-3.70)*	2.14 (1.36-3.37)*
Psychological torture				
No psychological torture	1	1	1	1
psychological torture	3.69 (2.59-5.27)*	3.56 (2.49-5.10)*	5.51 (3.13-9.72)*	5.41 (2.99-9.79)*
Suffered intimate partner abuse				
No partner abuse	1	1	1	1
Partner abuse	1.99 (1.46-2.71)*	2.04 (1.49-2.79)*	1.90 (1.22-2.95)*	1.88 (1.20-2.95)*
Surgical complaint				
No surgical complaint	1	1	1	1
Surgical complaint	1.71 (1.25-2.34)*	1.80 (1.30-2.49)*	3.15 (1.98-5.01)*	3.05 (1.90-4.89)*

6.3.3 Physical torture

In addition to sexual torture there were many forms of physical torture and respondents were more likely to have experienced beating or kicking (40%), forced labour(29.4%), severe tying or Tibay (23.4%) or detention by rebels(49.8) or militia(12.3%). There were other forms of physical torture including gunshots (15.7%), land mine injuries(14%) and deliberate maiming of body parts(13.9%). Women suffered as much physical torture as men even though the men significantly suffered more beating, tying, forced labour and detention.

Table 28: Experienced physical torture (N= 1158)

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	n	%	n	%	n	%	χ^2	P-value
Beating/Kicking	466	40.2	280	37.6	186	44.9	5.883	0.015*
Injury using bayonet/spear/ cutlass	168	14.5	106	14.2	62	15.0	0.114	0.736
Forced labour	341	29.4	183	24.6	158	38.2	23.567	<0.001*
Severe tying/Tibay	271	23.4	148	19.9	123	29.7	14.302	<0.001*
Deprivation of food/water	530	45.8	341	45.8	189	45.7	0.004	0.953
Deprivation of medicine	508	43.9	331	44.5	177	42.8	0.325	0.568
Burning with molten plastics	133	11.5	88	11.8	45	10.9	0.240	0.624
Gunshot injury	182	15.7	121	16.3	61	14.7	0.470	0.493
Suffered landmine	162	14.0	111	14.9	51	12.3	1.495	0.221
Hanging	89	7.7	57	7.7	32	7.7	0.002	0.967
Stripping naked	244	21.1	155	20.8	89	21.5	0.071	0.791
Suffocation using red pepper	68	5.9	36	4.8	32	7.7	4.021	0.045
Cutting of body parts such as ears, lips etc	161	13.9	106	14.2	55	13.3	0.206	0.650

** Statistically significant association*

Physical torture often leaves long term sequelae on the survivor, such as scars and deformities, chronic pain and a lingering sense of humiliation and anger which are associated with mental health problems. It is not suprising therefore that there was a significant association between having suffered physical torture during the armed conflict and having high psychological distress scores in both men and women as shown in Table 28.

6.3.4 Psychological torture

Another form of torture reported in Maryland and Grand Kru counties was psychological torture. This form of torture is also common in most conflict settings. Methods identified in this study population included being made to watch horrific scenes such as the killing of others (28.6%) or others being buried alive (8.4%). A few male respondents were forced to rape women in the presence of other people (3.9%) while others both men (3.6%) and women (3.1%) were forced to kill other people against their will. This form of torture has a very high potential for causing mental health problems as it is often associated with long term humiliation, shame and guilt. This was evident from the results of this study. There were significantly higher rates of psychological distress among those that suffered psychological torture than those that did not (Table 29).

Table 29: Experienced psychological torture (N= 1158)

Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	n	%	n	%	n	%	χ^2	P-value
Burying people alive	97	8.4	60	8.1	37	8.9	0.264	0.607
Splitting bellies of pregnant women	93	8.0	65	8.7	28	6.8	1.402	0.236
Detained by the army	279	24.1	170	22.8	109	26.3	1.760	0.185
Detained by rebels	577	49.8	342	46.0	235	56.8	12.400	<0.001*
Detained by Militia	143	12.3	78	10.5	65	15.7	6.687	0.010*
Forced to sleep in bush	623	53.8	389	52.3	234	56.5	1.921	0.166
Abducted	217	18.7	142	19.1	75	18.1	0.164	0.685
Lost property/livestock	680	58.7	428	57.5	252	60.9	1.226	0.268
Forced to join fighting groups	75	6.5	45	6.0	30	7.2	0.630	0.427
Forced to kill against will	38	3.3	23	3.1	15	3.6	0.237	0.626
Watched someone being killed	331	28.6	204	27.4	127	30.7	1.382	0.240
Denied toilet facilities	218	18.8	137	18.4	81	19.6	0.231	0.631
Denied sleep	383	33.1	245	32.9	138	33.3	0.020	0.889
Forced to rape	-	-	-	-	16	3.9		

** Statistically significant association*

6.3.5 Intimate partner violence

The WHO (IASC guidelines, 2007) has noted that intimate partner violence tends to increase significantly during or following conflicts in a given population. Various forms of intimate partner violence were reported in post conflict Maryland and Grand Kru. Women suffered significantly from isolation from family, threats of being chased from home, spouse marrying again, and loss of property to spouse without their consent. The rate of physical violence was nearly similar among men (7.9%) and women (7.6%). Although in the majority of cases of intimate partner violence, the man is the perpetrator and the woman

the victim. The results here imply that in the communities studied, both men and women suffer as well as perpetrate intimate partner violence. This phenomenon needs further exploration as it is unusual. Intimate partner violence was associated significantly with having a gynaecological problem as well as with having high psychological distress scores.

The associations above often form a vicious cycle. Conflict and war may lead to psychological problems in the population including chronic depression, morbid anxiety alcoholism and post traumatic stress disorder among others. All these are associated with high rates of irritability and may result in high rates of interpersonal problems like violence and relationship break up. Like wise, interpersonal problems and violence within a relationship may lead to the mental health problems mentioned above.

Table 30: Experience of intimate partner violence (N= 881)

Characteristics of Experience	Total (N= 881)		Females (n=581)		Males (n= 300)			
	N	%	n	%	n	%	χ^2	P-value
Spouse/partner/lover threaten to hurt you	129	14.6	89	15.3	40	13.3	0.624	0.430
Spouse/partner/lover threaten to hurt your children	72	8.2	46	7.9	26	8.7	0.148	0.700
Spouse/partner/lover says it is your fault if he or she hits you, then promises it wont happen again but does it again	124	14.1	88	15.1	36	12.0	1.619	0.203
Spouse/partner/lover puts you down in public or keeps you from contacting family of friends	58	6.6	45	7.7	13	4.3	3.745	0.053*
Spouse/partner/lover throws you down, pushes, hits, kicks, slaps, beats or threatens you with a weapon	130	14.8	93	16.0	37	12.3	2.123	0.145
Spouse, Partner/lover forces you to have sex when you don't want	70	7.9	48	8.3	22	7.3	0.233	0.629
Spouse/partner/lover insults you calling you urgly, says unpleasant things to you	140	15.9	94	16.2	46	15.3	0.106	0.745
Spouse/partner/lover ever threatens to chase you out of your matrimonial home	73	8.3	56	9.6	17	5.7	4.107	0.043*
Spouse/partner/lover married again	72	8.2	58	10.0	14	4.7	7.450	0.006*
Spouse/partner/lover gave away property without your consent to a new lover	59	6.7	47	8.1	12	4.0	5.295	0.021*
Suffered at least one form of physical abuse by a partner	70	7.9	48	8.3	22	7.3	0.233	0.629
Suffered at least one form of Psychological abuse by the partner	302	34.3	210	36.1	92	30.7	2.635	0.105
Suffered any form of abuse by a partner	314	35.6	220	37.9	94	31.3	3.681	0.055

** Statistically significant association*

6.4 The mental health and physical health link

The results of this study show that there is a relationship between mental and physical health. For both men and women, having a surgical problem and for the women having a gynaecological problem, it was associated with having high rates of psychological distress. This has the implication that dealing with these surgical and gynaecological problems may contribute towards relieving the mental ill-health of men and women in post conflict Liberia.

Conclusion

Although significant steps have been made to produce a mental health policy and an action plan in form of a strategic plan for mental health, these are yet to be translated into mental health services for this war affected population.

The study in Maryland and Grand Kru counties of Liberia show a two fold increased rate of psychological ill-health compared to a non-conflict society elsewhere in the world. Factors that were found to be associated with this psychological ill-health are high rates of loss and grief, physical, sexual and psychological torture experienced, a high rate of intimate partner violence and physical problems such as surgical and gynaecological problems. Although the men were not spared, the majority of those who reported psychological problems were women. Mental health services are therefore urgently required in post conflict Maryland and Grand Kru counties of Liberia to holistically address the post-conflict rehabilitation of the population and in particular that of the women.

Chapter Seven

REPRODUCTIVE HEALTH CONSEQUENCES OF WAR ON WOMEN IN LIBERIA

7.1 Introduction

Sexual violence including rape has often been used as a weapon of war in many conflicts including those in Africa (Chelala, 1988; Asia watch, 1993; Xiau,1999; Swiss, 1993). In some armed conflicts e.g in Rwanda, rape has been used as a deliberate strategy to subvert community bonds among the perceived enemy, and furthermore as a tool of "ethnic cleansing" (Swiss, 1993). As a result of sexual violence during war, women are inadvertently exposed to sexually transmitted diseases. Failure to diagnose and treat sexually transmitted diseases at an early stage results in serious complications like infertility (Kinyala,etal, 2010). Post infection tubal damage is responsible for 30% to 40% of female infertility (Westrom, 1989).

One of the major negative impacts of armed conflict is the disruption of the health system. The primary health care systems are often the first to disintegrate in states of chronic warfare. The accompanying displacement and breakdown of physical infrastructure further predisposes war survivors to harrowing medical experience and deprivation of medical care (Toole et al, 1993; Zwi and Ugalde, 1989). The lack of health services during armed conflict results in many women especially those in need of emergency obstetric care to develop serious complications like obstructed labour leading to debilitating conditions like vesico-vaginal fistulae (uncontrollable leakage of urine) and recto-vaginal fistulae (leakage of faeces in the vagina).

Previous Isis-WICCE medical intervention studies in war affected districts in Uganda showed that many women suffer from many reproductive health complications including chronic lower abdominal pain, infertility, abnormal vaginal discharge, leaking urine and/or faeces (Isis-WICCE 2006, 2002 and 2001). A situation analysis of the

women survivors of the 1989-2003 armed conflict in Liberia revealed massive sexual abuse of girls and women during the conflict thus the need to have a medical intervention.

7.2 Results

Seven hundred and forty four (744) women were screened and treated during the study and the results are below.

7.2.1 Gynaecological problems by age

Table 31: Gynaecological problems reported by age

Having at least one gynaecological problem	Total (n=732)* N (%)	≤18yrs (n= 25) N (%)	19-24yr (n=74) N (%)	25-34yr (n=219) N (%)	35-44yr (n=248) N (%)	45-64yr (n=145) N (%)	+65yr (n=21) N (%)
	369(49.6)	**5(20.0)**	**44(59.5)**	**120(54.8)**	**125(50.4)**	**70(48.3)**	**5(23.8)**
Abnormal vaginal discharge	172(23.5)	3(12.0)	26(35.1)	55(25.1)	50(20.2)	36(24.8)	2(9.5)
Vaginal and perineal tear	23(3.1)	1(4.0)	6(8.1)	7(3.2)	6(2.4)	3(2.1)	-
Leaking urine	34(4.6)	1(4.0)	8(10.8)	9(4.1)	6(2.4)	10(6.9)	-
Leaking faeces	11(1.5)	-	3(4.1)	1(0.5)	4(1.6)	3(2.1)	-
Protruding of the uterus	39(5.3)	-	5(6.8)	7(3.2)	15(6.0)	12(8.3)	-
Infertility	163(22.3)	1(4.0)	20(27.0)	48(21.9)	67(27.0)	24(16.6)	3(14.3)
Chronic lower abdominal pain	268(36.6)	4(16.0)	36(48.6)	90(41.1)	89(35.9)	46(31.7)	3(14.3)
Abnormal vaginal bleeding	97(13.3)	1(4.0)	8(10.8)	35(16.0)	38(15.3)	13(9.0)	2(9.5)
Swelling in the abdomen	64(8.7)	-	4(5.4)	19(8.7)	29(11.7)	11(7.6)	1(4.8)
Genital sores	56(7.7)	-	5(6.8)	17(7.8)	27(10.9)	7(4.80	-
Sexually transmitted infection	105(14.3)	2(8.0)	12(16.2)	40(18.3)	32(12.9)	18(12.4)	1(4.8)
Unwanted pregnancy	24(3.3)	-	3(4.1)	7(3.2)	10(4.0)	3(2.1)	1(4.8)
Sexual dysfunction	35(4.8)	-	4(5.4)	11(5.0)	15(6.0)	4(2.8)	1(4.8)

** Twelve women did not have their ages recorded on the screening form*

Table 31 shows the gynaecological problems reported by the respondents. About half 49.6% of the women reported having at least one gynaecological problem. The commonest problems were; chronic lower abdominal pain (36.6%), infertility (22.3%), abnormal vaginal discharge (23.5%), abnormal vaginal bleeding (13.3%). The other conditions were leaking urine, vaginal and perineal tears, swelling in the abdomen, genital sores and sexual dysfunction like painful sexual intercourse.

About three quarters (73.9%) of the respondents were in the most sexually active age group of 19 to 44 years. The high experience of chronic lower abdominal pain, abnormal vaginal discharge and abnormal vaginal bleeding can lead to reduction of libido (loss of interest in sexual intercourse) in these women thus negatively affecting their sexual relations, causing marital instability and predisposing them to high rate of Intimate Partners' Violence (IPV). Indeed in this study; having gynaecological problems was significantly associated with IPV as shown in Table 32 below, having a history of IPV associated almost twice (1.7 times) the risk of having a gynaecological problem. In addition, gynaecological problems lead to significant psychological distress. 42.7% of respondents who have significant psychological distress scores have gynaecological problems.

Table 32: Logistic regression for the association between having gynaecological problems and intimate partner violence both Unadjusted Odds Ratios (UORs) and Adjusted Odds Ratios (AORs)

Predictors	Unadjusted OR (95%CI)	§Adjusted OR (95%CI)
Suffered intimate partner abuse		
No partner abuse	1	1
Partner abuse	1.70 (1.26-2.30)*	1.77 (1.30-2.42)*

*****_statistically significant relationship_

§_Adjusted for county, age, religion and marital status_

7.2.3 Sexual torture

Nearly all forms of sexual abuse were reported by the women including gang rape and insertion of objects in the vagina.

Table 33: Forms of sexual torture reported by the female respondents (n=744)

Characteristics	N	%
Personal experience of sexual torture		
Rape single episode	50	6.7
Gang rape	30	4.0
Attempted rape	57	7.7
Forced marriage	46	6.2
Sexual comforting	35	4.7
Defilement	148	19.9
Sex in exchange for food etc	47	6.3
Forced incest	9	1.2
Abduction with sex	28	3.8
Child molestation	51	6.9
Widow inheritance	32	4.3
Grabbing property of deceased spouse	32	4.3
Inserting objects in vagina/rectum	12	1.6

Exposure to physical torture conferred almost two fold (1.9 times) and could increase the risk of developing a gynaecological problem (Table 33). No such risk was however observed with exposure to sexual torture and psychological torture. The absence of a significant association between exposure to sexual torture and having a gynaecological problem could be due to under-reporting of sexual torture given the stigma that is associated with it.

Table 34: Logistic regressional analysis of the association between torture experiences and having gynaecological problems both Unadjusted Odds Ratios (UORs) and Adjusted Odds Ratios (AORs)

Predictors	Unadjusted OR (95%CI)	§Adjusted OR (95%CI)
Suffered sexual torture		
No sexual torture	1	1
Sexual torture	1.24 (0.92-1.67)	1.28 (0.94-1.74)
Physical Torture		
No physical torture	1	1
Physical torture	1.88 (1.37-2.56)*	1.75 (1.28-2.38)*
Psychological torture		
No psychological torture	1	1
psychological torture	0.94 (0.67-1.31)	1.00 (0.71-1.41)

statistically significant relationship

§Adjusted for county, age, religion and marital status

7.2.4 Gynaecological problems and socio-demographic characteristics

The socio-demographic factors that conferred increased risk to developing gynaecological problems were: being employed in petty trade (1.4 times increased risk), being involved in a monogamous married/cohabiting relationship (1.7 times increased risk) and having been married two times (1.5 times increased risk). The reason for the increased risk of developing gynaecological problems by women involved in petty trade is probably due to low income associated with this form of employment forcing many women to subsidise their income/trade with sex for gifts and money. The reason for the increased risk to develop gynaecological problems in those in their second marital relationship relative to those in the first is probably due to two reasons. Firstly, it may be due to reasons related to the

failure of first marriage such as infidelity which is associated with an increased risk of sexually transmitted infections or secondly due to the inherent risks for STIs associated with establishing a new marital relationship.

The reasons for the increased risk associated with being in monogamous married/cohabiting relationship are not immediately clear and may be confounded by other factors as suggested by the loss of statistical significance for this relationship after statistical adjustment.

Table 35: Logistic regressional analysis between socio-demographic factors and gynaecological problems both Unadjusted Odds Ratios (UORs) and Adjusted Odds Ratios (AORs)

Predictors	Unadjusted OR (95%CI)	§Adjusted OR (95%CI)
Educational level		
No formal education	1	1
Elementary	0.94 (0.67-1.33)	0.97 (0.67-1.38)
Junior high	0.74 (0.48-1.14)	0.79 (0.50-1.24)
Senior high	0.66 (0.40-1.09)	0.81 (0.47-1.37)
Vocational/ Poly/Univ.	0.39 (0.12-1.29)	0.50 (0.14-1.73)
Employment Status		
Farmer	1	1
Not farmer	0.82 (0.62-1.10)	0.93 (0.68-1.26)
Pastoralist	1	1
Not pastoralist	1.01 (0.57-1.79)	0.94 (0.53-1.69)
Fisherwomen/men	1	1
Not fisherwoman/man	1.68 (0.78-3.60)	1.64 (0.75-3.56)
Professional	1	1
Non professional	1.18 (0.68-2.06)	1.15 (0.65-2.06)
Petty business	1	1
Not in petty business	1.40 (1.03-1.89)*	1.30 (0.95-1.78)
Unemployed	1	1
Employed	1.39 (0.55-3.51)	1.13 (0.44-2.89)
Marital Status		
Single	1	-
Married-monogamous,cohabit	1.69 (1.17-2.44)*	
Married-polygamous	1.43 (0.84-2.46)	
Divorced/separated/widowed	1.05 (0.62-1.78)	
Number of times married		
1	1	1
2	1.51 (1.03-2.21)*	1.46 (0.99-2.17)
3+	1.31 (0.65-2.63)	1.11 (0.54-2.27)

**statistically significant relationship*

§Adjusted for county, age, religion and marital status

7.2.5 Gynaecological, psychological and surgical problems

Having a surgical problem conferred a two fold increased risk (2.3 times risk) of having a gynaecological problem, while having significant psychological distress scores conferred a 1.5 times increased risk of having a gynaecological problem. The reasons for the increased risk of having gynaecological problems associated with having a surgical problem may be due to the nature of acquisition of both types of problems in a war situation. The same war torture experience may lead to both types of injuries. For example a violent rape incident may not only result in gynaecological problems but the associated physical assault may result in sublaxation of joints and soft tissue injuries.

The increased risk associated with having significant psychological problems may be due to the fact that both conditions (having a gynaecological problem and having a psychological problem) may have resulted from the same war torture experience as is the case in penetrative sexual torture.

Table 36: Logistic regressional for between psychological and surgical problems and having gynaecological problems both Unadjusted Odds Ratios (UORs) and Adjusted Odds Ratios (AORs)

Predictors	Unadjusted OR (95%CI)	§Adjusted OR (95%CI)
Surgical complaint		
No surgical complaint	1	1
Surgical complaint	2.27 (1.65-3.12)*	2.00 (1.44-2.79)*
Significant psychological distress		
No sign. Psychol. distress	1	1
Has sign. Psychol. distress	1.41 (1.06-1.89)*	1.43 (1.06-1.93)*

**statistically significant relationship*

§Adjusted for county, age, religion and marital status

7.2.6 Surgical problems

Over two thirds of the women (69.2%) and men (70.3%) had at least one surgical complaint. More than half 58.5% of women complained of backache. Other conditions reported include swelling of the limbs and abdomen; and presence of wounds on parts of the body. Since the majority of the people in Liberia are peasants and therefore rely on subsistence agriculture for food production, these incidents of ill-health can reduce their productivity resulting into reduced food production and thus leading to food insecurity.

Table 37: Surgical complaints (N= 1158)

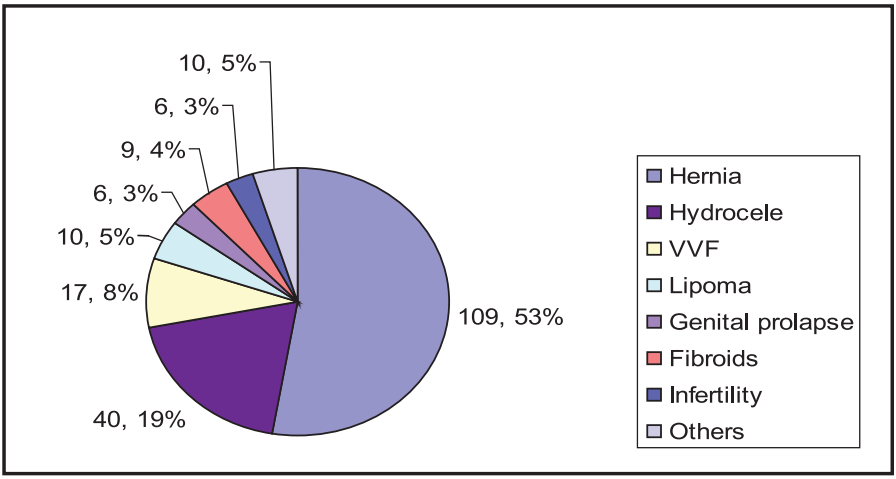
Characteristics	Total (N= 1158)		Females (n=744)		Males (n= 414)			
	n	%	N	%	N	%	χ^2	P-value
Having at least one surgical complaint	806	69.6	515	69.2	291	70.3	0.144	0.705
Backaches	654	56.5	435	58.5	219	52.9	3.356	0.067
Swellings of the limb	108	9.3	58	7.8	50	12.1	5.766	0.016*
Broken bone in any of your limb	39	3.4	22	3.0	17	4.1	1.080	0.299
Pain in the joints	404	34.9	247	33.2	157	37.9	2.613	0.106
Any wound on any part of the body	54	4.7	24	3.2	30	7.2	9.672	0.002*
Lost a limb or part of the limb	33	2.8	13	1.7	20	4.8	9.136	0.003*
Any swelling on your abdomen or in the groin area	243	21.0	136	18.3	107	25.8	9.183	0.002*
Burnt badly leading to malformation or disfigurement or disabling scars	20	1.7	13	1.7	7	1.7	0.005	0.944
Any part of your body been forcefully cut(Lips, Ears etc)	21	1.8	12	1.6	9	2.2	0.470	0.493

** Statistically significant association*

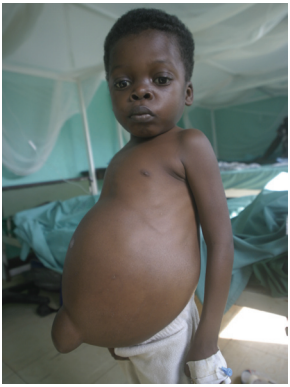
7.2.7 Surgical operations undertaken

Surgery was undertaken for 14 days at J. J Dossen Hospital, Cavalla Rubber Corporation Health Centre and Rally Time Hospital.

Figure 1: Cases operated



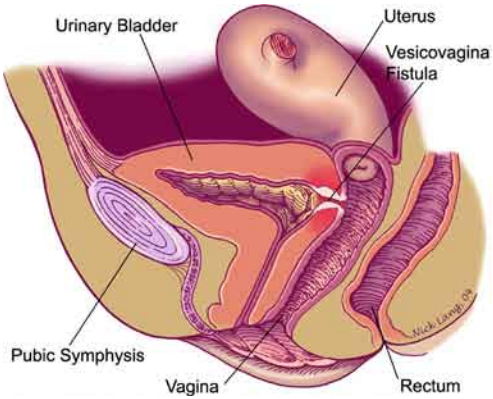
A total of 207 surgical operations were carried out on 203 patients. Some patients had more than one surgical operation. The women and children operated were 90/203 (44%) – comprising of 55 women and 35 children.



Children showed different ailments that the medical team had to decide on during the intervention

The biggest diagnostic category operated upon among women 17(31%) was vesico-vaginal fistulae (VVF), while the majority of children operated upon had hernia and hydroceles.

A vesico-vaginal fistulae (VVF) is an abnormal opening between the urinary tract system and the vagina which allows the uncontrolled leaking of urine. This disorder usually follows prolonged/obstructed labour – a common phenomenon in conflict and post-conflict situations following the breakdown of obstetric services. VVF has significant social consequences because of the constant urine leakage and bad smell of urine. Untreated this usually leads to social rejection of the women with VVF and marital separations.



VVF repair

A 30 year man from Cavalla shared:

> *"My mother had pepe (VVF in Liberian slang). During the war she ran to Ivory Coast. Many women who had pepe including my mother were packed in one house. One night, they were all burnt in the house .That is how I lost my mother"*

A female beneficially also shared:

> *"I have lived with these fibroids for 4 years and I had no hope of getting treatment. I could not afford transport and upkeep in Monrovia. I am glad that I have undergone surgery at no cost and I feel strong once again. Having special services for women is important. We hope we can have more of these so that those who were not able to access this service can benefit in future".*

A mass of fibroids that were removed from a womb of one patient during the exercise

The adult men operated were 113 with the most reported indication for surgery among men being hydroceles and hernias that was inhibiting their sexual and reproductive health. Hernia is a condition in which the intestines protrude through a weak point in the body. The most common point of weakness is the groin (inguinal region). The protrusion usually increases when there is increase in intra-abdominal pressure as normally happens on exertion under effort like in digging, lifting heavy load, etc. In most cases patients with hernias prefer to remain idle because of fear of the increased protrusion. This therefore reduces their productivity. Most patients in Maryland and Grand Kru counties were using ropes to tie around the groin in order to prevent the intestines from protruding through the groin. Although such coping strategies had been devised, they were of limited efficacy.

The hernias and hydroceles were of great concern to the men. Many of them reported loss of interest in sexual intercourse and various sexual dysfunctions which had resulted in various social problems including marital separation and domestic violence .

A 50 year old man from Maryland county who had a huge hydocele was at the verge of committing suicide.

> *"I developed this swelling of the scrotum 5 years ago. An operation was done four years ago but it recurred at a terrific speed. My penis has been swallowed inside the swelling. I can not walk properly and can not have sexual intercourse. Because I am now useless, my wife left me. I am very lonely and I want to commit suicide".*

Dr. Haruna Kamara preparing the patient for surgery

He was operated upon and spent almost three months in Rally Time Hospital. He was excited when he was able to walk freely and to put on trousers once again. His esteem and sexuality was restored.

A woman whose husband had a hydrocele further shared**:**

> *"I had become a laughing stock in our community because my husband had a hydrocele. This was affecting me emotionally even my children. Now that he has been healed we will work together as a family".*

The surgical team also handled abandoned and neglected cases like that of lactiferous duct ectasia or enlarged and elongated breasts of a 19 year old girl Ozata from Grand Kru county who had had this complication for five years. Whereas, the parents had tried all medications including traditional medicine, her problem could not be solved because there was no professional help in Grand Kru county, which is over 800 km from Monrovia.

"... it was a strange sickness and it puzzled us so much. The breasts suddenly started to grow long, big and bigger... We needed professional help but we had nowhere to go because we had no means ... we had no money to travel to Monrovia" Ozata's mother.

A case of lactiferous duct ectasia (enlarged and elongated breasts) that featured during the medical internention.

" ... I had to leave school because my colleagues used to laugh at me... I was ashamed, I was pained" Ozata

This case was referred to Monrovia at John F. Kennedy Hospital which had the appropriate facilities and the surgical procedure was udertaken successfully.

Conclusion

Sexual violence is a common phenomenon in armed conflict situations and with the breakdown of the health services, this results in untreated or poorly treated sexually transmitted infections. This consequently leads to serious gynaecological problems like chronic lower abdominal pains and infertility with the associated social problems. Indeed in this study, 49.6% of the women reported at least one gynaecological problem, the commonest problems being lower abdominal pain (36.5%) and infertility 22.5%.

In addition, breakdown of emergency obstetrics care as is the case in most societies emerging from conflict means that women who develop birth complications cannot get the care including surgery that they need. This results in prolonged obstructed labour and the consequent complications of VVF and RVF that have very negative social consequences for women war survivors. In this intervention, fifty five women had gynaecological operations; seventeen of which were for VVF.

7.2.8 Recommendations

1. Health units should be well equipped, well stocked with medicines and medical supplies. Support supervision at all levels should be regularly carried out in line with the Liberian Basic Package for health services
2. The health units should be adequately staffed and regular refresher workshops on reproductive health should be conducted
3. There is need to have frequent and regular outreach by the Fistula team to repair the VVFs and RVFs

Chapter Eight

REFLECTIONS ON THE HEALING PROCESS AND THE CHANGE

8.1 Introduction

The short term medical intervention in Liberia was a special window opened in the lives of the survivors of the long conflict that had a devastating effect on the lives of the population. It was an opportunity to address the health consequences of the conflict on the population where the main part of the health infrastructure was dysfunctional and inoperative in the country side. In Liberia, the initiative was highly welcome and valued given its unique approach of implementation. It was the first special camp organised to respond to women's post conflict health needs and especially that it went out looking for the women in their own communities rather than waiting for them to come to the hospitals. It was designed based on an earlier study that Isis-WICCE had conducted amongst women survivors in Uganda thus demonstrating the value of data and importance of going back to the communities as a means of accountability. It was indeed a learning opportunity for the partners in Liberia.

Healing the lives of women and men survivors in post conflict moves beyond the surgical ward and hospital. After recovery, survivors engage with other circumstances in their day to day lives. Isis-WICCE and its Liberian Partners continued following up the beneficiaries to monitor their progress. During the follow up, the following shifts were observed.

8.2 Enhanced knowledge and skills of health workers and leaders

The Short Term Medical Intervention helped in building health professionals' minds and skills base. Forty nine health workers (24 women and 25 men) acquired skills in the recognition and management

of physical and mental health effects amongst war affected survivors in Liberia. During the training, many had expressed that it was their first training since after the war. The fact that the health workers were too traumatized by the war, the training gave them space to share their own stories for the first time in addition to getting professional counseling, care and therapy. They were able to get skills of how to handle female and male clients with health problems but also with a traumatized background.

The training was a motivation for the health workers who had not been exposed to such training before. The skills acquired were a value addition to the health workers but also a resource for the community to continue accessing specialized and improved treatment and care. In Maryland and Grand Kru counties, the trained health workers and social workers have been able to improve on their mode of supporting the patients who visit the health centres. The health workers therefore used their newly acquired skills to support the process of addressing the trauma and reproductive health needs of women. They now have a better understanding of the different problems and how to identify trauma and support trauma patients. Basically, most of the health workers now know the importance of addressing both the medical and social problems of communities.

Some of them shared their perspectives below:

> "*The psychosocial skills I acquired have changed my practice. I am now invited to homes to mediate and solve conflicts between husbands and wives and am able to do this without taking sides. I have done this in six families so far*". Eugene Glomah, Pleebo.
>
> *I participated in the medical intervention as a social worker and never had any medical knowledge whatsoever. Having been part*

of this process exposed me to the suffering that women and the entire society was facing. I felt I needed to help my people more. I have now enrolled for in-service health training here at Pleebo Health Centre to get more skills and knowledge in health care. Women and men in the community call me nurse yet I have not finished my training. I believe when I finalise this training I will serve my people with commitment". Joan, Pleebo.

"My skills in counselling were built and I am now able to talk to people with different medical problems. I have been able to counsel a security guard at the hospital and two students who were almost committing suicide due to frustration and economic hardships." Dedesco, Harper.

"*I saw many strange diseases during the surgical camp that I had never seen before in my nursing carrier. I was challenged to do more research to understand these complications much more*". Diana Klar

Through the medical intervention, women leaders (as health workers and community leaders) were able to acquire skills in the management of trauma and the physical health of women and men in post conflict situations. The skills enhanced their communication abilities as well as their level of understanding on the importance of counselling as a healing therapy. The space also enabled these leaders to speak about their own trauma experiences and received counselling which enhanced their appreciation of the value of caring for the self before moving out to care for others.

8.3 Restored esteem, dignity and health status

Women and girls with complications like VVF who had lived with

the condition for close to 10 years were repaired and healed. They had lived with stigma and low self esteem, could not engage in any communal activities, and others had dropped out of school. With the surgery, they were able to live a normal life.

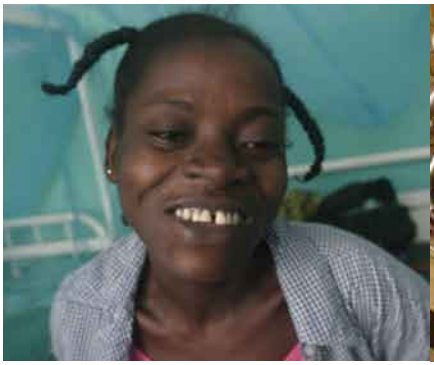
Most of the beneficiaries testified how the medical intervention has transformed their lives, and has made them to begin to think about how they can rebuild their lives and contribute to post conflict reconstruction.

Lucy Wallace a 53 year old woman shared her testimony;

> "*I had a growth in the stomach and had high bleeding for 2 years. I could not go and interact with other people and therefore stayed in-doors. I went to MERCI for check up and was told to go to J.J Dossen Hospital but I had no money. Wherever I sat, the blood flowed and I was wet all the time. I was advised to go to a country medicine man but it didn't work. I used to sell palm wine but had to stop because of this problem. I became too thin and emaciated.*
>
> *After the surgical camp, my fibroids were removed and I was healed. See me now, after 8 months, I have put on weight, I look good and am happy. I can do my own housework and I will soon start some small income generating project*".

A young girl in Pleebo was able to return to school after the operation,

> "*I had Vesico Vaginal Fistulae and was leaking all the time. I could not go to school any more. After the surgery and healing, I have enrolled back to school and am very happy*". Mary Sarwea.



Sarwea just after surgery

Sarwea after healing and back to school

A parent also shared the progress of her son,

> "*My 13 year old son had appendicitis and benefited from surgery. I thank the team for making him healthy. He is now back to school*" A parent.

"I feel happy that my child healed well."

Another woman in Barclay Ville who was operated upon is now engaging in selling fish which has boosted her income. Most of those who benefitted have regained energy and self esteem "*We are no longer a laughing stock*" they proudly declared to the Isis-WICCE monitoring team.

The intervention was also given publicity that was important for raising community and policy makers' awareness of the unaddressed needs of war survivors in Liberia. Whilst treating urgent surgical, gynaecological and some psychological problems, it also identified the huge need for further interventions of this kind including a holistic/rights approach with a psychosocial trauma treatment and economic empowerment programme involving war survivors and service providers.

8.4 South to South exchange of skills and knowledge

The short term intervention was very special because it brought a team of a special group of people together to learn, share and work with each other. Traveling to remote areas of the country was also very rewarding to the intervention team who had never moved beyond the capital cities.

> *"... this has been a great experience for me and it has improved my outlook on health issues affecting women in the countryside. It has increased my resolve to help them considering their health challenges*". Dr. Jallah Wilhemina.

The medical team (Liberian and Ugandan medical doctors) were also able to share knowledge and skills during the surgical phase. This contributed to building their clinical and surgical skills. It also gave them exposure to adjust and practice in an environment that has limited tools and facilities yet yielding great results and satisfaction for them as practitioners.

The opportunity to care for all of the patients also made a special impact and left a lasting impression on the health workers. The medical doctors in J.J Dossen and Rally Time Hospital in Liberia have continued to interact and consult the Ugandan medical consultants who were part of the surgical team for knowledge on different medical areas.

8.5 Linkages for sustainable models

The Ugandan doctors who participated in the Medical Intervention have continuously profiled the health situation in Liberia to encourage other partners to support the recovery of the health systems and structures. They engaged the Peter C. Alderman Foundation *(a Foundation that establishes mental health clinics in war torn countries to help heal emotional wounds of victims of terror),* to consider supporting Liberia. As a result the foundation committed itself to open a trauma wellness clinic in Bong county and the modalities to formalise the partnership with the Ministry of Health and Social Services were finalised.

8.6 Women's needs are indeed unique

The initiative enabled the community women leaders to understand that women had deeper issues beyond those always highlighted in post conflict reconstruction programmes especially with regard to the sexual, reproductive and psychological problems which they live with for a long period. This in a way had hampered their mobilisation, organising and engagement in the rehabilitation of their lives and participation in the reconstruction initiatives.

> *"Having participated in the medical intervention enhanced my mobilisation skills and opened my doors to be an efficient practitioner. I was able to learn about so many problems that women continue to live with, which I was not aware of though*

> *I had been a community leader for several years. Since the intervention, women continue coming to ask me when a similar programme will be organised, and I continue to give them hope that their situation will be addressed. I am now a better leader informed by the needs of women and continue to speak out to raise awareness about their challenges*". Anna Wreh, Grand Kru.

With a populace that is healthy, their task of mobilisation had been eased and they were now conscious in the way they handled and responded to women's issues.

The intervention raised the profile of the effects of sexual violence and torture during war on communities and the importance of addressing the body, mind and justice issues in a holistic programme. It also gave profile to the importance of implementation of the Isis-WICCE (2008) research recommendations, in line with the UN Security Council Resolution 1325. It was unique in that it restored the hope and was an answer to the many questions that women had raised during the study on why they should be providing information about their experiences with no immediate practical response.

8.7 Organised spaces for women deliver immense results

Isis-WICCE and her partners used a community based media approach and reached out to the isolated and marginalised. Using the church, town criers, schools, putting messages on tree trunks, holding talk shows on community radios and moving from house to house was an effective strategy that enabled members of the community to learn about the opportunities the medical intervention was providing. Women survivors were able to get information and move out to access the first ever model of health care at their disposal.

More so,the medical camp restored the confidence amongst women that indeed there can be a special service focused on their special needs which does not require them to pay huge sums of money as in the regular camps that focused on men alone. As a result, most of the women and girls who missed the opportunity have continued to ask when and how soon this special women's medical camp will be organised once again.

8.8 Multi-stakeholder partnerships: Together we achieve more

The initiative valued the contribution of participating organisations and Ministries in Liberia and thus involved them in all the processes from the planning phase up to the phase of engaging policy makers. The participatory approach contributed to the realisation of great achievements as shared in this report. Each party strived to ensure that the set objectives were realised. This proved that civil society and government machinery can garner their resources to respond to the same cause and achieve a common goal.

8.9 Motivation of health staff for quality delivery

The medical intervention in a number of ways motivated the team that participated. This boosted their work practices. This can be attributed to the participatory nature of project implementation, where the views and positions of all team members are respected. This made many of them own the process of implementation and developed some level of commitment to ensuring that set objectives are achieved. In addition, members of the intervention team had the commitment and the passion to see change in the lives of beneficiaries.

> "*The food and drugs that were provided lasted for a longer period beyond the surgical camp. This enabled us to take care*

of the patients who had to be monitored for 3 months as well as the hospital staff. This in addition to the stipend was a great motivation and kept staff in good working mood." John Klar, Rally Time Hospital Administrator.

"*Having participated in the medical camp enabled me to see beyond Monrovia and was an eye opener for me. I was able to sympathize and empathise and have become an advocate for women's rights and needs. I used to see about 10 women only everyday, but now I see more than this. I now even spare some more time to see women on Saturdays. The medical costs here at John F. Kennedy Hospital are very high. Am advocating for change and review of strategy*". Dr. Jallah Wilhemina.

"... we received 20 mattresses which we just placed on the floor for the patients who had undergone surgery to sleep on. We were inspired but also challenged given that non Liberians had got the inertia to support us. We therefore bought beds and more mattresses for the surgical ward". Mr. Adolphus Gborlic, Physician Assistant, C.R.C.

A ward at the time of the intervention

After the intervention

Conclusion

Responding to the needs and aspirations of survivors in post conflict settings as Isis-WICCE and her partners did in the two counties of Liberia is not only a satisfying but also a challenging engagement. War and conflict lead to the destruction and neglect of the infrastructure. In conflict affected Liberia; it crippled all basic tenets for social economic survival of the population. In most instances, women survivors ended up living despicable and traumatised lives due to the neglect of the health situation when they were the ones that suffered the main brunt of sexual atrocities that included gang rape.

For the women in Maryland and Grand Kru Counties who were beneficiaries of this medical intervention, it was gratifying to see many smile after their numerous health concerns were addressed. This did not only signify a new beginning for them, but provided them with the courage to inquire about their health status many years after the end of the war.

This was no doubt a healing opportunity to enable them engage in activities for rebuilding their lives and that of their community. The short term medical intervention therefore, showed that addressing women's concerns through post conflict recovery efforts is a sure way to achieve the Millennium Development Goals, as well as setting the ground for ending violence against women.

In retrospect, the short term medical intervention was an eye opener about the immense problems that women face during conflict and the challenges of addressing them in the post conflict phase. It did not only show the big gaps in the health sector particularly the dearth in addressing the sexual and reproductive health challenges women

faced during the war, but also the neglect and destruction of the infrastructure. As such, the intervention remains a drop in the ocean because of the overwhelming reproductive health needs of the women war survivors in the two counties; which depict the situation in the whole country. Even up to the last operation, women were still lining up to be screened to get treatment. There is therefore a huge need for similar interventions for those women who missed the opportunity.

The greatest challenge in the Liberian health setting is the problem and failure of some of the beneficiaries to get proper healing especially due to the illiteracy, destitute living conditions and isolation due to the poor state of the roads; which still militate against equitable access to health. It is because of such situations that for example a mother in Pleebo town who failed to take her child back to the health centre for post operative review leading to the reoccurrence of the child's case. This indicates that for the community to heal, much more has to be done to ensure that a post conflict community heal completely and is able to actively participate in post conflict reconstruction activities.

All this puts a demanad on the government of Liberia to view squarely the challenges of the population that experienced heinous atrocities in the long conflict. It is now that the government must work towards addressing the infrastructure problems to ensure that women access health and other social services. Even then, government must ensure that health facilities have the necessary equipment and drugs to enable appropriate response to women's reproductive health needs. These will also not be meaningful without an appropriate cadre of health personnel; well facilitated and motivated to respond to the health needs of women in the country. Isis-WICCE's response is just a signpost to point the way but government of Liberia must cease the opportunity and respond NOW. Isis-WICCE and its partners are proud to have made this happen.

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APPENDIX 1

HEALTH WORKER PARTICIPATION IN MENTAL HEALTH & REPRODUCTIVE HEALTH SERVICE PROVISION

Name of Health worker: .....

County .....

Name of health facility where stationed: .....

1. Nature of facility visited

1. Hospital
2. Health Centre
3. Others specify .....

2. What is your position in this health Unit ? .....

A. Mental Health Services

3. Does your health Unit have a mental health Programme?

1 = Yes
2 = No

4. In a few words describe the nature of mental health services provided

.....
.....
.....

5. Have you been playing any role in providing mental health services?

1 = Yes
2 = No

6. In a few words describe your role in the provision of mental health services

.....
.....
.....
.....

7. What problems do you experience in providing mental health services to your patients ?

.....
.....
.....

8. Could the following be a problem in your efforts to deliver mental health services ?

	Response 1 = Yes 2 = No
1. Lack of adequate knowledge about mental health	
2. Lack of drugs to treat mental illness	
3. Lack of skills in the assessment of patients with mental illness	
4. Lack of counseling skills	
5. Lack of support by the hospital/health centre administration	
6. A heavy work load	
7. Lack of interest	
8. Others describe	

9. What recommendations do you want to make of how to improve the delivery of mental health services in your region.

.....
.....
.....

B. Reproductive Health Services

14. Does your health Unit have a reproductive health Programme?

1 = Yes
2 = No

15. In a few words describe the nature of services provided under the reproductive health programme

.....
.....
.....

16. Have you been playing any role in the provision of reproductive health services ?

1 = Yes
2 = No

17. In a few words describe your role in the provision of reproductive health service3

.....
.....
.....

18. What problems do you expepience in providing reproductive health services to your patients

.....
.....
.....
.....

19. Could the following be a problem in your efforts to deliver reproductive health services ?

	Response 1 = Yes 2 = No
1. Lack of adequate knowledge about reproductive health	
2. Lack of clinic space to treat reproductive health problems	
3. Lack of drugs to treat reproductive health problems	
4. Lack of skills in the assessment of patients with reproductive health	
5. Lack of equipment to treat reproductive health problems	
6. Lack of support by the hospital/health centre administration	
7. A heavy work load	
8. Lack of interest	
9. Others describe	

20. What recommendations do you make of how to improve the delivery of reproductive health services in your region.

.....

.....

.....

Date .....

Signature .....

APPENDIX 2

SCREENING QUESTIONNIARE FOR THE MEDICAL INTERVENTION

Name of Interviewer ..... **Date**: .....

Starting Time: ..... **Ending Time**: .....

---

100. IDENTIFICATION **FORM NUMBER .....**

101: Name of Respondent:

Family name: ..... First name: .....

200. SOCIAL DEMOGRAPHIC CHARACTERISTICS OF THE SURVIVOR

201. Current Residence

1.1 Village .....

1.2 District/City.....

1.3 County .....

202. Sex

1=Female
2=Male

203. How old are you (age in completed years)? .....
.

204. How old were you when you first experienced armed conflict?
.....

205. Tribe/Ethnic Group (tick the relevant one)

a. Kpelle
b. Bassa
c. Gio
d. Kru
e. Grebo
f. Mano
g. Mende
h. Mandingo
i. Gbandi
k. Lorma
l. Kissi
m. Krahn
n. Sapo
o. Other- (specify).....

206. Religion

1. Christian
2. Islam
3. African Traditional Faith
4. Other (specify).....

207. Education (what is the highest level of formal education you have attained?) – Please tick only one answer.

1. Elementary
2. Junior High
3. Senior High
4. Vocational School
5. Polytechnic
6. University
7. Other (specify) .....

208. Employment status 1= Yes 2= No

	Response 1= Yes, 2= No
Farmer	
Pastoralist	
Fisherwomen/men	
Professional (specify e.g. teacher, etc)	
Petty business / Yanajus	
Marketeer/ Craft person	
Driver/carboys	
Unemployed (sick, disabled, too old, Retired, etc) – *Please specify*	
Other (specify)	

209. Marital status

1. Married – Monogamous (church, mosque, customary)
2. Married – Polygamous (mosque, customary)
3. Divorced/ Separated
4. Cohabiting (woman friend/ man friend)
5 Widowed
6. Single
7. Remarried

210.

1. Number of times married .....
2. Age at first marriage .....

211. Who is the head of this household?

1. Woman
2. Man
3. Girl Child
4. Boy Child.

*** *A child means one below 18 years.*

How many children have you had?

212. No of children Alive ..... Female .....
Male: .....

213. No of children dead ..... Female .....
Male: .....

214. Methods of family planning **(Ask females only)**

1. Modern contraceptives
2. Traditional contraceptives
3. Both modern and traditional methods
4. None

300. ECONOMIC STATUS

301. (a)Property currently owned; **Yes = 1 No = 2**
(b). **Household property currently owned** (For each row 1= Yes and 2=No)?

Household property	**Response; 1=Yes, 2= No**
A= Mobile phone	
B= Radio	
C=Television	
D=Motorcycle	
E=Bicycle	
F=Car	
G=Trucks/Lorry	
H= Foam mattress	
I=Blanket	
Cooking utensils	
J= Saucepans	
K= Iron pots	
L= Clay pots	
M= Plates	
Agricultural implements	
N= Hoes	
O= Cutlass	
P=Axe	
Q= Tractor	
R=Furniture	
S=Generator	
T= Others specify	

400. WAR TRAUMA EXPERIENCE

401. Did you ever lose (e.g. . through death, disappearance, abduction etc) any of the following persons as a result of war?
1= Yes 2= No

1ai. Husband

If Yes, what was the nature of loss
1= Natural causes (specify) .....
2= Killed
3= Disappeared/Unknown
4=Abducted
5= Hunger
6= Abandonment

1aii. Wife

1b. If Yes, what was the nature of loss
1= Natural causes (specify) .....
2= Killed
3= Disappeared/Unknown
4=Abducted
5= Hunger
6= Abandonment

1aiii. Parent

1b. If Yes, what was the nature of loss
1= Natural causes (specify) .....
2= Killed
3= Disappeared/Unknown
4=Abducted
5= Hunger
6= Abandonment

2a. Child(ren)

2b. If Yes, what was the nature of loss

1= Natural causes (specify) .....
2= Killed
3= Disappeared/Unknown
4=Abducted
5= Hunger
6= Abandonment

3a. **Other close relatives** (auntie, uncle, cousin, grandparent)

3b. If Yes, what was the nature of loss
1= Natural causes (specify) .....
2= Killed
3= Disappeared /Unknown
4=Abducted
5=Hunger
6=Abandonment

402. Have you personally or do you know any person who experienced any of the following? 1=Yes 2=No

	Event	**Response**	
		Self	Others
a.	Rape (Single episode)		
b.	Gang Rape (being raped several times)		
c.	Homosexual rape (man raping man)		
d.	Attempted Rape (Failed rape)		
e.	Forced marriage (against your will)		
f.	Sexual comforting (put in barracks or rebel camp passed from one soldier/rebel to another in temporary marriages)		
g.	Defilement (sex before age 18 years)		
h.	Sex in exchange for food, etc		
i.	Forced incest (with close family members)		
j.	Abduction for sex		
k.	Child molestation		
l.	Widow inheritance		
m.	Grabbing property of deceased spouse		

n.	Inserting objects in vagina (describe objects inserted)		
O	Others (specify)		

403. Have you ever experienced any of the following?

1. Yes 2. No

	Event	Response
1.	Beating/ Kicking	
2.	Injury using Bayonet/ Knife / Spear / Cutlass	
3.	Forced labour	
4	Severe Tying/Tibay	
5.	Deprivation of food /water	
6.	Deprivation of medicine	
7.	Burning with molten plastics	
8.	Gunshot injury	
9	Suffered a land mine injury	
10	Hanging	
11.	Burying people alive	
12.	Splitting bellies of pregnant women	
13.	Stripping naked	
14.	Suffocation using red pepper	
15.	Cutting of body parts such as ears, lips etc	
16.	Others (specify)	

404. Have you ever experienced the following?

1. Yes 2. No

	Event	Response
1.	Been detained by the army?	
2.	Detained by rebels	
3.	Detained by militias	
4.	Forced to sleep in the bush?	
5.	Abducted?	

6.	Lost property/livestock through destruction and looting?	
7.	Forced to join the army or rebel ranks against your will?	
8.	Forced to kill someone against your will?	
9.	Witnessed someone sexually abused?	
10.	Watched someone killed?	
11.	Denied access to food/water?	
12.	Denied access to medicine?	
13.	Denied toilet facilities?	
14.	Denied sleep	
15.	Forced to rape	
16.	Others (specify) a. ..... b. ..... c.	

405. Has any of the following groups been involved in perpetuating the above war related experiences (from page 10 – 12)? (More than one answer is expected)

1= Yes 2=No

Group	Response
1= Armed Forces of Liberia (A.F.L)	
2= Movement for Democracy in Liberia (MODEL)	
3=National Patriotic Front for Liberia (NPFL)	
4=Independent National Patriotic Front for Liberia (INPFL)	
5=Liberia Peace Council (LPC)	
6=United Liberation Movement – Johnson (ULIMO-J)	
7=United Liberation Movement – Kromoh (ULIMO-K)	
8=Liberia United for Reconciliation & Democracy (LURD)	
9=Police	
10=Militia	
11=Prisons officers	
12=Others (specify)	

406. INTIMATE PARTNER VIOLENCE ASSESSMENT QUESTIONNAIRE:

(To be asked to persons who are married/in intimate partnerships or have ever been married/ ever been in intimate partnerships)

Does your spouse/partner/lover ……	***Responses 1=Yes; 2= No***
1. Threaten to hurt you ?	
2. Threaten to hurt your children ?	
3. Say it is your fault if he or she hits you, then promise it won't happen again (but does it again) ?	
4. Put you down in public or keep you from contacting family or friends ?	
5. Throw you down, push, hit, kick, slap, beat, or threaten you with a weapon ?	
6. Force you to have sex when you don't want to ?	
7. Insult you calling you ugly, says unpleasant things to you ?	
8. Did you partner ever threaten to chase you out of your matrimonial home ?	
9. Did your partner ever chase you out of your matrimonial home ?	
10. Did you partner marry another wife ?	
11. Did your spouse giving away property without your consent to a new lover	

500. HIV/AIDS

501. Have you been tested of HIV/AIDS?

1= Yes
2= No

502. If yes above what is your HIV status ?

1= Positive
2= Negative
3= Results were not clear
4= I never picked my results

503. If never taken the HIV test how do you assess your risk of contracting HIV/AIDS over the next few years?

1= High
2= Medium
3= Low
4= None

504. MENTAL HEALTH PROBLEMS

This instrument assesses the level of psychological distress the patient may be experiencing or (may have experienced in the last two weeks).

Yes = 1 No = 2

	Signs/symptoms*	**Mark here**
1.	Do you often have headaches?	
2.	Has your appetite been poor ?	
3.	Do you sleep badly?	
4.	Are you easily frightened?	
5.	Do you hand shake/tremble all the time?	
6.	Do you feel nervous tense or worried?	
7.	Is your digestion poor?	
8.	Do you have trouble thinking clearly?	
9.	Do you feel un happy?	
10.	Do you cry more than usual?	
11	Do you find it difficult to enjoy your daily activities?	
12.	Do you find it difficult to make decisions?	
13.	Are you unable to play a useful part in your life?	
14.	Have you lost interest in things?	
15.	Do you feel that you are worthless person?	
16.	Has the thought of ending your life been in your mind?	
17.	Do you feel like killing someone ?	
18	Do you feel tired all the time?	
19.	Do you have uncomfortable feeling in your stomach?	
20.	Are you easily tired ?	

21	Do the above conditions affect your daily work?	

(If someone has more than 6 positive or no. 17 is positive refer to the hospital); *Should be explained clearly.

505. GYNAECOLOGICAL (answered only by women)

Respondent with 1= Yes 2= No

	Gynaecological condition*	**Response**
1.	Abnormal vaginal discharge	
2.	Vaginal and perennial tear	
3.	Urinary fistula (leaking urine)	
4.	Rectal fistula (leaking faeces)	
5.	Prolapse of the Uterus	
6.	Inability to have children (infertility)	
7.	Chronic lower abdominal pain	
8.	Abnormal vaginal bleeding (too heavy or bleeding for too long)	
9	Swelling in the abdomen	
10.	Genital sores	
11.	Sexually Transmitted Infections/Diseases	
12.	Unwanted pregnancy	
13 .	Sexual dysfunction	
14.	Others (specify)	

(If someone has any of these conditions refer to the hospital)

506. SURGICAL

Do you suffer from any of these following complaints (2 weeks or more)

1= Yes 2= No

	Complaints*	**Response**
1.	Do you have backaches	
2.	Do you have swellings of the limb	
3.	Do you have a broken bone in any of your limb	
4.	Do you have any pain in your joints	
5.	Do you have any wound on any part of your body (severe wound that has been long standing)?	
6.	Have you lost a limb or part of your limb?	
7	Do you have any swelling on your abdomen or in the groin area?	
8.	Have you ever been burnt badly leading to formation of disfigurement or disabling scars	
9.	Has any part of your body been forcefully cut away (lips, ears etc)?	
10.	Others (specify)	

(If someone has any of these conditions refer to the hospital)

507. THE SENSE OF COHERENCE SCALE- SHORT FORM (SOC-13)

The following questions assess one's response and adaptability to the psychosocial stressors of living through conflict and post conflict situations. They can be self administered or read to the person being interviewed. Tick the column that best describes respondent.

	Never or rarely 1	A little 2	Sometimes 3	Quite often 4	Very often 5
1. Do you have feelings that you don't care about what goes on around you ?					
2. *Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well ?					
3. Has it happened that people whom you counted on disappointed you ?					
4. Until now your life had: (no clear goals or purpose at all)					
5. Do you have the feeling that you are being treated unfairly ?					
6. Do you have the feeling that you are in unfamiliar situation and don't know what to do ?					
7. Doing the things you do everyday is: (a source of deep pleasure and satisfaction)					
8. Do you have mixed-up feelings and ideas ?					
9. Does it happen that you have feelings inside you that you would rather not feel?					
10. *Many people –even those who are strong/resilient –sometimes lose hope in certain situations. How often have you lost hope in the past ?					
11. When something happened, have you generally found that: (you overestimated or underestimated its importance) ?					
12. How often do you have feeling that there's little meaning in the things you do in your daily life ?					
13. How often do you have feelings that you're not sure you can keep under control ?					

* = reverse score

* = reverse score

508 THE INTERVENTION

IN WHICH AREAS DID YOU (the health worker) OFFER TREATMENT TO THIS RESPONDENT ?

1= Yes 2= No

		Response
1.	Mental health complaints	
2.	Gynaecological complaints	
3.	Surgical complaints	
4.	Others specify _____	

509. WHAT TREATMENTS WERE GIVEN

THANK YOU VERY MUCH FOR SPENDING YOUR MOST VALUABLE TIME TO TALK TO ME AND FOR THE NARRATION OF YOUR EXPERIENCES DURING THE ARMED CONFLICT!!!

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