# *Mental health of Children Formerly Associated with the Fighting Forces in Liberia: a Cross Section Study in Lofa County*

A child describes happy and difficult moments of his biography with the help of flowers and stones

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Dakar, the 30.04.2008
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# 1. Abbreviations and Acronyms

| | |
|---|---|
| AIDS | Acquired immune deficiency syndrome |
| ADHD | Attention deficit/ hyperactivity disorder |
| CAFF | Child Associated with fighting forces |
| CFAFF | Child formerly associated with fighting forces |
| CWPS | Child without parental support |
| DDRR | Disarmament, Demobilization, Rehabilitation and Reintegration |
| DSM-IV | Diagnostic and Statistical Manual of Mental Disorders, 4th Edition |
| ECOMOG | Economic Community of West African States Monitoring Group |
| ECOWAS | Economic Community of West African States |
| FHI | Family Health International |
| FGD | Focus Group Discussion |
| FAFF | Formerly Association with the Fighting Forces |
| HIV | Human Immunodeficiency Virus |
| ILO | International Labour Office |
| LURD | Liberian United for Reconciliation and Democracy |
| NGO | Non Governmental Organization |
| NPFL | National Patriotic Front of Liberia |
| OVC | Orphans and Vulnerable Children |
| PSC | Psychosocial Counselor |
| PTSD | Posttraumatic Stress Disorder |
| RUF | Revolutionary United Front |
| STI | Sexually Transmitted Infection |
| ULIMO | United Liberation Movement of Liberia for Democracy |
| UNHCR | United Nation High Commissioner for Refugees |
| UNICEF | United Nations' Children Fund |
| WFP | World Food Program |

## 2. Executive summary

**Background and objective:** Liberia has been affected by over a decade of civil war. According to estimations, 15.000 children have been voluntarily or forcefully recruited by regular and irregular fighting forces during the periods of armed conflict. The objective of the current study was to assess the psychosocial needs of these children in order to develop recommendations for better assistance of children formerly associated with the fighting forces. The study was part of a regional research project conducted in five selected Plan program countries in West Africa (Togo, Burkina Faso, Cameroon, Sierra Leone and Liberia).

**Method:** The study was implemented over a two month period from November 2007 to January 2008 in five communities in Lofa County. The field team, three Liberian psychosocial workers, conducted seven focus group discussions, 197 individual interviews and nine (9) case studies in Pidgin English. The age range of the participants was from 8 – 20 years. We used a matched case-control study design to investigate differences in psychosocial needs of children formerly associated with the fighting forces ("child soldiers") compared to a control sample of children who had never been part of a fighting force for longer than a week.

The exposure sample was matched with the control group according to age, sex and education. In the individual interviews we assessed socio-demographic data including the family situation, distressing life events and their impact, emotional wellbeing, coping and resilience as well as mental health. All quantitative and qualitative data collected in the individual interviews was analyzed disaggregated by sex. For the case studies, we used a biographical exercise. The focus group discussions were stimulated with five short stories developed to identify the children's perceptions of their needs for psychosocial support. All severely affected children (n=52) identified during the study received individual psychosocial support over a period of at least three months after completion of the research project.

**Results:** The majority of the participants of the exposure and the control group had been exposed to multifaceted traumatic life experiences. Many children have lost their parents and were confronted with war related violence and atrocities during the periods of armed conflict. The comparison of former child soldiers with the control sample revealed,

however, that the exposure group had to cope with significantly more adversity: former child soldiers had a higher exposure rate than children of the control sample to

- life-threatening events in general (accidents, community violence, bad illnesses),
- war atrocities,
- loss of parents and
- different types of domestic violence.

Furthermore, girls formerly associated with the fighting forces were significantly more often exposed to sexual violence than girls of the control group: almost 60% had experienced sexual violence during the war while this was only the case for slightly over 20% of the control group. The findings implied that girls, who had been sexually abused during the war, were more likely after the war to become involved in transactional sex. As a consequence, teenage pregnancy was common among former girl soldiers and they were more at risk for sexually transmitted diseases including HIV. Almost half of the interviewed girls had already been pregnant and most of these girls had children. Others had undergone abortion without medical assistance or had miscarriages.

The investigation of different factors assessing emotional wellbeing showed that children of both groups are in need of psychosocial support. Sleeping problems, for instance, were an almost universal problem. Many participants of both groups stated feelings of sadness and hopelessness or had already run away from home. Despite a general impairment of wellbeing in the overall sample, girls formerly associated with the fighting forces were the least resilient group: they scored significantly lower on most variables measuring wellbeing than girls of the control group.

About 20% of the interviewed children were at high risk for committing suicide. But again, children formerly involved with the fighting forces were considerably more at risk than the control sample. The participants displaying the strongest suicidal behavior were girls formerly associated with the fighting forces: 36% of them had already attempted to commit suicide or had established a plan on how to put an end to their lives. While the suicidality in the control group was definitely lower than in the exposure group, it was still at a disquieting level: more than one child out of ten (in the control group) was feeling so affected that they have recently attempted to kill themselves.

Overall, girls showed less resilience than boys; they had a lower self esteem, less prosocial skills and a notably higher suicidality than boys. Neglect and sexual abuse were identified as predominant factors for the low resilience of many girls.

The assessment of mental disorders showed generally high rates of posttraumatic stress disorder and major depressive disorder. The exposure groups were significantly more affected by these disorders than the control groups: for children formerly associated with the fighting forces, the rates were around 90% for PTSD and aroud 70% for major depressive disorder. In the control samples, about 60% of the children suffered from PTSD and nearly 30% from major depressive disorder.

**Conclusion and recommendations:** After 14 years of civil war, most children are more familiar with war than with peace. Communities and families are still in a process of reconstruction. Victims and perpetrators have to live next to each other. Many children are still distressed by the loss of family members and by the war related violence they have lived. There are children who have sufficient resources to recover from the war without or little external help. That notwithstanding, there is also an important number of children who suffer from severe mental disorders and a high suicidality. Children formerly associated with the fighting forces are more likely than other children to be in this group of children with defeated coping mechanisms. Without adequate help, they will fail to reintegrate in the society and they are likely to reproduce the violence that they have experienced: on themselves, on their (future) children, and, once they are grown up, on other community members. In order to enhance the fragile peace process of the country, it is crucial to provide psychosocial assistance to severely war affected children, and in particular, to those who have been part of the fighting forces.

In order to avoid further stigmatization of children formerly associated with the fighting forces, we propose the development a holistic and integrated response to vulnerable children in this area. The response should primarily focus on (1) Strengthening the capacity of caregivers to support their children, (2) Building up the resilience of children and protecting them from violence, (3) Providing individual psychosocial support to severely affected children, in particular children formerly associated with the fighting forces and (4) supporting teenage mothers and girls enrolled in transactional sex.

# 3. Background

West Africa has ever-growing numbers of children living in very difficult circumstances. The HIV epidemic and the international concern about orphans have contributed to exposing the plight of children in West Africa who are living on the streets, who are trafficked and/or exploited for child labor, or who are forced into combat in armed conflicts. These difficult living conditions negatively affect children's development and expose them to the risk of domestic violence, discrimination, HIV infection and exploitation.

As programs and initiatives are starting to emerge to address these issues, it is becoming increasingly clear that there is little knowledge about the needs of children for psychological support in West Africa. All available studies have been either conducted in the East or in the South African region. In West Africa, the impact of poverty and other difficult life circumstances on the psychosocial well-being of children has barely been investigated. Existing studies focus more on living conditions than on mental health and coping strategies of the individual and of communities in the West African context. Plan and AWARE/FHI recognize the need to investigate pan-West Africa wide patterns of psychosocial support for distressed children and their families. Thus, the two organizations recruited a regional research team in order to explore what and how children are affected, in what context and what are good practices to assist these children. The project activities focus on two sections: (1) the assessment of the mental health state and psychosocial needs of children in five different high risk contexts and (2) the analysis of existing services in all countries of the West African region. For the first activity, we conducted in-depth studies in five different countries: communities with high prevalence of child trafficking in Togo, communities with high prevalence of repatriated children in Burkina Faso, communities with high HIV-prevalence in Cameroon and communities affected by armed conflicts in Sierra Leone and Liberia. The current report presents the results from the field study in Liberia.

## 3.1 Objectives

The focus of our study was to assess the mental health of children living in communities affected by armed conflict in one region of Liberia. The overall goal was to develop,

based on the study results, an inventory of methods and approaches adapted to the specific psychosocial needs of children in this region of the country.

The specific objectives of the study were as follows:

- Describe the mental health state of different groups of children, their resilience and their needs in terms of psychosocial support in relation to their specific life context;
- Assess the incidence of distressing events (including domestic violence), their psychosocial impact as well as the children's coping mechanisms;
- Investigate the differences in reactions of participants according to sex and age;
- Ascertain specific needs of children formerly associated with the fighting forces.

# 4. Methods

We carried out an extensive literature review and met with representatives of different institutions working with children affected by the war in Liberia for the preparation of the field study. The findings are presented in two parts: firstly, we present a literature review on the armed conflicts in Liberia and analyze the results of existing studies and reports regarding the psychosocial impact of armed conflicts on children in Africa. Secondly, we present and discuss the results of the field study conducted in Lofa County, Liberia. This report does not include findings of the institutional analysis (second activity axis of the research). They are presented in a different report recapitulating the outcome of the institutional analysis carried out in several West African countries.

## 4.1 Organization of the field study

Work plan

- Literature review: 1st January 2007 to 31st February 2008;
- Preparation of the field studies in Liberia and Sierra Leone (including the recruitment of the researchers and their training): 8th October to 6th November 2007;
- Pre-test: The pre-test took place in Foya town from 10th – 11th November 2007. The pre-test was followed by a two-day evaluation (12th -13th November 2007);
- Data collection in four different communities: 15th November 2007 to 15th January 2008;
- Data transfer from Lofa County to Monrovia, Liberia: 27th – 30th January 2008;
- Data entry: February 2008
- Data analysis : March 2008
- Report writing: April 2008
- Study result dissemination: planned for summer 2008

### 4.1.1 Preparation of the field studies

We recruited a team of three field experts (two men and one woman) who were native to the research area. They had gained extensive experience on psychosocial support due

to several years of employment as Psychosocial Counselors (PSC) for the Centre of Victims of Torture (CVT). The research preparation included 16 days of training. The field experts were trained in Kailahun town, Sierra Leone, together with the Sierra Leonean experts. After the training, we carried out a pre-test of tools, approach in Foya (Liberia) and made sure that questionnaires were filled out correctly and with objectivity. The training workshop was structured in four different sections:

- Study context : situation during the war in the study area and the socio-anthropological environment in the study communities;
- Field study approach: approach of communities, target groups and ethical considerations for the project;
- Theoretical background: introduction to child and youth psychopathology, resilience, core mental disorder of children and youth according to DSM -IV and ICD-X;
- Methods: research tools, adaptation and translation in Pidgin English.

After the training, the researchers stayed for two months in the field. They resided for the entire time of the data collection in the study communities in order to be as close to the target populations as possible and to gather multiple observations during day to day activities.

### 4.1.2 Selection of communities for data collection

The project covered one region of the Liberian territory. We opted for Lofa County as it represents one of the most war affected areas and many children were enrolled in fighting forces during the war. Lofa County is in the North of the country and has borders with Guinea and Sierra Leone. The selected communities and the number of interviews and focus group discussions conducted are displayed in the following table.

**Table 1: Number of interviews and FGD per chiefdom and per community**

| District | Study area | Number of interviews | Number of focus group discussions |
|---|---|---|---|
| Foya | Foya town | 47 | 2 |
| | Foya Tengia | 43 | 1 |
| Kolahun | Kolahun town | 54 | 2 |
| | Harleypo | 28 | 1 |
| | Ngihema | 25 | 1 |
| | **Total** | **197** | **7** |

### 4.2 Methodological approach for the individual interviews

As displayed in the table above, we conducted individual interviews with 197 children in five communities. Basic prerequisites for the recruitment of the participants were the

- availability,
- age between 8 and 20 years (for participants formerly associated with the fighting forces: age below 18 at the time of recruitment) and
- written consent given by the children and their guardians.

During the recruitment, we neither sought to identify children who appeared to be suffering nor to recruit only healthy and happy looking children. All children expressing interest and being available could participate.

As a first step, we recruited a sample of 100 “child soldiers” or “children formerly associated with the fighting forces”. As a second step, a control sample of the same size was recruited and talked to with the same assessment tools. The exposure sample was matched with the comparison group according to specific criteria that are likely to influence the outcome (age, sex, education). The data analysis particularly focused on comparing the two groups in terms of significant differences in terms of psychosocial development.

We used the definition adopted by UNICEF and the Coalition to Stop the Use of Child Soldiers:

*“Any person under 18 years of age who is part of any kind of regular or irregular armed force in any capacity, including but not limited to cooks, porters, messengers, and those accompanying such groups, other than as purely family members. It includes girls recruited for sexual purposes and forced marriage. It does not, therefore, only refer to a child who is carrying or has carried arms.”* (UNICEF 1997)

The table below describes in detail the recruitment criteria for the child soldiers and the control group. A child was classified in the control sample on the condition that it did not match any of the criteria of the exposure group and vice versa.

**Table 2: recruitment criteria for the exposure and the control sample**

| Exposure group: children formerly associated with the fighting forces | Control sample |
|---|---|
| A person was part of any kind of regular or irregular armed force before the age of 18 years for more than seven (7) days. | A person younger than 21 years who was never associated with any kind of fighting force for longer than seven (7) days |
| This includes persons<br>• who fought in the war before the age of 18 years;<br>• who carried ammunitions or other materiel before the age of 18 years;<br>• who cooked, cleaned, washed for the rebels/ military employees or their families before the age of 18 years;<br>• who were used as security guards, spies, messengers before the age of 18 years;<br>• who were used as wives, girlfriends, for sexual entertainment before the age of 18 years;<br>• who participated in was atrocities (looting, abduction, killing, raping, burning houses, amputating etc.) before the age of 18 years | This includes persons<br>▪ who had never been in captivity or voluntarily with a fighting force for longer than one week;<br>▪ who never carried out work for the fighting forces for longer than one week.<br>▪ who were never forced to carry weapons and to kill, rape, torture or to commit any other atrocity for fighting forces |

4.2.1 Exclusion criteria for participation in individual interviews

We excluded all participants younger than 8 and older than 20 from the involvement in the individual interviews. Further exclusion criteria were mental retardation, psychotic disorders or neurological or neuropsychological factors impeding the capacity of the child to answer the interview questions.

4.2.2 Approach of the target populations

We used a participative approach for the identification of participants. The researchers used games and the focus group discussions for the identification of children formerly associated with the fighting forces. They explained to the children that our objective was to learn more about their experiences, strengths and difficulties. The group activities facilitated the contact with the first candidates for individual interviews. After the first interviews, the researchers asked the participants to present them to other children corresponding with one of the profiles of the exposure group.

Another recruitment strategy of the researchers was to spend time in places of public gathering (such as markets, sport activities etc.) in order to get in touch and discuss in

an informal manner with children. The partaking in day to day talks and debates helped them to identify further interested candidates for individual interviews.

### 4.3 Research tools

The assessment of social variables and mental health was carried out with qualitative and quantitative research instruments. These included participative exercises, standardized questionnaires and semi-structured in-depth interviews. All interviews were conducted in Pidgin English, the lingua franca of Liberia that is spoken by most children regardless of their ethnic group. In order to ensure the data quality, the entire assessment kit was translated from English into Pidgin respecting the following steps: the three Liberian consultants discussed each item, wrote it down and registered it on a tape recorder after having found a consensus. Once the entire toolkit was translated, the field team read over and listened repetitively to the consensus translations before their departure for the data collection in order to ensure an objective application of the tools. As Pidgin English is very close to the English language, the translation task was relatively quickly done, compared to other countries, such as Togo or Burkina Faso, where we had to translate in local languages with little connection to the official language.

We used the following methods for data collection:

1. Focus group discussions
2. Individual interviews
3. Case studies
4. Observations during the stays in the communities

#### 4.3.1 Focus group discussions

When arriving in a new community, the researchers always started their work by gathering as many children as possible. Once they had assembled a large number of children, they organized games and implemented the focus group discussions (FGD).

The tool applied for moderating the FGD aims to stimulate the expression of children regarding their perceptions about adequate means of psychosocial support in different situations of distress. The researcher, taking up the function of the moderator, tells a short story in which a child is suffering from a difficult living situation. After the depiction of the story, the researcher asks the children to share what kind of feelings the story's

main character experiences and what solutions they propose. The exercise contains five different short stories that address the following situations:

- Loss of a parent
- Domestic violence
- Bad memories of the war
- Serious somatic problems: epileptic crisis (convulsions)
- Difficulties in school.

The age of the participating children varied from 8 to 20 years. All children of the village regardless of religion, education level or ethnic groups were invited to participate in the group discussions. An advantage of the FGD is that they do not only permit to collect information about the children's point of view about their needs in difficult circumstances. The period of FGD is also useful for establishing a relationship with the children in a playful manner and to create an atmosphere of sharing and opening up about difficulties.

### 4.3.2 Individual interviews

The table below summarizes the objectives and the tools used in the individual interviews. We provide detailed descriptions and psychometric data for each tool in the sections following the table. All tools were integrated in an individual interview. Participants did not have to fill out the questionnaires themselves.

**Table 3: tools used for the individual interviews**

| | Target indicators | Tool |
|---|---|---|
| 1 | Introduction of the research to parents and the child as well as signature of written consent | Research introduction and written consent record |
| 2 | Socio-demographic and background information | Semi-structured interview: Socio-demographic data questionnaire |
| 3 | Emotional wellbeing and resilience | Emotional well-being questionnaire of CARE/SCOPE & FHI (Zambia 2003) |
| 4 | Potentially traumatic life experiences (life-time and during the last month); identification of most traumatic life event, assessment of current post-traumatic symptoms | UCLA PTSD Index (DSM IV) (Rodriguez, Steinberg et al. 1999) completed by a domestic violence checklist from Catani, Schauer et al. (2002) |
| 5 | Pro-social skills and peer relationships of children | 2 scales from the Strength and Difficulties Questionnaire (SDQ) (Goodman 1997) |
| 6 | Self-esteem | Rosenberg's self esteem Scale (Rosenberg 1989) |
| 7 | Axis I mental disorder of the DSM IV-TR | Structured clinical interview : M.I.N.I. KID English version 5.0 (Sheehan, Shytle et al. 2006) |
| 8 | Additional exploration of attitude, feelings and behavior of the child during the interview | Observation sheet |

#### 4.3.2.1 Semi-structured interview on socio-demographic data

The socio-demographic interview inquires about basic personal information (e.g. age, village, ethnic group, education level, family status, religion etc.). Furthermore, details on living situation and well-being at home are explored. Certain questions related to the loss of a parent/ parents and war related experiences (refuge, captivity, life among the fighting forces) were evidently only posed to children who had made this experience.

#### 4.3.2.2 Emotional wellbeing assessment from CARE/SCOPE & FHI

The emotional well-being is a tool based on 23 questions. Apart from eight (8) open-ended questions, the questionnaire explores 15 structured questions on a 3-point Likert-scale. The answer of the child is matched with one of the three answer options (often, sometimes, never). Further answer options are “I don’t know” or that the child does not answer the question for whatever reason.

#### 4.3.2.3 The UCLA PTSD Index questionnaire for adolescents, the domestic violence checklist and assessment of exposure to war related violence

This questionnaire explores the exposure to potentially traumatic life experiences and the degree of post-traumatic stress. The questions assessing PTSD symptoms correspond to the diagnostic criteria of the DSM-IV and provide provisionary information on PTSD-diagnosis. We used this questionnaire to identify the frequency of exposure to different events and to evaluate the degree of post-traumatic-stress related to this exposure. The definite diagnosis of PTSD was established after the application of the M.I.N.I. Kid (see paragraph 4.2.2.7). The UCLA questionnaire is divided in three parts:

- Exposure to traumatic life events (life-time and during the past month),
- Cognitions and emotions during the most distressing event (criterion A of the DSM-IV), and
- Post-traumatic symptoms measures on a 5-point Likert-scale from 0 (“never”) to 4 (“most of the time”).

We added an item-list assessing to the first part of questionnaire asssessing the incidence of domestic violence developed by Catani (2002) including questions about physical abuse, verbal violence, neglect and sexual abuse. We extended the list with one item evaluating transactional sex (“*Have you ever made love to someone for getting*

*money or presents?").* Furthermore, we added another item-list about to do with assessing exposure rates to war related violence.

4.3.2.4 The Strength and Difficulty Questionnaire (SDQ) (of Goodman, R. (1997)

The SDQ is a 25 question screening tool exploring strengths and problems of children from 4 to 16 years of age regarding emotional and behavioral factors. Strengths and difficulties are assessed on five different sub-scales. In order to avoid repetition with items from other questionnaires, however, we only used the two following subscales:

- Peer problem scale and
- Prosocial scale.

For each of the scales, five questions are asked to obtaining a total score. The psychometric properties of the questionnaire have been evaluated in different studies. The results show that the validity of the questionnaire (criterion as well as construct validity) and the reliability (internal consistency test-re-test and inter-rater reliability) are acceptable (see for example Goodman 1997; see for example Goodman 1999; Goodman, Ford et al. 2003; Muris, Meester et al. 2003). For more detailed information, we refer to the webpage of the questionnaire: www.sdqinfo.com.

4.3.2.5 The Rosenberg self-esteem scale

The Rosenberg scale is one of the most commonly used tools to measure self-esteem. It has been tested several times in developing countries. In East Africa, for instance, it was used to evaluate the well-being of orphans and vulnerable children (see for example Kiirya 2005). The questionnaire, developed in 1960 by Morris Rosenberg, is composed of 10 items. The response options are organized on a 4-point Likert scale from “strongly disagree” (0) to “strongly agree” (3). Five questions of the tool are positively coded and five negatively. The possible scores range from 0 to 30 points, with a maximum score of 30 points. A high score indicates a high level of self-esteem.

The questionnaire has good psychometric properties with a test-retest correlation ranging from .82 to .84. and an internal consistency from .70 to .90 (see Blascovich & Tomaka, 1993; Rosenberg, 1986; Vallières and Vallerand (1990) for further details).

4.3.2.6 Structured clinical Interview: The Mini International Neuropsychiatric Interview for children and adolescents (M.I.N.I. KID) English version 5.0

We opted for the M.I.N.I. KID for assessing mental disorders in the study sample. The M.I.N.I. KID is a structured clinical interview to diagnose principal axis I disorders of the DSM-IV (mood disorders, anxiety disorders, substance related disorders, psychotic disorders and certain disorders usually diagnosed in childhood and adolescence). We used the tool in its original form except for one adaptation. Most of the proposed drugs on the substance list are not available in the research area. We therefore substituted a list of locally available drugs, using the names commonly employed in local languages in Lofa County.

4.3.2.7 Case studies

We implemented the case studies with the support of a tool named “life-line-exercise”. The tool was developed in East Africa in the scope of psychological assistance to refugee populations (Schauer, Neuner et al. 2004). The exercise represents a playful way of establishing a life trajectory of a child with the help of a rope, flowers and stones (see title page) and facilitates the documentation of important life events of the child in a chronological order. Further information about the method is available in the booklet *“Narrative Exposure Therapy. A Short-Term Intervention for Traumatic Stress Disorders after War, Terror, or Torture”* (Schauer, Neuner et al. 2004).

### 4.4 Ethical considerations

The research team acquired permissions from the village or area chiefs in all communities participating in the research. For participation in an individual interview or a case study, a written consent was signed by all children and by their guardians.

The research project aimed to generate information on the mental health and resilience of children living in communities affected by armed conflict. We hope that the results will help develop and improve initiatives and strategies for child protection in rural communities. However, our intention was not restricted solely to providing information for future programs, but also to make available immediate assistance to severely affected children identified during the data collection. All children identified to be in serious danger at the moment of the interview (for reasons of domestic violence or/and high

suicide risk) were systematically integrated in a three-month follow-up project offering psychological and social support.

### 4.5 Data entry and analysis

We explored all qualitative data (case studies, FGD, observation sheets) individually. In a second stage, qualitative data was organized in categories according to relevant topics while taking into consideration socio-demographic variables. This enabled us to identify and analyze certain tendencies and to characterize and observe common factors in groups of children.

Frequencies and mean values of socio-demographic characteristics and other *quantitative* data were analyzed with SPSS software (Statistical Program for Social Sciences, French version 12.5). For statistical analysis of differences between groups, chi-square tests (nominal data) and *t*-tests and analysis of variance (ANOVA) for independent samples (metric data) were used. When the expected frequencies were lower than 5 for the chi-square tests, the results were controlled with Fisher's Exact-Test. In case of significant differences indicated by the ANOVA, we applied the post-hoc Bonferroni test to explore the differences between groups in detail. When the data did not meet the assumptions of ANOVA or of the independent *t*-test (hypothesis of Gaussian distribution and homoscedasticity), we validated the results with a non-parametric test (Mann-Whitney-*U*-Test for the independent *t*-Test and the Kruskal-Wallis-Test for the ANOVA).

### 4.6 Difficulties and limits of the study

The difficulties concerned the methodological approach of the exposure group and the preparation and implementation of the data collection.

#### 4.6.1 Recruitment of the field expert team

We were looking for researchers with skills in interviewing children, experience in mental health diagnostic, a bachelor degree in social sciences (to ensure good writing skills) and working experience in rural areas. Another prerequisite for the field team was to speak either Kissi, Mende or Gbandi in order to be able to socialize with the target populations in Lofa County. We had to realize during the one week recruitment process that it was not feasible to find researchers with a university degree in Social Sciences *and* field experience in psychosocial work with children. Candidates with a university

degree usually had no or very little knowledge on psychosocial work and mental health of children. The psychosocial workers applying for the post, on the other hand, had substantial knowledge on mental health and a lot of field experience, but they had at best a high school degree and sometimes not even that. Consequently, we were worried about their report writing capacity. A particular challenge was to find women with good written and oral expression skills. We finally opted for three psychosocial workers without university degrees, but with profound working experience in the domain of psychosocial support and originally from Lofa County. In order to help them to best accomplish their task, we integrated a module on report writing in the training and took more time than usual for the explanation and adaptation of tools.

### 4.6.2 Realization of administrative and financial procedures associated with the research implementation

The researchers were trained together with the Sierra Leonean team in Kailahun town, Sierra Leone. Kailahun town is about three hours from our research area in Lofa County and located in a very remote district, about eight hours from the Sierra Leonean capital. The road infrastructures are severely damaged and working facilities are unreliable or not existent. Power is only accessible over generators and Kailahun town experienced several fuel shortages during the training leading to restricted periods of electricity supply during working hours. The internet connection was unreliable and often cut off for several days during the training period. Furthermore, there is no scanner in the district and photocopies can only be made in small quantities. As a consequence, the communication for the research implementation, the preparation of contracts, the payments of the consultants and the multiplication of research documents took more time than planned and demanded a significant amount of extra work. It was also difficult to arrange transport for the research coordination team and the non-availability of vehicles delayed the training and pre-test implementation several times.

### 4.6.3 Methodological difficulties and limits

As explained in section 4.2, we had elaborated during the training a list of recruitment criteria for the exposure group. Although we tried as best as possible to develop operational recruitment criteria for the exposure and the control group, we realized that the duration of time spent with the fighting forces is an important factor for measuring the

impact of having been associated with the fighting forces. The definition from UNICEF, however, does not include a time criterion. In Lofa County, many children have been captured or retained for some hours or for a couple of days and carried during this short time looted goods and ammunition for the fighting force. According to the definition, these children are former child soldiers although they have only been part of the fight forces for a very short time.

In order to exclude children who had only been with the fighting forces for very short periods, we proposed seven (7) days as the cut-off timeframe between exposure and control group. By and large, this proposed time was applicable, but we realized that is has several limits:

- some children had difficulties to precise the timeframe of their captivity;
- the “one-week”-time criterion is not an ideal solution because it does not take into consideration what kind of experiences the children have made during this time. It is clear that a child who has stayed for six days with the soldiers, but who has been forced to kill family members, might be more marked than a child who has carried ammunition for three weeks;
- the profile of the child soldiers in our study is very wide: there are, on the one hand, children who were fighters or sex slaves for four years and on the other hand, children who did domestic work for a fighting force for a couple of weeks. We recommend for future studies to assess the duration of the time spent with the fighting force and its impact on the mental health of children.

Another difficulty was registering the correct age of the children. Many of them have been born in situations of displacement and have no documentation of their age. Parents sometimes adjust the real age of their children for the purpose of school enrolment or other benefits. We adopted therefore the following methodology: we registered for each child his official age and the age estimated by the field expert. If the official age given by the child and the estimated differed for two years or more, the age estimated by the consultant was taken into account for the calculations of the data analysis.

#### 4.6.4 Transportation and working facilities of the researchers during the data collection

The only frequently available means of transport in Kailahun district are motorbikes. What is more, the roads were in very bad conditions at the time of the research (end of the rainy season). It represented a considerable challenge for the researchers to

organize their transportation from one study area to the next, to travel safely and to stick at the same time to the agreed timelines for the data collection in each research area. Another problem was the access to computers and Internet connection in Lofa County. The consultants had to rent computers and had to travel to Voinjama town for Internet access each time they had to send draft of their report and for receiving the feedback.

### 4.6.5 Limits of the study

The main limitations of this study are the small sample size and its geographical restriction to one region of the country. The sample is not representative for the country as we focused only on five communities in one region of Liberia. The findings cannot be generalized to the entire Liberian territory, and certainly not to other countries.

The sample of 197 children has no statistical representativeness for the child population of Lofa County. Many of our findings should not be accepted as conclusive evidence, but rather as hypotheses to be explored in further studies using larger samples.

The usefulness of the data is further limited by the cross-section design of the study. A more informative study of the differences between children formerly associated with the fighting forces and controls would have to use a longitudinal study design.

Finally, we relied primarily on oral testimonies, except for the analysis of the drawings in the case studies. Oral testimonies do not forcibly correspond to real facts; they might represent the reality in a distorted manner. Nevertheless, we believe that the children's voiced perceptions, even if they were sometimes misrepresenting the reality, were adequate for the assessment of their mental health status and for the development of child protection strategies.

The discussed difficulties did not limit the overall validity of the study. Despite the methodological limitations, the study revealed important information about the impact of the war on the mental health of children in Liberia.

The following chapters are structured as follows: Section 5 provides information about the armed conflict in Liberia and its impact on the life of children. Section 6 presents the results of the field study. In the final sections, we synthesize our results, draw conclusions and develop recommendations for policies and programs.

# 5. Literature review

## 5.1 The first (1989 – 1996) and second civil war (1999 – 2003) in Liberia

In 1980, a group of army officers lead by Samuel Doe organized a military coup. They overthrew the government and killed current President William R. Tolbert who had governed the country for nine years. Doe and his supporters belonged to various indigenous ethnic groups and he became the first Liberian President who was not descending from Americo-Liberian settlers. As a result of his undemocratic regime, the economy soon collapsed. Furthermore, the President's ethnic group – the Krahn - started molesting violently other ethnic groups which increased the tensions. In 1989, Charles Taylor and his rebel formation which later became known as the National Patriotic Front of Liberia (NPFL) invaded Nimba County. The Liberian Army struck back hard and burnt entire villages in order to conquer the rebels. In 1990, large parts of Liberia were affected by the armed conflict. Charles Taylor's NPFL ruled most of the country side, while another guerilla force led by Prince Johnson had overtaken most of the capital, Monrovia. He captured and killed President Samuel Doe in the same year. In 1991, the United Liberation Movement of Liberia for Democracy (ULIMO) was formed by supporters of the assassinated President and the former Armed Forces of Liberia (AFL). The ULIMO supported the Sierra Leonean army in their efforts to fight back the Revolutionary United Front (RUF) and started the combat against the NPFL in Lofa and Bong County in September 1991.

After Doe's murder, the ECOMOG tried to put in place an interim government, but the NPFL attacked Monrovia in 1992. The ECOMOG forces preserved the city and persuaded the three forces, the interim government, the NPFL and the ULIMO to sign a treaty and to set up a coalition government. In 1996, the first Liberian civil war ended. The stability of the country, however, remained fragile over the next years. Elections were organized in 1997. Taylor and his NFPL won with a large majority. It is estimated that between 6000 and 15.000 children were recruited in the first Liberian civil war by regular or irregular fighting forces. Many of them were re-engaged when the second civil war broke out (David 1998; UNICEF Liberia 2004).

The second Liberian war broke out when splinter parts of the ULIMO set up a new rebel group: the Liberian United for Reconciliation and Democracy (LURD). They invaded Lofa

County in 1999 and progressively gained control of large parts of Northern Liberia. Another dissident group emerged in early 2003 in the South-Eastern region, the Movement for Democracy in Liberia (MODEL) and attacked Taylor's government troops from the South. After having besieged the capital over several months, the LURD started conquering parts of Monrovia. Taylor resigned in August 2003 and soon after, a 15.000 head strong peacekeeping mission, the United Nations Mission in Liberia (UNMIL) replaced the ECOWAS forces. The Second Liberian Civil War came to end with the arrival of the peacekeepers, although violence persisted in form of riots in 2004. The demobilization process was finalized in late 2004. According to the National Commission on DDRR, 8704 boys and 2517 girls had been enrolled in the DDRR program. Children represented 11% of the demobilized fighting forces (9% boys and 2% girls (NCDDRR 2004). A study published by the ILO ascertained that the majority of girl soldiers aged between 15 – 24 years did not participate in demobilization (Specht 2004).

The 14 years of armed conflict in Liberia have cost the live of hundreds of thousands Liberian citizens. About two million people were displaced inside Liberia and into neighboring countries (Specht 2004). Large parts of the economic infrastructure were destroyed (Wikipedia 2008). It was estimated that 75% of the children who had participated in the DDR process had suffered from sexual abuse and exploitation during the war (Specht 2004).

### 5.2 Psychosocial needs of children formerly associated with the fighting forces in Africa: the point of departure for the current study

By and large, the international community has dedicated various publications during the past years to the psychosocial effects of armed conflicts and to strategies for the rehabilitation of affected populations (Murthy and Lakshminarayana 2006). They provide policies and recommendations for general frameworks for supporting war affected populations (for example Baingana, Fannon et al.; UNICEF 2005). The issue of child soldiers has attracted particular attention of international agencies and the media. The Coalition to stop the use of child soldiers has annually published reports about the situation of children associated with fighting forces around the world in order to advocate and to inform about their plight. More information is available under http://www.child-soldiers.org/home. That notwithstanding, we identified only three studies focusing on the experiences of child soldiers that were conducted closely to our research area. One of the studies was conducted in Liberia, the second in Sierra Leone and two other African

war affected countries (McKay and Mazurana 2004) and the third also in Sierra Leone (Denov, Kemokai et al. 2004). The first two studies focused explicitly on girls formerly involved with the fighting forces.

The studies describe primarily the presence, the experiences and the coping mechanisms of the children during the war. The results shed light on the hardship that children endured during their time with the fighting forces: little protection from bad weather conditions, constant hunger, violence during the training (and sexual violence for girls) and permanent witnessing on how other people die. The solidarity, peer support and organization modes of women combatants to protect themselves against violence and sexual abuse were also highlighted. Moreover, reasons are depicted why girls formerly associated with the fighting forces are rarely found in the DDRR programs (e.g. repression of war memories, obligation to the family, unable to hand in weapons or ammunitions). The authors underlined as predominant psychosocial effects of the war on children

- the rejection and stigmatization of former child soldiers by communities,
- unwanted pregnancy and motherhood without paternal support,
- continued sexual abuse by former rebel commanders,
- physical complaints (injuries, gynecological problems),
- displacement and
- feelings of guilt, shame and loss.

The reports conclude that reintegration and support to former girl combatants are crucial for the development of their country and its future stability.

### 5.2.1 Mental health of children formerly associated with the fighting forces

Only a very small number of empirical studies have focused on the psychological impact of war on children in Africa (Denov, Kemokai et al. 2004; McKay and Mazurana 2004; Specht 2004; Gupta and Zimmer 2008). Moreover, most of the existing studies assessing mental health have not worked with a case-control sample approach and it is difficult to interpret the findings as there is no data available regarding the mental health status of the general population. Furthermore, the majority of these few existing studies focus primarily on exposure to traumatic life experiences and PTSD assessment, but pay little attention to other mental health issues such as depression, suicidality, behavioral disturbances and social resources (Derluyn, Broekaert et al. 2004; Schaal and Elbert 2006; Gupta and Zimmer 2008). Last but not least, only two studies have

adopted a particular focus on children formerly associated with the fighting forces, but none of them have worked with a control sample.

The findings of the existing and accessible studies[1] can be resumed as follows:

- The nature, duration and magnitude of armed conflicts vary widely from country to country and even from region to region within one country. The psychosocial reactions and consequences, however, are highly context specific and cannot be generalized from one conflict to another (Zivcic 1993; Savin, Sack et al. 1996; Jones, Rustemi et al. 2003).
- The most commonly assessed symptoms in war affected children have been post-traumatic stress reactions, depression, sleep and behavioral disturbances, learning and concentration difficulties (Albertyn, Bickler et al. 2002; Mollica, Lopes Cardozo et al. 2004; Neuner, Schauer et al. 2004).
- The severity and prevalence rates for mental disorders and symptoms diverge from country to country, and, if conducted in the same country, from study to study. The prevalence of post-traumatic stress symptoms in child soldiers varies from 34% -97% (Derluyn, Broekaert et al. 2004; Bayer, Klasen et al. 2007). It is important to take note, however, that both studies did not assess all diagnostic criteria for PTSD, but used solely symptom-severity- scales that do not allow diagnosing PTSD.
- A recently conducted study with child soldiers in Ugandan and Congolese child soldiers indicated that children with levels of post-traumatic stress show less openness to reconciliation and have more feelings for revenge than children with low levels of post-traumatic stress (Bayer, Klasen et al. 2007).
- The existing findings indicate that childhood trauma induced by armed conflict is not only leading to short –term consequences, but can cause long-term impairment of social skills, coping mechanisms, self esteem and learning ability (Nader, Pynoos et al. 1993; Sack, Clarke et al. 1993; Bayer, Klasen et al. 2007).

[1] The project consultants did not dispose of a budget to buy articles from scientific journals. As a result, only articles free of charge and accessible on the internet could be taken into account for the literature review.

- Mental disorders are more common in post-war societies and refugee populations than in population groups without exposure to war related violence (Karunakara, Neuner et al. 2004).
- The level of exposure to life-threatening events and war atrocities as well as the adversity imposed on civilians during the conflict are major determinants for the mental health outcome. Several studies have shown that high levels of exposure to war experiences lead to high rates of PTSD in the population (Bradburn 1991; Nader, Pynoos et al. 1993; Neuner, Schauer et al. 2004).

# 6. Results of the field study

## 6.1 Socio-demographic information of the interviewed sample

We conducted individual interviews with 197 children; 99 girls and 98 boys from 8 - 20 years in five communities in the districts of Kolahun and Foya in Lofa County. We recruited 100 children formerly associated with the fighting forces and compared them to 97 controls (for methodological concept, see paragraph 4.2). Boys and girls are represented in equal proportions in the case- and the control sample. The age range of the participants was from 8 – 20 years old, with an average age of 16.6 years of age. All children enrolled in the study were able to state their age. The education level of the enrolled children varied from 1 -13 years of schooling. The average number of years of school enrolment was 5.8 years. Boy participants were enrolled in school slightly longer than girls (6.0 years vs. 5.8 years); the difference, however, is not statistically significant ($t(195) = 0.60$; $p > 0.05$). At the moment of the data collection, six (6) boys and seven (7) girls had definitely dropped out of school. Many other children, however, reported a frequently interrupted school enrolment due to the fact that they are from time to time temporarily driven out of school for not having paid their fees. The majority of children were enrolled in government (71.4%) and mission schools (23.1%). The remaining children go either to lay private (2.2%) or vocational schools (3.3%). The following table shows socio-demographic key variables such as age, education level and religion for the case and the control sample disaggregated by sex.

**Table 4: *Socio-demographic variables***

| | Total sample (*n* = 197) | girls FAFF (*n* = 49) | Control group girls (*n* = 49) | Boys FFAF (*n* = 51) | Control group boys (*n* =48 ) |
|---|---|---|---|---|---|
| **Age** | | | | | |
| Mean | 16.6 | 16.7 | 16.4 | 16.8 | 16.5 |
| Standard deviation | 2.25 | 2.26 | 2.06 | 2.29 | 2.43 |
| Range | 8-20 | 8-20 | 10-19 | 9– 20 | 9 – 20 |
| **Education level (in years)*** | 5.9 (2.58) | 6.1 (2.51) | 5.4 (2.08) | 6.3 (2.97) | 5.8 (2.66) |
| **Religion** | | | | | |
| Muslim | 57 (31.3%) | 6 (12.2%) | 7 (14.6%) | 10 (20.0%) | 5 (10.4%) |
| Christian | 125 (68.7%) | 43 (87.8%) | 40 (83.3%) | 40 (80.0%) | 43 (89.6%) |
| Traditional religion | 1 (0.5%) | 0 (0.0%) | 0 (0.0%) | 1 (2.1%) | 0 (0.0%) |

**standard deviation in parenthesis*

Only five participants (two boys and three girls) had already started working (farm work, carpentry and NGO community facilitator). Eleven of the girls and four of the boys were married. Almost half of the interviewed girls (43 out of 99) had already been pregnant and 37 of them had one or two children. Six girls were at the moment of the interview without child although they had already been pregnant. They reported miscarriages or abortions during the first six months of pregnancy. The proportion of boys who reported to have impregnated a girl was smaller: only ten boy participants answered this question positively. Out of the 10 boy participants, 3 stated to have a child.

A minority of children (11.7%) had already received assistance from NGOs or governmental institutions such as skill trainings, sports activities and educational assistance of counseling from the NGO Center for Victims of Torture (CVT).

### 6.1.1 Comparability of the case and the control sample

The comparability of the four groups was analyzed disaggregated by sex. The matching regarding education level case and control group was successful for boys and girls: the children formerly involved with the fighting forces and their controls do not show significant differences regarding their education level [for girls: ($t(97) = 1.69$; $p > 0.05$) and for boys ($t(96) = 0.54$; $p > 0.05$)]. The case and the control sub-samples were also comparable in terms of religion [for girls ($\chi^2(1) = 1.01$; $p > 0.05$) and for boys ($\chi^2(1) = 1.64$; $p > 0.05$)]. Furthermore, independent t-tests confirmed that the samples do not differ significantly in terms of age: neither for the girl sub-samples ($t(97) = 0.77$; $p > 0.05$), nor for the boy sub-samples ($F(96) = 0.61$; $p > 0.05$). Furthermore, there are no notable differences between the average age of girls and boys ($t(181) = -0.46$; $p > 0.05$).

### 6.1.2 Ethnic groups represented in the interviewed sample

Liberia is native to more than 16 indigenous ethnic groups (Wikipedia 2008). Out of this number, seven are represented in the interviewed sample. The figure below displays the proportions of ethnic groups to which the children belong. The largest groups within the interviewed sample are the Gbandi and Kissi.

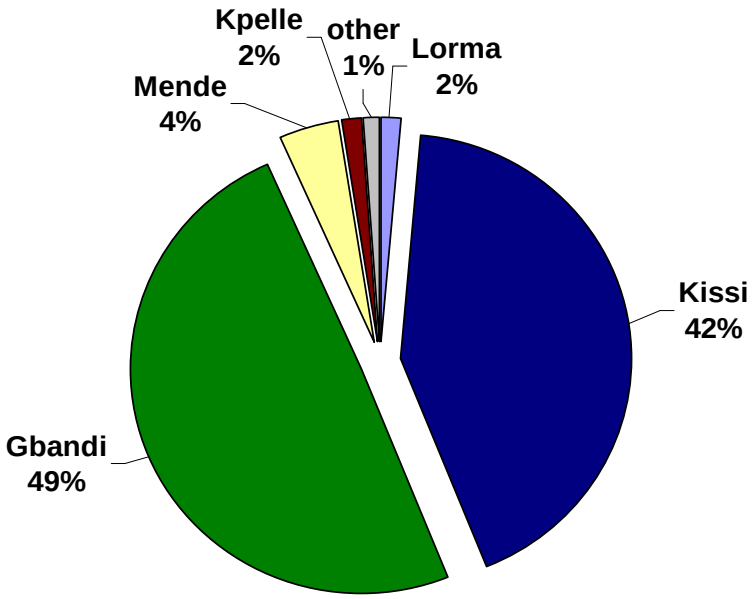


**Figure 1: repartition of represented ethnic groups in the interviewed sample**

### 6.2 Life among the fighting forces: experiences of the exposure group

The majority of children were recruited by irregular fighting forces or rebel groups (64.2%), another one third (35.8%) were enrolled governmental groups. Main recruiters in Lofa County were the LURD and ULIMO fractions and government militaries. The majority of the children was abducted by force (64.6%) or had to join the rebels because of a lack of alternatives (31.0%). Only a small minority of five children (4.4%) volunteered for serving the rebels, hoping for a better future and protection among their midst. These numbers might be influenced by a reporting bias. As children reported that former “small soldiers” are nowadays often blamed for their past implication with rebel groups, it is also possible that they did not want to reveal to have joint them on their own accord.

The recruitments took place at home or during displacements. The children were discovered by members of the fighting forces in their hiding places or were caught while traveling towards the Guinean or Sierra Leonean border or towards safer areas in Liberia. Others were surprised by rebels in their homes.

- *"It was one morning at my house when two LURD soldiers came and arrested me. They told me that I am going to be a small soldier. I said that I don't want to join the soldiers. I was beaten, threatened and forced to follow. We arrived and eight other boys and I were jailed up for two days without food. Then, they brought us outside for training. It lasted two weeks. I was given a gun and was sent out to fight along with them." (boy FAFF, 18 years, Kolahun town)*
- *"When the rebels attacked Foya town, we left for Guinea. On our way to Guinea, my mother, father and I were captured by the rebels. The killed my parents and forced me to become their wife. I was with them for sometime until I managed to run away and to make my way through to Guinea." (girl FAFF, 19 years, Foya town)*
- *"When the war started, my parents and I were running away. On our way to Sierra Leone, we were arrested by government forces. My father was beaten badly and my mother was killed. I was forced to go with them as a small soldier. Otherwise they would have killed me as well. My father went to Guinea, but got ill and died." (boy FAFF, 17 years, Foya town)*

The allegiance of the children was imposed by death threats and severe punishments. Several children witnessed family members being killed after refusing to serve the rebels or because they had pleaded to spare their children. The testimonies of the children show the constant fear of being harmed or killed after having being recruited by the rebels.

- *"One day during the war, I went out with my friends to look out for some food for the family. On our way, I was captured by the rebels and they asked me to join them in the fighting or they would kill me. I was forced to obey in order to save my life." (boy FAFF, 17 years, Foya Tengia)*
- *"I was arrested by LURD while hiding in the bush. I was forced to go with them to Voinjama. When I tried to escape, I was beaten, threatened and they cut my neck with a knife. Blood ran all over me. I stayed with them for six months, carrying ammunition and looting properties for them. Then I managed to run away and to cross the border to Guinea." (girl FAFF, Harleypo, 18 years).*

The children were implicated in a wide range of activities during their life among the fighting forces. Predominant tasks were domestic work (cooking, cleaning, laundering), carrying and dispatching of goods, spy missions, combat participation and, for girls, sexual services. Many children (78%) were involved in at least three different types of activities. Moreover, 20% of the participants had to loot properties and to burn houses (12% of the girls and 37% of the boys); 15% of participants were forced to abduct and punish other children (4% of the girls and 31% of the boys). While boys were more intensely involved in combat activities and destruction of properties (looting and burning of houses), girls were more attached to domestic tasks and sexual services.

- *"My father was killed during the war. My two sisters and two brothers were taken away by government forces. My mother and I decided to seek refuge in Guinea. On our way, we were arrested by rebels who did not let us cross the border. After two days, my mother and the other people were released, but I was forced to live with them for two months. I was*

*forced to have sex with different rebel commanders and obliged to do cooking, washing clothes and stealing from people's properties after the attack." (girl FAFF, 18 years, Kolahun town)*

- *"I was arrested in the bush by two rebel soldiers. They forced me to carry looted material to Kolahun. In Kolahun, I was forced with two younger boys to carry ammunition to Fassama. It was in Fassama that we were trained to become soldiers. I learnt to dismantle guns and how to behave during the fighting. After the training, we fought for the rebels. We looted properties, punished other soldiers and civilians. All this for two years. I was forced to burn towns and villages. I also had to serve as a guard, I had to do night patrols and identify roads." (boy FAFF, 18 year, Kolahun town).*

Many girls stated to have been predominantly recruited "as bush wives", meaning as sexual slaves and distraction for male rebels. Some girls were younger than 12 years at the moment of becoming "bush wives". If a girl was "married" to one specific member of the fighting forces, she was sometimes protected from being sexually violated by other men. Many, however, had to be available, often under threats and verbal abuse, to different partners. Rape and gang rape were common experiences for the girls during their time with the fighting forces. Five participating girls gave birth during their time with the rebels.

- *"I was eleven years when the rebels captured us. Many people were killed and there were dead bodies lying all over. My grandmother, my sisters and I were kept by the fighters to be their wives. Since my grandmother could not see clearly, the rebels decided to burn her. My sister refused to be their wife and was also killed. I had no alternative, but to go with them. I was so scared of being killed. I used to be the sex partner of many rebels. They all wanted me as their wife. We moved from one place to the other and they attacked many places. After the attacks, we were forced to burn or bury the bodies of the people killed by the rebels. I was staying with them for 13 months." (girl FAFF, 18 years, Kolahun town)*
- *"My mother used to be with a man before the war started, but she left him. He joint the rebels and came back to kill her. My mother managed to escape, but he kidnapped me instead. I was nine years old. I was taken to a training based and trained for two days. The rebels took me as bush wife whenever they wanted. I had to a lot of cooking and laundering. The rebels also used me as a spy before attacking a town."(girl FAFF, 16 years, old, Kolahun town)*
- *I was born by two rebel parents, but they were killed soon after my birth. They were burnt in their house during an attack from the government troops. I was taken as a bush wife by government soldiers when I was eleven. I learnt very soon that the only way to survive and help yourself is to drink and to take drugs." (girl FAFF, 15 years, Foya town)*

Children were often very young when joining the fighting forces and were gradually involved in more demanding activities. Others, however, were directly enrolled, after the abduction, in straining military training that included apart from maltreatment and indoctrination, the use of light arms and physical exercise. In order to prepare the children for combat and to force their allegiance different forms of torture such as intimidation, tying up, starvation, beatings and voluntary inflicting of injuries were used

by the rebels. All together, 30% of the children formerly associated with the fighting forces participated in military training (12% of the girls and 55% of the boys).

- *"I was having a hiding place in the bush, but one day the LURD rebels discovered me and forced me along with others to come to Kolahun. Then, we were trained on the ground: we were beaten and threatened to death with guns and knives. Later, we were taken to Fassama where we completed our three months training. I was injured on a pull back and was sent to Guinea for treatment. But it was very bad, I lost one leg." (boy FAFF, 18 years, Kolahun town)*
- *"When going into refuge to Guinea, we were arrested by LURD forces. My parents pleaded them to let me go, but they forced me away and I underwent a three months training. So much threats and punishments: a lot of beatings and sometimes they tied me up. After the training, the war could not be any more inhuman than what I had already lived." (Boy FAFF, 18 years, Harleypo town)*

One out of ten children formerly associated with the fighting forces killed someone (4% of the girls and 16% of the boys). Drug use concerned 13% of the interviewed children (11% of the girls and 15% of the boys) and was particularly common among children involved in frontline fighting and among girls providing sexual services.

- *"I was eleven when I became a bush wife. I was given drugs in order to be brave and to continue obeying them. I was trained how to fight, shoot and operate guns. They forced me once to kill a woman and many times to punish people that had been captured. Every day, we had to burn houses, to steal and to destroy." (girl FAFF, 19 years, Kolahun town).*
- *"After becoming a bush wife, my life became unbearable. When they gave me drugs for the first time, I was unconscious for two days. I was put in a hammock for recovery. I soon got used to it" (girl FAFF, 15 years, Foya town)*

The case studies showed that many of the children tried and sometimes succeeded - despite the death threats - to flee the fighting forces. Others were only freed after getting wounded or when the war ended. Only seven of the 100 CFAFF were disarmed after the war, but none of them participated in reintegration activities.

- *"One night, I was crying and one of the small soldiers asked me why I was crying. I explained that I wanted to go to Guinea and he said that he was going to help me if I agreed to have sex with him. I consented, what other choice did I have? After having sex with him, he told me to take my bag and to follow him. We walked through the bushes after nightfall and reached the border. He called the Guinean soldiers and they helped me to cross the border. I went to the nearest camp where I met my mother. We cried for a long time. We had lost so many of our family."*
- *I had been living the ULIMO for over a year, when I was freed during the disarmament process. I was very scared at first, not knowing what was going to come next. But then I understood that I gained humanity back. In 2006, I decided to go back to school. I am thankful to God. Life finally seems to become normal again." (girl FAFF, 18 years, Kolahun town)*

### 6.3 Experiences during the war (exposure and control group)

### 6.3.1 Displacement, separation from parents and life in refugee camps

The mobility of the participants was extremely high during the war and many children have only recently returned or moved to Lofa County (see also section 6.3.4). All families of the interviewed children were displaced during the war. During the displacements, 72% of the children got separated at least one time from their parents or guardians. The displacement during the rebel attacks exposed the children to multiple traumatic life experiences. Exposure to war was almost universal among former child soldiers (98%), but also common in the control group (77%). Only some of the younger participants or those who have been born in camps or in refuge areas, have not come close to combat or situations of war related violence.

The children formerly associated with the fighting forces were highly significantly more exposed to all events listed in the table below than the control group. The experience of girls and boys did not differ significantly for most variables. Boys had more often witnessed than girls how another child was punished to death ($\chi^2(1) = 4.86$; $p \leq 0.05$) and were also more likely to have carried dead or wounded bodies during the conflict ($\chi 2(1) = 7.70$; $p \leq 0.01$).

**Table 6: Exposure to traumatic war experiences**

| Event | Total sample (*n*=197) | CFAFF (*n*=100) | Control group (*n*=97) | *Group comparison* ($\chi^2$) |
|---|---|---|---|---|
| To witness a landmine explosion | 55 (28.1%) | 48 (48.0%) | 7 (7.3%) | ($\chi^2(1) = 40.21$; $p \leq 0.001$) |
| To witness another child being punished to death | 86 (44.1%) | 61 (36.4%) | 25 (26.3%) | ($\chi^2(1) = 23.77$; $p \leq 0.001$) |
| To be surrounded, lying underneath or stepping on dead bodies | 115 (58.4%) | 84 (84.0%) | 31 (32.0%) | ($\chi^2(1) = 54.88$; $p \leq 0.001$) |
| To carry a dead or wounded body during the conflict | 44 (22.3%) | 33 (33.0%) | 11 (11.3%) | ($\chi^2(1) = 13.32$; $p \leq 0.001$) |
| To have one's home or properties looted | 163 (82.7%) | 95 (95.0%) | 68 (70.1%) | ($\chi^2(1) = 21.37$; $p \leq 0.001$) |
| To see houses being burnt | 156 (79.2%) | 96 (96.0%) | 60 (61.9%) | ($\chi^2(1) = 34.83$; $p \leq 0.001$) |
| To witness a forced recruitment/ abduction | 116 (58.9%) | 85 (85.0%) | 31 (32.0%) | ($\chi^2(1) = 52.22$; $p \leq 0.001$) |
| To be forced by violence or threat of violence to leave one's family | 130 (66.0%) | 88 (88.0%) | 42 (43.3%) | ($\chi^2(1) = 43.84$; $p \leq 0.001$) |
| To see a family member being injured with a weapon | 109 (55.9%) | 72 (72.0%) | 37 (38.9%) | ($\chi^2(1) = 21.59$; $p \leq 0.001$) |
| To see a family member threatened to be killed or being killed | 138 (70.8%) | 86 (86.0%) | 52 (54.7%) | ($\chi^2(1) = 32.02$; $p \leq 0.001$) |

### 6.3.2 Life in refugee camps

Most of the children (71.4%) went to live with their families in refugee camps in Sierra Leone and Guinea. Yet even in refuge, their life continued to be unstable and the greater part of the children moved repeatedly and lived at least in two different refugee camps. Due to the lack of safety in the camps close to the Sierra Leonean and Liberian border in Guinea, the families were forced to move from one camp to the next. An important proportion of the participants (23.6%) witnessed a rebel and/or military invasions in the refugee camps during the period of spill-over fighting from Liberia in 2000 to 2002. Many families were temporarily captured by dispersed rebel groups or had to witness another time forceful abductions, torture and killings.

- *"My mother and I where in refuge in Gueckedou when the rebels attacked. I heard gun shots, people dropped dead and I mother was skinned alive in front of me. People screamed orders such as: take your mother's body, it is your own share and go, go away! I don't know who was talking to me, who was pushing me. I just remember myself running, escape with other refugees who had known my mother." (Boy FAFF, 15 years, Foya town)*

The living conditions in the refugee camps were difficult. The majority of the participants reported access to clean water, but food and shelter were insufficient for many children. Girls reported particular difficulties to accessing shelter. Many of them also complained about restricted movements and lack of security. The difficult living conditions probably pushed the girls to get engaged in transactional sex: 32% of the girls had sex with camp workers in order to receive money, clothes, food or material for shelter in return for their services. The results imply that girls are likely to be more vulnerable to (sexual) exploitation in refugee camps and should benefit from specific protective measures against this kind of abuse. Although basic living resources were scarce, most children had access to school during their time in the refugee camps. There were no significant differences regarding the life conditions in refugee camps between the exposure and the control group (see figure below). Case studies, however, indicated that boys who had fought for rebel groups were more restricted in movement and were subjected to recurrent investigations.

- *"In May 2001 many children in the camps were targeted to be arrested by the Guinean police and soldiers. Someone told them that there were ex rebel fighters among the children in the camp. Three of the indexed small soldiers admitted that they had important positions in the rebel army. But they were forced to join the rebels at a very young age, between 10 and 13 years. They were taken for further investigation to Kissidougou. The harassment of other suspected children continued. Although I never told anyone about my time with the rebels, I was not allowed to move and could not go to*

*school regularly any more. The camp became a bad place for me and I feared all the time to be indexed as a rebel." (boy FAFF, 15 years, Ngihema)*

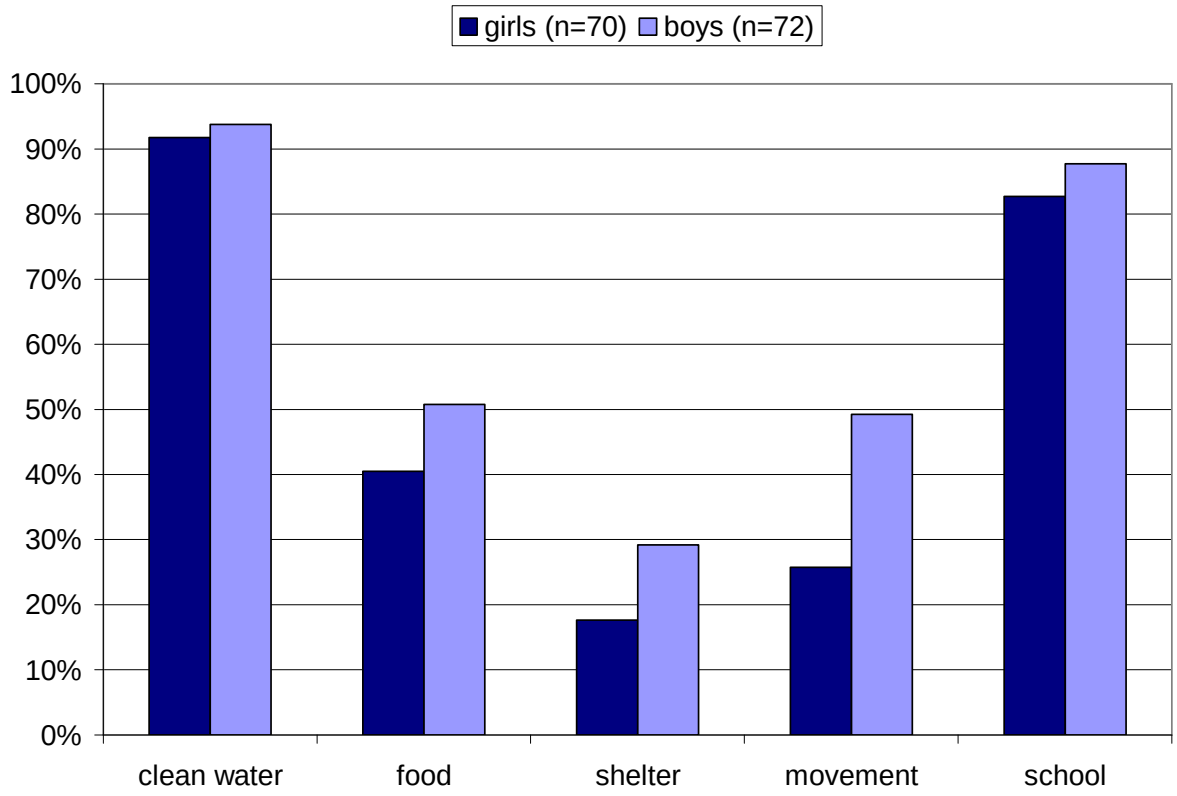


**Figure 2: reported access to basic resources and education in the refugee camps**

### 6.3.3 Loss of parents

Numerous children (71.6%) have lost at least one parent in the war. Children of the exposure group were more likely to have lost a parent than participants of the control group ($\chi^2(1) = 7.78$; $p = 0.02$). Most of the parents died during the war (79.3%) or briefly after the war (12%). The majority (63.0%) did not die of a natural cause, but were killed according to the testimonies of the children. The circumstances of the parent's death were often highly traumatic. The children had to testify how their parents or other family members were assassinated. The parents were often killed for pleading to spare their child from forceful recruitment. As a consequence, the children have often nourished a feeling of guilt for being partly responsible of their parent's death.

- *"When government forces attacked, I and my parents including my bigger sisters and brothers were trapped in the house. They pointed the weapons at us and forced us to come outside. The soldiers wanted to take my older sisters as wives. My older brother tried*

*to beg them to leave them with us, they took him behind the house and cut his throat. They took my sisters away and I have never seen them again." (girl FAFF, 18 years, Kolahun town)*

In addition to the trauma of witnessing the slaughter of family members, the children were often deprived of the possibility of organizing proper funeral ceremonies for the deceased. At the moment of the interviews, several children were still distressed by the fact that their mother or father had not yet received a proper burial ritual.[2]

### 6.3.4 Arrival in Lofa County district after the war

The families repatriated gradually from Guinea and other refuge areas to their region of origin. Almost 95% of the children came back to Lofa County between 2003 and 2007, only a few children were repatriated before 2003. The following table displays the arrival periods of the children in Lofa County. Interestingly, boys came proportionally back earlier than girls: almost half of the girls have re-settled in Lofa County during the past two years while this was not even the case for 20% of the boys who came mostly back the years before.

Coming back home was a painful experience for many families. Access to shelter was difficult and a new life basis had to be established. Some children came back with friends or relatives while their parents remained in Guinea.

- *"I was happy when we decided to go back home in September 2005. But once we arrived, I was terrified. There was a heavy rain and all the food and other things we had received from the UNHCR were stolen. My father and I went to his former house, but there were only big trees and thick bushes. When my father tried to reach any of his friends or relatives in their former homes, they were either dead or had not come back yet. We had to stay in an open veranda of the police station for two weeks. Coming back from refuge was disappointing and deeply discouraging." (boys FAFF, 15 years, Foya town)*

**Table 7: proportions children for different arrival periods in Lofa County**

| | ***Total sample*** | ***Girls*** | ***Boys*** |
|---|---|---|---|
| 2006- 2007 | 34.9% | 46.8% | 19.1% |
| 2003 – 2005 | 58.7% | 46.8% | 74.5% |
| Before 2003 | 6.4% | 6.5% | 6.4% |

[2] In the area of the research, communities believe that a late person has to cross over a river in order to rest in peace. The only means to cross the river is by means of a particular funeral ceremony carried out by a pastor or a traditional leader.

### 6.4 Current household and family situation

About 40% of the participants lived with one or both parents; 14.2% resided with both parents, 19.1% lived with their mother and 5.2% lived with their father. Another two children (1.1%) stayed with one parent and a new spouse. Another considerable proportion (44.4%) stayed with relatives, such grandparents, aunts and uncles, brothers and sisters. Out of the groups of relatives, aunts and uncles were playing the most important role in fostering children (18.6%), followed by the grandparents (13.9%) and brothers and sisters (11.9%). The majority of children (84%) were residing with a more or less closely related family member. However, a child in Liberia naming an "aunt", "sister" or a "grand-mother" as a guardian is not necessarily applying the Western concept of these terms. An "aunt" or a "sister" can be, for instance, the sister of the wife of a cousin or the sister of a second wife of the father. In many cases, there is no biological relationship between the child and the guardian. Children living outside family networks are either living alone (7.7%) or in non-relative foster care (5.2%). Two children were living with friends and one child was living permanently in the street at the moment of the interview.

The death of a parent was not the only reason for confiding a child to a member of the extended family. In fact, even slightly more than 30% of the children who still have one or both parents were fostered by relatives. Non-orphans were fostered for diverse reasons such as chronic illness, separation, physical handicaps, need for domestic labor support in another family or for facilitating the education or socialization of a child.

In total, almost 60% of the interviewed children lived in foster care in the extended family and *not* with one or both of their biological parents.

### 6.5 Emotional wellbeing

The answer of the children to the question "how happy are you living in your home" showed that slightly over 65% of the children are either "very happy" (8.9%) or "happy" (56.2%). The remaining 35%, however, reported to be sad (29.2%) or very sad (5.7.0%) at home. The analysis of potentially influencing factors showed that girls FAFF had a significantly lower probability of being happy at home than girls of the control group ($t(97) = 3.17$; $p \leq 0.01$). There were no significant differences, however, between the boys FAFF and their control counterparts. The findings showed also no significant differences between girls and boys ($t(181) = 0.54$; $p > 0.05$).

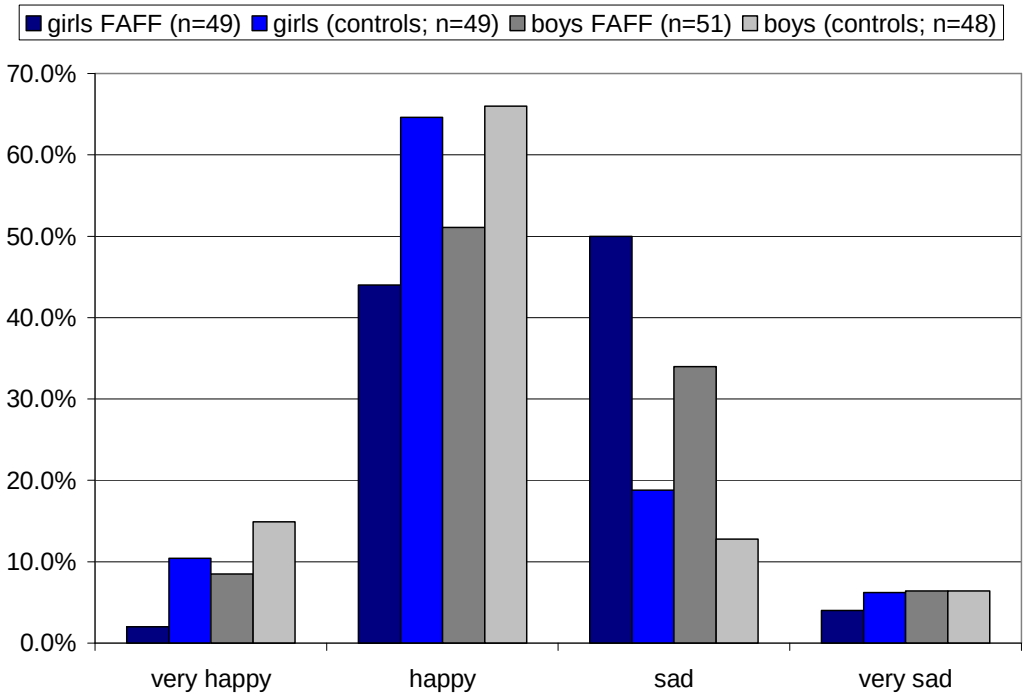


**Figure 3: degree of satisfaction of different sub- samples at home**

In spite of the considerable proportion of children being unhappy at home, the majority of them (89.6%) declared to have at least one person in the family offering love and protection. The remaining 10.5% (20 children), however, stated to have no attachment figure in their family.

The protecting person was often the mother (22.7%), an aunt or an uncle (19.8%), one of the sisters or brothers (15.1%) or a grandparent (12.8%). Some children (8.1%) consider their father as their protective person and eight children (4.7%) name both parents as accountable for their protection. Friends represent another important protection resource for 30 children (16.9%).

### 6.5.1 Important factors determining well-being of children

All analyzed factors regarding the emotional wellbeing of children are displayed in Table 8. In general, the percentage of children reporting to be sometimes or often unhappy is at 97.4% in the study area of Liberia. The proportion of children answering *never to be happy* is at 6.2% in the interviewed sample which is comparable to the proportion of children in Sierra Leone (8.0%) where we conducted a study focusing on children without parental support.

The proportion of children that reported to *feel never hopeful about the future* indicates also a severely affected resilience among some children: more than 11% of the participants reported to feel *never* hopeful about what their future is going to bring.

Moreover, trouble sleeping is an almost universal problem and concerns all but one of the interviewed children. The feeling of wanting to run away from home was assessed in 30 children (16.1%) and 28 of them have already put these thoughts into action: 17 of the interviewed girls and 11 of the boys have already run away from home at least one time in the past six months, in the majority of the cases, more than three times. The reasons for running away were usually linked to family conflicts, domestic violence or rejection from caretakers driving children from their homes to seek refuge with relatives or friends.

The former girl child soldiers scored significantly lower on most of the analyzed variables regarding emotional well being (see table below). For the boy sample, on the other hand, the exposure group scored only significantly lower on two variables: *feeling unhappy* and *feeling hopeful about the future*.

The impaired well being of the exposure group is certainly not only linked to the war trauma, but also due to current stigmatization of former child soldiers at community level. Some of them felt stigmatized and reported to be hold responsible by others for the crimes that they had committed during the war. Feelings of guilt are certainly also certainly also having a negative influence on the well being of former child soldiers.

The comparison of girls and boys indicated that the sexes do not differ for the variables *being unhappy, angry, being content, having fear of new situations, having difficulties making new friend* and *wanting to run away from home.* Nevertheless, considerable differences became apparent on the scales of *being worried* (*U*-test, 3892.5; $p \leq 0.01$), *trouble sleeping* (*U*-test, 4076.0; $p \leq 0.05$) and *feeling hopeful about the future* (*U*-test, 3548.5; $p \leq 0.05$) on which girls scored significantly lower than boys. In general, the analysis of the different factors of well being showed that the resilience of many children in all groups has been affected, however, the group of girls FAFF seems to be particularly vulnerable.

**Table 8: Analyzed factors regarding the wellbeing of children**

| Factors of wellbeing | Difference between girls FAFF and the control group | Difference between boys FAFF and the control group |
|---|---|---|
| **Being unhappy** | (*U*-test, 981.0; $p \leq 0.05$) In disfavor of CFAFF | (*U*-test, 1004.5; $p \leq 0.05$) In disfavor of CFAFF |
| **Being worried** | (*U*-test, 764.0; $p \leq 0.001$) In disfavor of CFAFF | (*U*-test, 1063.5; $p > 0.05$) No significant differences |
| **Being content** | (*U*-test, 890.5; $p \leq 0.01$) In disfavor of CFAFF | (*U*-test, 1152.0; $p > 0.05$) No significant differences |
| **Being angry** | (*U*-test, 1179.0; $p > 0.05$) No significant differences | (*U*-test, 1078.0; $p > 0.05$) No significant differences |
| **Fear of new situations** | (*U*-test, 1135.5; $p > 0.05$) No significant differences | (*U*-test,980.0; $p > 0.05$) No significant differences |
| **Trouble sleeping** | (*U*-test, 848.0; $p \leq 0.01$) In disfavor of CFAFF | (*U*-test, 1056.0; $p > 0.05$) No significant differences |
| **Difficulties making new friends** | (*U*-test, 1028.0; $p > 0.05$) No significant differences | (*U*-test, 1090.5; $p > 0.05$) No significant differences |
| **Being hopeful** | (*U*-test, 982.5; $p > 0.05$) No significant differences | (*U*-test, 835.5; $p \leq 0.05$) In disfavor of CFAFF |
| **Wanting to run away** | (*U*-test, 1200.5; $p > 0.05$) No significant differences | (*U*-test, 898.5; $p > 0.05$) No significant differences |

### 6.6 Self esteem and pro-social skills

We evaluated the self-esteem of children with help of the Rosenberg questionnaire. The control groups reported higher self esteem than the children FAFF; the differences, however, are not statistically significant [girls *(t*(96) = -1.80; $p > 0.05$); for boys *(t*(95) = -1.95; $p > 0.05$). The self esteem of boys was significantly higher than of girls *(t*(193) = -6.31; $p \leq 0.001$) which is in line with findings from studies conducted in different children populations around the world (Bagley, Bolitho et al. 1997; Chabrol, Carlin et al. 2004; Behrendt and Mbaye 2007).

Apart from self esteem we also explored prosocial skills of children in the scope of the assessment of the children's resilience. Pro-social skills were measured by the "prosocial-scale" of the Strength and Difficulty Questionnaire (SDQ) from Goodman. About 62% of the girls and 61% of the boys were within the range of average scores for pro-social skills: they scored higher than the cut-off score proposed by the author of the questionnaire. However, 18.4% of the girls and 32.6% of the boys showed problems in social interactions with other children and adults and were be classified in the score range "borderline". Another proportion of 19.4% of the girls and 6% of the boys scored in the lowest category, named "abnormal", indicating impaired prosocial skills. In our study in Cameroon, where we applied the same questionnaire in an area of high HIV prevalence, only 4% of the interviewed children fell beneath the cut off score and none

of them were in the score range of the category “abnormal”. The comparison of boys and girls of the exposure group to the counterparts of their control sample did not show significant difference between the CFAFF and controls [for girls: *(t*(96) = -1.32; *p* > 0.05) and for boys: *(t*(95) = -0.57; *p* > 0.05)]. There were, however, noteworthy difference between boys and girls: the girls put on view significantly lower prosocial skills than the boys *(t*(193) = -2.64; *p* ≤ 0.01).

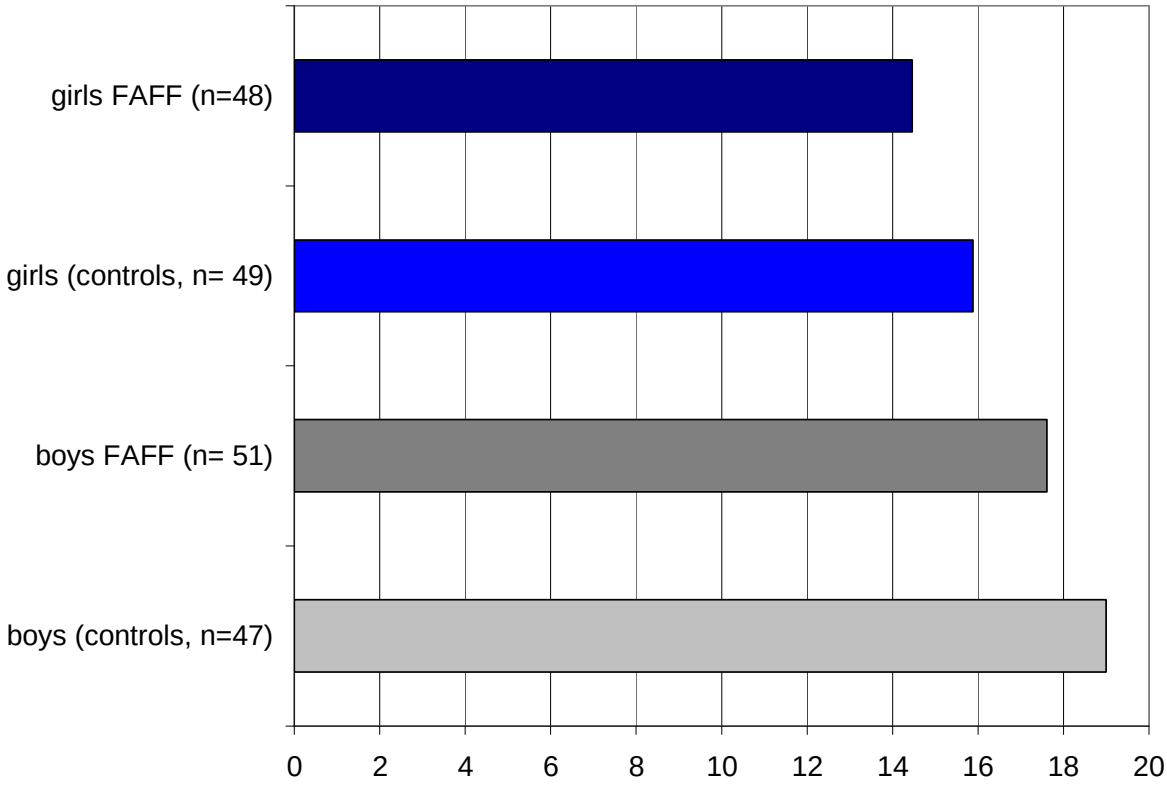


**Figure 3: Total score of the Rosenberg self esteem questionnaire for the different sub-samples**

6.6.1 Influencing and correlating factors of self esteem

Age did not have an impact on the self esteem of a child: there was no correlation between self esteem and age. The number of years of school enrolment did also not seem to play a role: there was no correlation between the number of years in school and the degree of self esteem. Influencing factors were neglect and sexual abuse: children subjected to ongoing neglect scored significantly lower on the self esteem scale than non neglected children *(t*(192) = -2.00; *p* ≤ 0.05). In the same sense, children who had been sexually abused in their life, had a lower self esteem than non abused children *(t*(181) = -4.68; *p* ≤ 0.01).

Furthermore, fostered children had a significantly lower self esteem than children living with one or both parents *(t*(189) = -2.32; *p* ≤ 0.05). In the same line, being happy at home showed a highly significant correlation with a high self esteem score *(Pearson: r= .34*; *p* ≤ 0.01): children that feel happy at home have a higher self esteem.

Suicidality, on the other hand, showed a highly noteworthy negative correlation with self esteem: as lower the self esteem, as higher the proportion of children expressing a high risk of suicide *(Pearson r= .34*; *p* ≤ 0.01). As to be expected, children suffering from major depressive disorder and from PTSD also showed a significantly less self confidence than mentally healthy children [for major depressive disorder: *(t*(180) = -3.56; *p* ≤ 0.01) and for PTSD: *(t*(177) = -3.10; *p* ≤ 0.01)].

### 6.7 Suicidality

Thoughts about committing suicide were quite common among the children in the sample: 85 participants (43.4%) had already felt so bad on at least one occasion in their life that they wished to be dead. The children shared how suicidal ideas crossed their minds in particularly difficult moments of life. The fear of pain and punishment and the knowledge that people committing suicide will not receive official prayers during their funeral usually prevented them from taking action and limited their despair to mere *thinking* about suicide.

- *"When rebels took over Kolahun town, I and some other girls were arrested and forced to come with them. For two years, there was no escape. I was forced to be the wife to one of the soldiers. When I heard that my father was killed by the government forces, I just wanted to die." (girl FAFF, 18 years, Kolahun town)*
- *"I was in Kolahun when the war reached us. Government forces arrested me and brought me to Vahun. They took all the food, money and clothes away from us. I got separated from my father. I arrived with a woman in Sierra Leone. She tried to help me a bit. One morning I learnt that my father had also crossed the border of Sierra Leone. But I never saw him again. I was told that he was dead after being beaten, tied up and tortured by LURD forces. Sometimes I would like to be dead, just like him."(girl FAFF, 18 years, Kolahun town)*

Thoughts about suicide do not signify that a person is at risk of committing suicide. In our study, we considered children as having a "*suicide risk*" or *"high suicidality"* if there was high probability that they would take concrete action to end their life. More precisely, we considered a child to be at risk of suicide if the child

- had repeatedly wished to be dead in the past month or expressed an intention of hurting or injuring himself or herself during the interview and
- had already elaborated a concrete plan on how to commit suicide or

- had attempted in the past four weeks to commit suicide.

The prevalence of high suicide risk among the groups of children in the study is shown in Figure 4. The overall rate of suicide risk in the entire sample was 20%, with girls (26.3%) having a significantly higher risk than boys (13.4%) ($\chi^2(1) = 5.08$; $p \leq 0.05$). These findings are alarming: more than two children out of ten are feeling so bad that they express concrete intentions to commit suicide. The rate of suicide risk is particularly high in the sample of girls formerly associated with the fighting forces where more than 36% showed suicidal behavior. As shown in the figure below, the differences between the exposure and the control groups are highly significant [for girls ($\chi^2(1) = 7.19$; $p \leq 0.01$) and for boys ($\chi^2(1) = 7.41$; $p \leq 0.01$)].

The most startling finding about the high suicidality was that numerous children had already made plans on how to commit suicide, or had even gone as far as putting their plan into action. Out of 197 interviewed children, 41 (21%) had already attempted to commit suicide at least one time in their life. Some of the young mothers did not only attempt to kill themselves, but included their babies in their plan and tried to kill their babies before themselves. The communities seemed to be aware of the high suicidality of children. Participants that were caught attempting to kill themselves were either physically punished by family members or taken to the nearest police station. At the police, the children were usually kept in detention for a short time before released without any follow up.

- *"I am sad and worried. Last week, my grandmother insulted me and drove me out of the house. I did not know what to do any more and bought rat poison. But before I could eat it, I was discovered and brought to the police. Now I am back with my grandmother, but things have not changed. I just don't see a way out."(girl FAFF, 18 years, Kolahun town)*
- *"I have bought rat poison on two occasions to end my life. I can't stand seeing my father and mother getting drunk any more. As I am a cripple, I cannot be of great use to anyone." (boy FAFF, 18 years, Kolahun town)*
- *"I just lost my mother who was helping me and my two brothers. I tried to kill myself already during the war, but they took my gun away and made me carry looted goods. Now I think about it again. There is no hope in life." (boy FAFF, 18 years, Harleypo town)*
- *"When the war started, my parents went to Nimba County in Liberia because my mother is from the ethnic tribe of the Krahn. The war became soon very serious in Nimba and we had to come back to Foya where my parents left me with a pastor. Since then, they don't care for me any more. What's worse, the pastor also abandoned me. I am staying with a friend, but I have no money to go to school. My father has now divorced my mother, but my mother does not care about me. I went to see my father two years ago, but he is having a new wife and does not want to have me around any more. I was so sad that I tried to kill myself when I came back to Foya. I bought caustic soda. Only my friend stopped me from taking it. But I am still thinking about doing it." (boy FAFF, 18 years, Foya town)*

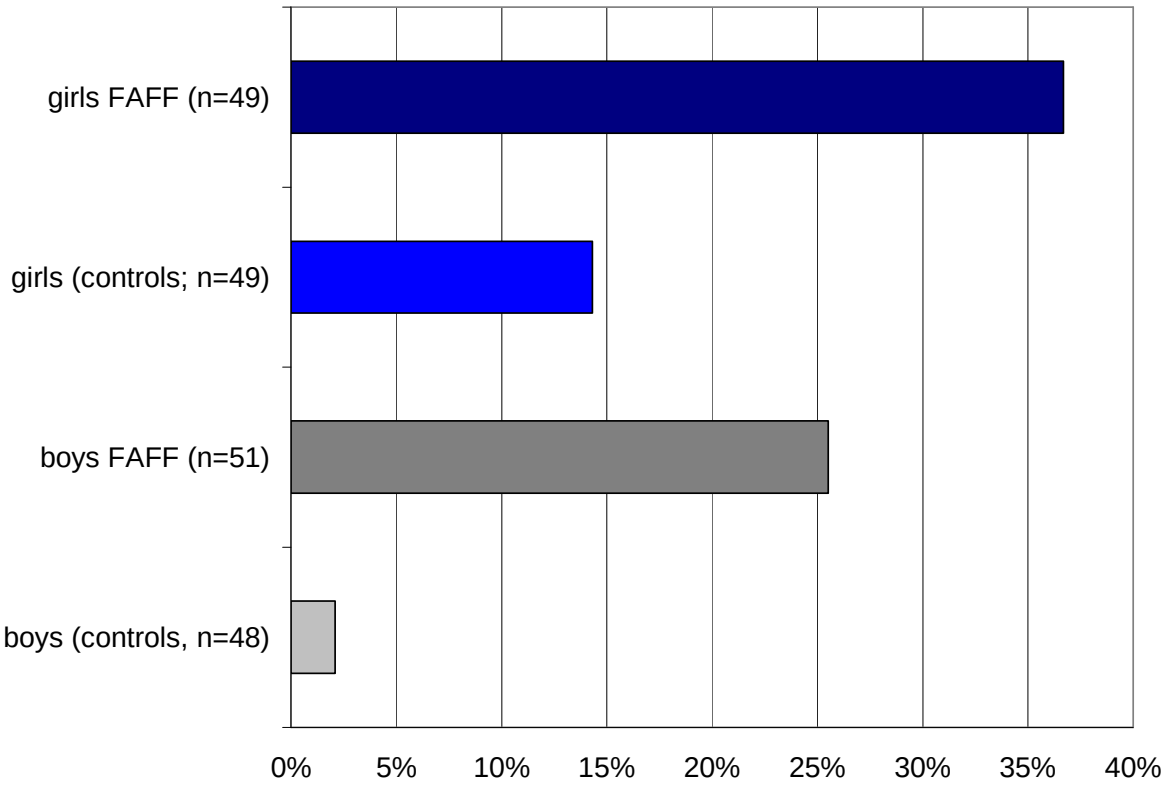


**Figure 4: Suicide risk rates in the different sub-samples**

Influencing and correlating factors for high suicidality

Apart from the factors "being a girl" and "being formerly associated with the fighting forces", we tried to find out other variables in order to learn more about the children with a high suicide risk. We identified the following common factors of children with high suicidality:

- having lived sexual abuse ($\chi^2(1) = 17.52$; $p \leq 0.01$);
- being currently victim of verbal violence ($\chi^2(1) = 7.07$; $p \leq 0.01$);
- being currently victim of neglect ($\chi^2(1) = 6.29$; $p \leq 0.05$);

Education levels measured in the numbers of years in school ($t(194) = -0.76$; $p > 0.05$) and fostering status ($\chi^2(1) = 3.51$; $p > 0.05$) had no impact on the suicidality of children. The age groups from 8 – 15 and from 16-20 showed also no noteworthy differences ($\chi^2(1) = 0.11$; $p > 0.05$). In general, participants with high suicidality had in common that they feel rejected from their family and the community and that they miss solid bonds with adults. They observe how other children receive better treatment and want to end the suffering that they are exposed to.

Another reason for the increased suicidality might be that children often hear about and even witness suicide attempts. Within the interviewed sample, 55 children (28.1%) had already witnessed someone committing suicide. This experience was significantly more common among participants of the exposure group ($\chi^2(1) = 9.99$; $p \leq 0.01$) which explains to some extent the higher suicidality of children formerly associated with the fighting forces. Furthermore, children in case studies reported to have lost family members through suicide. The apparently elevated suicide rate in the general population probably incites children to plan, attempt and sometimes to succeed in committing suicide themselves.

### 6.8 Exposure of children to traumatic life experiences

The children in our study had come face to face with a wide range of life threatening events. Apart from the war associated experiences (section 6.3) and domestic violence (section 6.9, 6.10 and 6.11), common experiences among the interviewed children included natural disasters (61.7%), seeing a dead body outside funerals (73.0%), hearing about the violent death or serious injury of a loved one (77.6%) and dangerous illnesses/ injuries or scary hospital treatments (63.8%). Moreover, an important number of children had already been involved in serious motor vehicle accidents (27.0%) and 53 children already have witnessed a mob execution (27.0%).

The exposure range for different types of traumatic life experiences was from 1 – 57 events. On average, participants had been exposed to 24 different potentially traumatic events in their life. The average level of exposure to different types of traumatic life experiences for the case and control sub-samples is displayed in Figure 5. As visible in the figure below, girls and boys FAFF were exposed to significantly higher numbers of life threatening events than their counterparts from the control group [for girls ($t(96) = 6.90$, $p \leq 0.01$); for boys: ($t(93) = 7.79$, $p = p \leq 0.01$)]. Although girls have a higher exposure rate than boys, the differences are not yet statistically notable ($t(191) = 1.69$, $p > 0.05$). It could have been expected that children in the age group from 8 – 15 years had lived noticeably less traumatic life experiences compared to the age group from 16 – 20. This is, however, not the case ($t(191)$ -0.84, $p > 0.05$). Even young children have been highly exposed to a lot of different life-threatening experiences.

The number of traumatic life events experienced by a child is an important factor for the mental health outcome. We found highly significant positive correlations between the number of traumatic experiences and

- the degree of post traumatic stress (Pearson $r$ = .46; $p \leq 0.01$);
- the degree of suicidality (Pearson $r$ = .43; $p \leq 0.01$).

The results generate the following hypothesis: a high exposure rate to different traumatic life experience increases the risk for PTSD and for suicidal behavior.

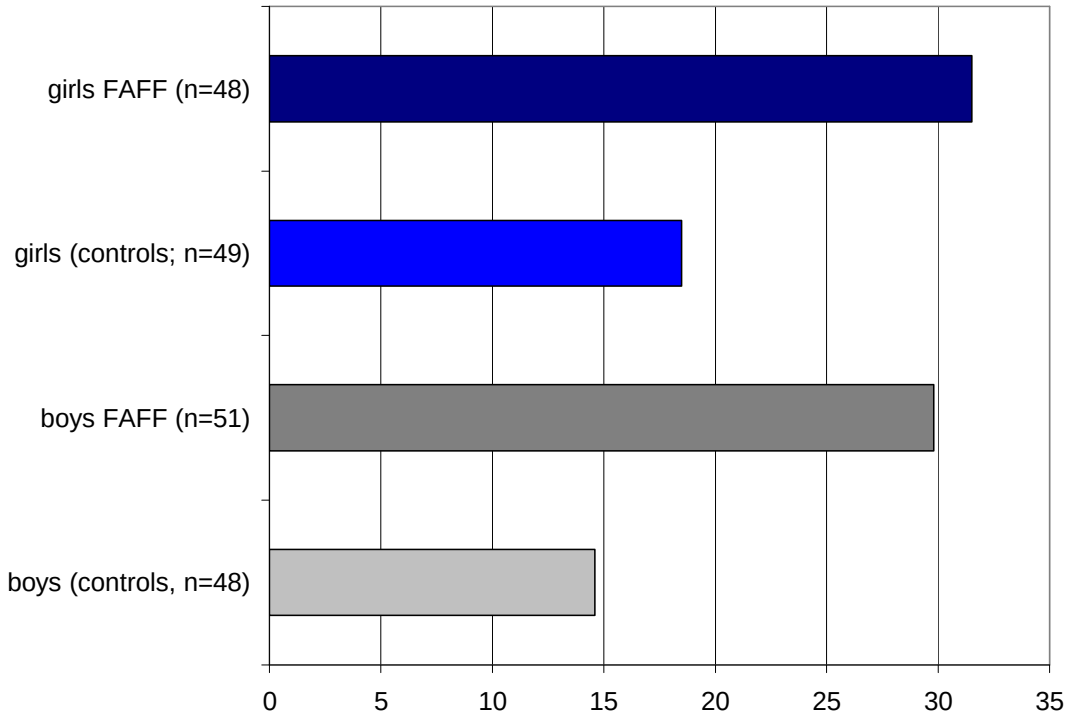


**Figure 5: Number of different types of traumatic life events already experienced by the different groups of children**

### 6.9 Exposure of children to domestic violence in life-time

In order to assess the prevalence of exposure to domestic violence, we collected two sets of data. We inquired if the children had experienced a specific type of violence at least one time in their lives. If the answer was affirmative, we asked whether they had experienced this type of violence within the past month. The large majority of children had been exposed to different forms of maltreatment at least once in their life. As displayed in Figure 6, different forms of physical and verbal abuse were common experiences for most children. The testimonies of the children demonstrate how domestic violence has affected their life.

- *"I am now living with my aunt. My father was killed and we don't know up to now where my mother is. My aunt does not love me. Sometimes she cooks only for her own children while I remain with an empty stomach. I would so much like to have someone who cares for me" (boy FAFF, 10 years, Ngihema)*

- *"After my parents died, I went to stay with my aunt. She beat me all the time. She maltreated me so badly that I ran away with the help of my friends. I went to stay with a friend, but she told people that I was stealing money from her so I had to move again. Another friend brought me to her house and at the beginning things were fine. But now I want to leave the house again, because her mother starts beating me and I have to do so much housework." (girl FAFF, 18 years, Kolahun town)*

Differences between the case and the control group become apparent on the variable of verbal violence (see figure below). Boys and girls FAFF have been more often subjected to verbal violence [for girls ($\chi^2(1) = 5.72$; $p \leq 0.05$) and for boys ($\chi^2(1) = 13.28$; $p \leq 0.01$)]. Furthermore, girls FAFF were highly more often sexually abused ($\chi^2(1) = 11.15$; $p \leq 0.01$) than girls of the control group.

Gender comparisons indicate that boys and girls were equally exposed to physical abuse, verbal violence and neglect [for physical abuse ($\chi^2(1) = 0.00$; $p > 0.05$), for verbal violence ($\chi^2(1) = 1.80$; $p > 0.05$) and for neglect ($\chi^2(1) = 1.28$; $p > 0.05$)]. Not surprisingly, girls were highly significantly more at risk for sexual abuse ($\chi^2(1) = 33.93$; $p \leq 0.01$).

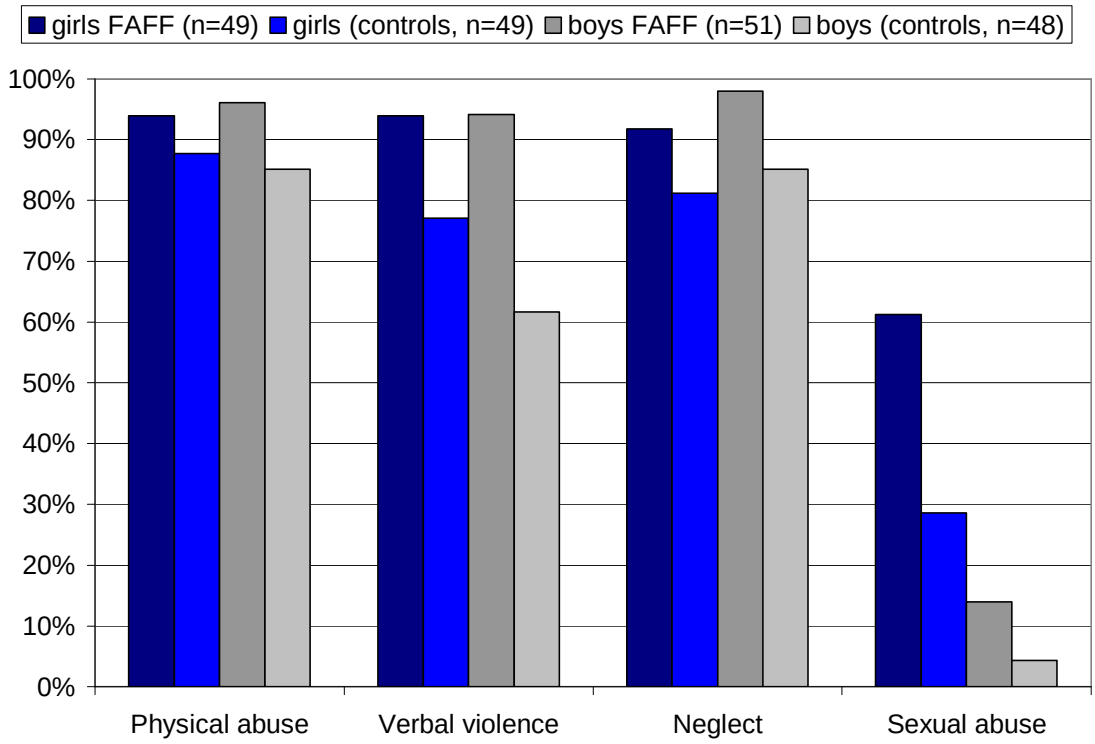


**Figure 6: Exposure to different forms of domestic violence (life-time)**

6.9.1 Sexual abuse and engagement in transactional sex

Sexual abuse was assessed if a child

- had been touched against his/ her will in intimate body parts by a person much older than him/ her or
- had been subjected to vaginal or anal penetration against his or her own will.

Transactional sex, meaning sexual relationships with several clients in order to receive money or goods, was not classified under sexual abuse but assessed separately.

More than 45% of the girls and slightly over 8% of the boys had been subjected to sexual abuse at least one time in their lives. As illustrated in the Figure 6 (above), girls FAFF were the most vulnerable group with an abuse rate above 60%. Sexual violence attained high levels during the war. Most testimonies of the girls refer to rape and gang rape during rebel attacks and refugee invasions. All but one of the sexual abuses of boys had also occurred during the war. The incidence of sexual violence has decreased after the war, however, the case studies show that an important number of girls were still lacking protection from sexual abuse.

- *"After the war, when I was 14 years, my mother decided to send me back to school in Kolahun town. I had to drop out one year later. The 45 year old teacher approached me and I became pregnant. I have a baby now, but apart from my mother no one helps me to take care of it. The teacher denies what happened and refuses to pay for the child." (girl, control group, 17 years, Ngihema)*
- *"I was forced to have sex several times during my time with the rebels. But even last week, a man caught me not far from my place and raped me. All my family members are dead. There is no one to protect me." (girl FAFF, 18 years, Kolahun town)*

Out of the interviewed girls' sample, more than 28% of the girls had at least one time in their life slept with someone in order to receive money or goods in return. Generally, the girls made themselves available for men in order to be able to cover basic living resources and, sometimes, to pay their school fees. Girls who had been sexually abused in their life were highly significantly more likely to be involved in transactional sex ($\chi^2(1) = 38.49$; $p \leq 0.01$). In line with these findings, girls formerly associated with the fighting forces were also more often involved in transactional sex than the comparison group ($\chi^2(1) = 4.70$; $p \leq 0.05$). As a consequence, former girl soldiers are particularly vulnerable to STI including HIV.

The testimonies of the case studies show that girls sometimes opt for illegal abortions under dangerous circumstances. As abortions are not done in hospitals, the girls seek help from traditional healers or swallow chemical products in order to abort. Moreover, the high rate of rape and gang rape during the war and the considerable number of girls involved in transaction sex has created a phenomenon of young and non-supported mothers who don't know the father of their child or who have no support from him.

- *"While I was trying to recover from the deaths of my parents, my older sister got sick. She tried to abort a baby, but it did not go well. She was brought to the Kolahun hospital, but it was too late. She died in August 2007." (girl, control sample, 14 years, Kolahun town)*
- *"After my life as a bush wife, I was all by myself and did not know where to go. I finally went to Monrovia in order to find someone to support me. In Monrovia, six men made me drunk and made love to me. I became pregnant, but unfortunately I could not remember the faces of the man. In order to find someone to support the pregnancy, I had sex with many men, hoping that one of them would belief that he was the one who made me pregnant. But when I was six months pregnant, I was still without a father for the baby. I decided to abort and went back to Foya afterwards. I am still a sex mate to different men and I go around town and insult women that I will take their husbands for making love." (girl FAFF, 15 years, Foya town)*
- *The last terrible event in my life is when I got pregnant, but I did not know whom I was pregnant from. I felt like dying. I did not know what to do. They refused to help me with the abortion at the hospital, so I had to use traditional medicine. It worked but up to now, I am suffering from constant stomach aches." (girl FAFF, 18 years, Kolahun town)*
- *"When I got pregnant, I was sick for weeks. I thought I must die. The baby was born without major problems. But we are both often sick. The father refuses to recognize the child and we have no one to support us."(girl, control group, 17 years, Ngihema)*

### 6.10 Exposure to domestic violence during the war

Maltreatment was a common experience for many children during the war, and, as visible in the figure below, particularly common for children associated with the fighting forces. Both, boys and girls of the exposure group were more physically and verbally abused than the children of the control group [for physical abuse: girls ($\chi^2(1) = 10.61$; $p \leq 0.01$), boys ($\chi^2(1) = 17.21$; $p \leq 0.01$) and for verbal violence: girls ($\chi^2(1) = 11.91$; $p \leq 0.01$), boys ($\chi^2(1) = 18.05$; $p \leq 0.01$)]. Girls associated with the fighting forces were also more neglected and more often sexually abused than their peers of the control group [for neglect: ($\chi^2(1) = 11.23$; $p \leq 0.01$) and for sexual abuse: ($\chi^2(1) = 16.11$; $p \leq 0.01$)].

The gender comparisons showed that boys were more exposed to neglect than girls ($\chi^2(1) = 9.93$; $p \leq 0.01$) during the periods of armed conflict while girls were more exposed to sexual violence ($\chi^2(1) = 6.68$; $p \leq 0.01$).

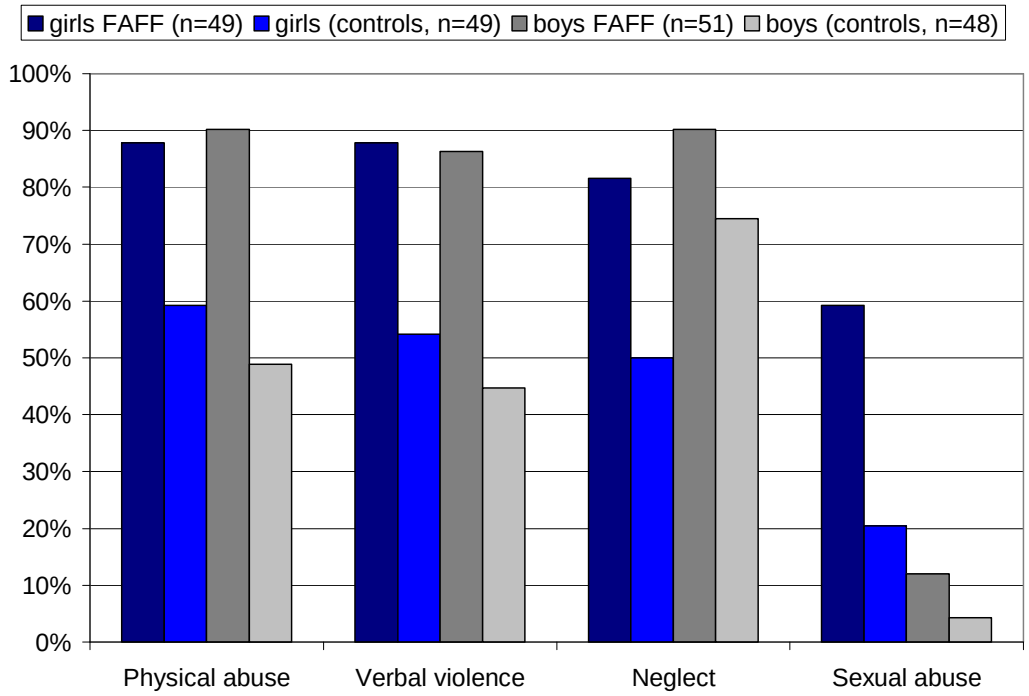


**Figure 7: Exposure to different forms of domestic violence during the war**

### 6.11 Recent exposure of children to domestic violence

In order to ascertain current incidence of domestic violence, we asked the children who had reported a life-time experience of domestic violence whether this type of violence had also taken place in the past month. The rates of children subjected to different forms of domestic violence are summarized in Figure 8. The most common form of maltreatment is neglect that concerns about 50% of the children. Group comparison confirmed that there are no significant differences between the exposure and the control samples. Gender differences, on the other hand, became apparent: girls were significantly more often exposed to ongoing physical abuse ($\chi^2(1) = 4.82$; $p \leq 0.01$) and to ongoing sexual violence ($\chi^2(1) = 10.69$; $p \leq 0.01$) than boys.

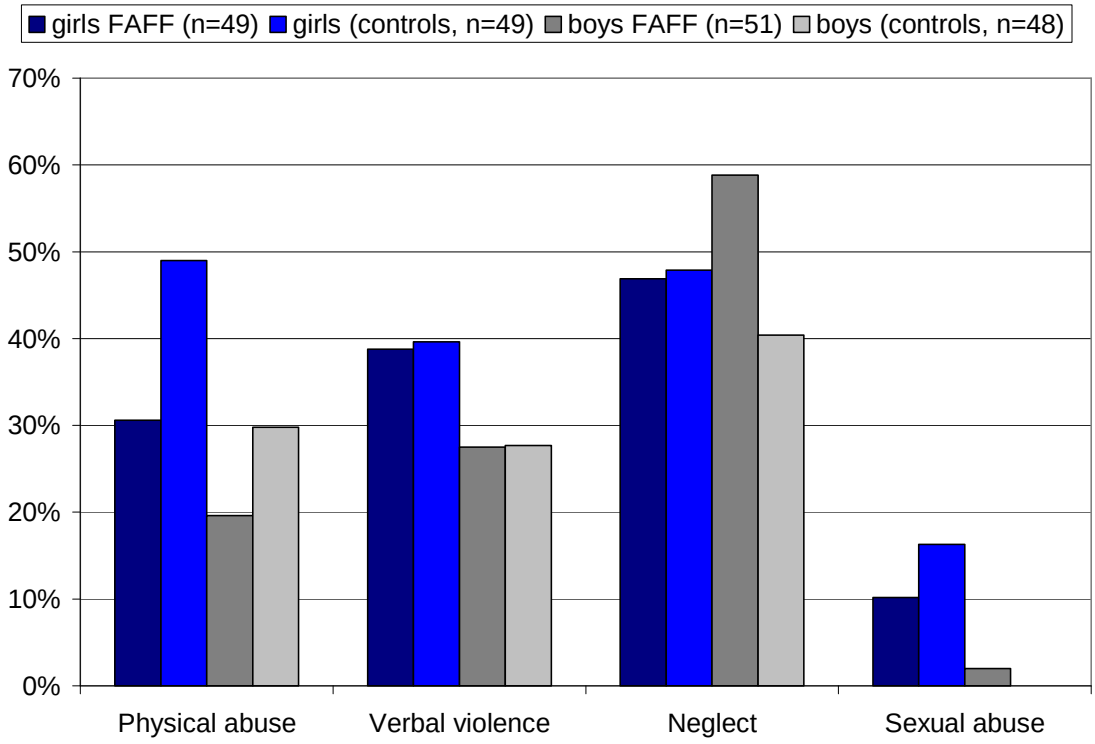


**Figure 8: Ongoing exposure to different types of domestic violence**

### 6.12 Risk factors for domestic violence

As domestic violence is a widespread phenomenon in the interviewed sample, we conducted a risk factor analysis in order to better understand the profile of maltreated children. We used physical abuse and neglect as determining variables for risk of maltreatment. The results of the analysis showed that:

- fostered children were more often exposed to ongoing neglect than children living with one or both parents ($\chi^2(1) = 9.70$; $p \leq 0.01$), but not more to physical abuse ($\chi^2(1) = 0.77$; $p > 0.05$);
- younger children were more often neglected ($t(196) = -3.84$; $p \leq 0.01$) and maltreated ($t(194) = -4.95$; $p \leq 0.01$) than older participants;
- ethnic group affiliations were no indicator: no significant differences were found among the participating ethnic groups in regard to domestic violence;
- there were no significant differences between Christian and Muslim participants regarding the exposure to domestic violence;
- education levels did also not represent explaining factors for ongoing domestic violence.

### 6.13 The most distressing event experienced ever

We asked all children during the interview to let us know which life experience had been the most frightening and difficult to cope with. The responses to this question are clustered in six categories and summarized in Table 9. Several children could not designate one particular experience as their worst event because they had been exposed to multiple traumatic events. These cases were not included in the event typology. More than half of the answers are classified the category "*torture or murder of a loved one*". Many children are still having nightmares and intrusions about family members getting tortured or assassinated. Some children had to witness the event or were even forced to harm a family member themselves. Others got separated from their parents and learnt later about the circumstances of their death. They still struggled to fully belief what happened or are still distressed because they could never say goodbye and organize a proper burial ceremony from them. Feelings of guilt are also often named. The children blame themselves for not having acted differently in a situation where a family member was killed.

- *"We fled into the bush when Kolahun was attacked and went back when things calmed down. My parents went back to our house for food, but were captured in front of the house by government forces. When we arrived at the house, our parents lay there dead. They had cut their throats and left them there, bleeding to death". (girl, control group, 14 years, Harleypo)*
- *"When government forces attacked, I and my parents including my bigger sisters and brothers were trapped in the house. they pointed the weapons at us and forced us to come outside. The soldiers wanted to take my two bigger sisters as wives. As my older brother tried to beg them to leave them with us, they took him behind the house and cut his throat. They took my sisters away and I have never seen them again. I was also raped three times. Even last week it happened again to me because I have no caretaker or family member to help me any more." (girl FAFF,18 years, Kolahun town)*
- *When the war started, I got separated from my parents. I escaped into Sierra Leone, leaving my parents behind me. I just ran without looking back. I learnt later that my father was captured, beaten and almost killed. A bit later he died from internal bleeding. I feel bad about not having assisted him and still wish I would have stayed to assist him. (boy, control group, 19 years, Kolahun town)*
- *"I was hiding in the bush, when the LURD forces found me and took me with them. For the time coming I became a bush wife of several men. Life was awful with them and I was thinking about running away all the time. When I later met my uncle in Guinea, he told be that my father had been killed by the LURD forces. I did not even see his body and could never say goodbye to him." (Girl FAFF, 16 years, Harleypo)*

Further important categories included *"war atrocities*", (witnessing sexual violence and assassinations, being forceful abducted or forced to kill someone, undergoing military training etc.) and the death of disappearance of a family member (excluding murder).

- *"When we heard that the LURD forces had taken over Kolahun, my parents, brothers and sisters went into the bush to be safe. While trying to go near an old farm to get Cassava leaves, I and my older brother were arrested. We were beaten bitterly. We were forced to carry loads for them to Kolahun town. I could escape, but my brother was caught and killed." (boy, control group, 18 years, Ngihema)*
- *"In 2001, when LURD forces attacked my home, I was in the bush. Before I could come back to town to meet my parents, everybody was gone, including my parents. I was so scared that they were killed. A friend and I struggled over three days in the bush before we could make it to Sierra Leone. I was so worried about my parents. Arriving in Sierra Leone I was informed that they were also looking for me so I quickly went to their place. I was full of joy when I saw them." (boy, control group, 17 years, Foya Tengia)*

Remaining categories for the most terrifying experience were "ongoing domestic violence", "rape or attempted rape" and "encounter with wild animals or supernatural powers". Nine of the interviewed girls named rape or attempted rape as their most terrifying experience. Apart from the category "rape", there were no notable differences between boys and girls regarding their most difficult experience. Children involved with the fighting forces, however, were more likely to name a *war atrocity* as their most terrifying experience while children of the control group named more frequently the category *torture or murder of a loved one*.

**Table 9: Categories of the most disturbing events ever lived by the children**

| Event category | Total sample (*n*=173) | CFAFF (*n*=92) | Control group (*n*=81) |
|---|---|---|---|
| Rape | 9 (5.2%) | 7 (7.2%) | 2 (2.5%) |
| Torture/ murder of a loved one | 87 (50.3%) | 41 (44.6%) | 46 (56.8%) |
| War atrocity | 33 (19.1%) | 23 (25.0%) | 10 (12.3%) |
| Ongoing domestic violence | 14 (8.1%) | 7 (7.6%) | 7 (8.6%) |
| Death/ disappearance of a loved one | 24 (13.9%) | 13 (14.1%) | 11 (13.6%) |
| Encounter with wild animal/ supernatural power | 6 (3.5%) | 1 (1.1%) | 5 (6.2%) |

## 6.14 Mental disorders

The diagnostic criteria for psychological disorders do not only require the existence of psychopathological symptoms, but also a critical impairment of the social and professional capability of children in day-to-day activities, for example, not being able to succeed in school and not having any friends because of disturbed behavior. Although we excluded children with obvious psychosis during the sampling process, we still found a very high prevalence of mental disorders among the children in the study. The

symptoms appeared at moments were the coping resources of a child were greatly defeated. They were sources of inconvenience to the children and severely bothered and upset them in every day life. Children with severe mental disorders, marked by "bizarre" or aggressive behavior, reported that they were stigmatized, mocked and sometimes punished.

- *"While I was trying to get over the death of my parents, my bigger sister on whom I totally depended, died from illegal abortion. That was last year. Since then, life has been very frustrating and painful. I did not recognize myself as a human being for two months. All my hope and positive relationships have been destroyed….I feel like this event is a curse from God." (girl, control group, 14 years, Harleypo town, suffering from Major depressive disorder and PTSD)*
- *"They say that my father was a general of rebel forces and I myself was a bush wife. I don't trust anyone. I drink, gamble and offer my services to men. I am alone because people don't accept my way of living. I can't go near other people. I feel hopeless and very tired, but people say that I am aggressive." (girl FAFF, 15 years, Foya town)*

### 6.14.1 Mood and anxiety disorders

In the result presentation of mood and anxiety disorders, we will focus primarily on major depressive disorder and post-traumatic stress disorder (PTSD). These two mental disorders were strongly represented in the interviewed sample, both in the control and the exposure group. The overall prevalence of major depressive disorder was 48% in the interviewed sample; PTSD rates were considerably higher at 72.7%. These numbers are disquieting and show that many children in Lofa County suffer from impaired mental health. As visible in the figure below, girls and boys formerly associated with the fighting forces were significantly more impaired by major depressive disorder [for girls: ($\chi^2(1) = 20.56$; $p \leq 0.01$); for boys: ($\chi^2(1) = 9.90$; $p \leq 0.01$)]. Regarding the PTSD prevalence, difference between the exposure and the control group were also highly significant ([for girls: ($\chi^2(1) = 14.69$; $p \leq 0.01$); for boys: ($\chi^2(1) = 9.31$; $p \leq 0.01$)]. The comparison between boys and girls, however, were not significant [for Major Depressive disorder: ($\chi^2(1) = 0.02$; $p > 0.05$); for PTSD: ($\chi^2(1) = 0.15$; $p > 0.05$)].

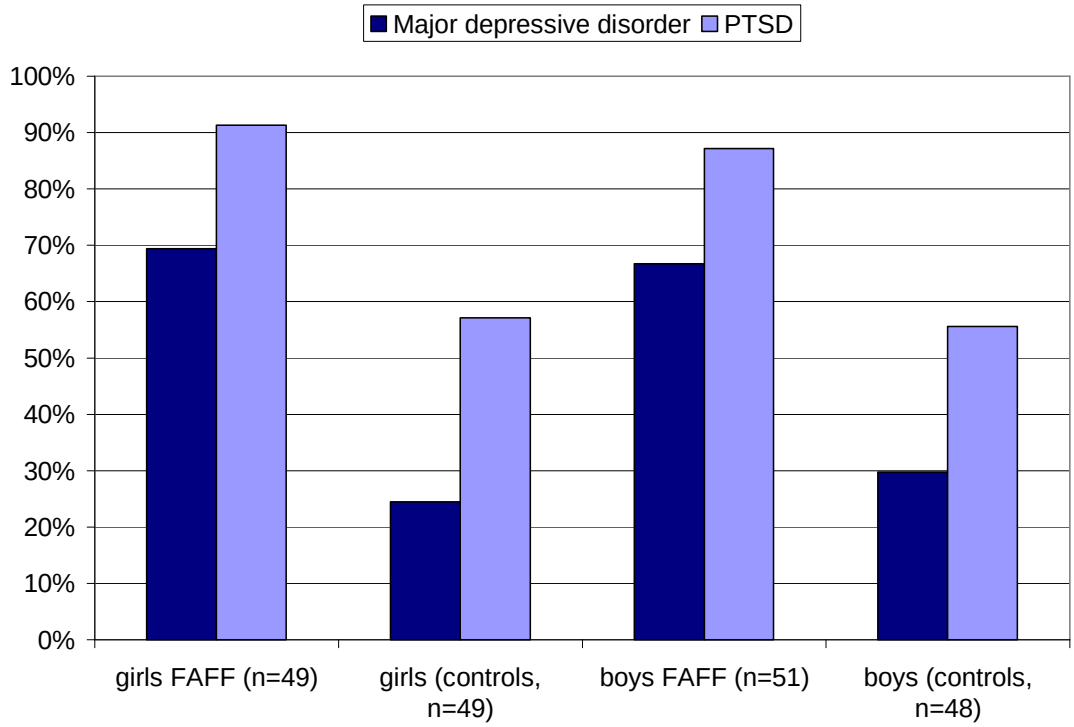


**Figure 9: Prevalence of mood and anxiety disorders in the different sub-samples**

6.14.2 Substance related disorders

We assessed systematically with all children whether or not they consume regularly alcohol or drugs (medical and traditional). An alcohol or substance dependence was only indexed if the subject has over the past 12 months:

- developed a tolerance towards the substance,
- withdrawal symptoms as soon as it stops consuming the substance,
- shown lack of control regarding the consumption of the substance,
- spent a lot of time to get or consume the substance and
- abandoned or reduced important social, professional and leisure related activities due to the consumption of the substance

Substance abuse is a less severe phenomenon that is quite common in adolescents. It is indexed if there is a “pattern of continued pathological use of a medication, non-medically indicated drug or toxin, that results in repeated adverse social consequences related to drug use, such as failure to meet work, family, or school obligations, interpersonal conflicts, or legal problems” (cited after Wikipedia 2008). The frequencies

of substance related disorders in the four sub-samples are displayed in the figure below. We differentiated between alcohol related disorders and substance related disorders.
In general, substance related disorders were rarely assessed. There were only three participants reporting alcohol dependence and five participants described symptoms of substance dependence other than alcohol. This is somehow amazing taking into consideration that drug abuse was common during the war. The low rate might be due to reporting bias or to limited access to drugs in the children's current locality.

6.14.3 Disorders usually diagnosed in childhood and adolescence

A diagnosis of conduct disorder requires that the child had exhibited persistent and repetitive antisocial behavior over a period of at least one year including:

- aggression towards people and animals,
- destruction of property,
- deceitfulness or theft,
- serious violations of rules.

The rate of identified conduct disorders was low: only eight of the interviewed children, five girls and three boys, showed conduct disorders. As a matter of fact, many children put to view aggressive behavior before, during or after the interview. They did not comply, however with all mandatory diagnostic criteria for conduct disorder.
The diagnosis of attention deficit/ hyperactivity disorder (ADHD) requires a group of signs and symptoms including distractibility, difficulty to concentrate and to focus, forgetfulness, problems organizing ideas, tardiness, impulsivity, and difficulties in planning and execution. These are common symptoms that were only classified as a "disorder" if they seriously impaired the performance in school and relationships with others, or if they were a source of anxiety or depression. Among the children in our study, ADHD, just as conduct disorders, were uncommon: only seven of the girls fulfilled the criteria. The children with ADHD encountered difficulties to stay focused during the interview and to sit still for longer periods of time. Usually, several appointments were necessary in order to complete the entire set of questionnaires with them. They also reported the same difficulties at school or at home.

## 6.15 Results of the focus group discussions with the children

As described in the methodology section, the focus groups were structured around standardized stories of children with difficulties. The aims of the focus group discussions were to gather information about what kind of help the children would like to receive when confronted with situations of distress. All together, seven focus group discussions were conducted in five research communities.

The children identified themselves easily with the main character of the stories. Some showed signs of distress during activity: the short story about a child suffering from bad war memories and the experience of a girl having lost her parents reminded them of their own painful experiences, similar to those of the story character.

They children singled out without difficulty a large scale of feelings for the stories' character:

- feelings of fear and trauma: helplessness, feeling like a "slave", feeling to end one's life (suicide), feeling like that bad thing (war trauma) is going to happen all over again.
- feelings of sadness and depression: feeling to be abandoned, frustration, hopelessness, anger, discouragement, shame and guilt;
- feelings of loss: missing the dead parents or other family members.

The children did not only name the feelings, but also brought forward direct consequences of their emotions: crying, loss of interest in things, constant worrying, isolation and desire to run away from home. The different solutions proposed by the children on how to ease the suffering of the story's characters can be grouped in three answer categories: external support for immediate needs, emotional support and internal coping strategies.

- External support for immediate physical needs: the most frequent answers were suggestions related to support from community members either by peers, parents or health personal (for somatic problems). The participants proposed giving medication or money to the child in need of help and to share food with him.
- Emotional support: further suggestions to ease the suffering of a story character were to show love and affection, to talk to the child and to encourage him/ her to forget about his/her problem. The children also pointed out the importance not to isolate the child, but to be with him/her during the difficult moments. In case of

domestic violence, the children sought it best to ask community elders to mediate or to send their parents in order to calm down the violent caretaker.

- Internal coping strategies: the children recommended also several individual coping strategies for a distressed story character: to go and play with peers, to ask for forgiveness, to go to the mosque or the church or to join homework groups. These strategies point out spiritual and societal resources for overcoming difficulties.

The answer categories indicate that children refer to individual, peer, family and community based resources rather than to external supporting or protective structures. None of the children suggested, for instance, getting help from institutions such as the state departments or non governmental structures. A more important resource for them seems to be religious establishments where people can socialize and ease their suffering in individual and group prayers.

# 7. Result synthesis and discussion

The findings of the current study assessed the psychosocial impact of the war and the post-war context on children in Liberia. The data collection was carried out in Lofa County, one of the most war affected areas of the country. We assessed diverse social and psychological factors determining the mental health of children and compared the mental health outcomes of a sample of children formerly associated with the fighting forces to a control group. The conclusions and recommendations of the current study are supposed to orientate and to improve psychosocial interventions focusing on children in African countries recovering from long periods of armed conflict.

Our findings imply that the armed conflict has up to now a severe impact on the mental health of children in Lofa County. Both, children of the exposure and of the control group show difficulties to overcome the war related experiences and to re-construct their lives in their community of origin. In the following sections, we will discuss the various effects of the war and the post-war conflict on the development of children (7.1). In a second step, we will discuss the results of the comparison of the exposure and the control group. Additionally, we will try to shed light on factors contributing to the impaired resilience of children formerly involved with the fighting forces (7.2). Within the paragraphs, we will also highlight the differences between boys and girls.

## 7.1 Effects of the war on the development of children

Some of the immediate and most devastating effects of the war on the psychosocial development of children were the:

- Exposure to highly traumatizing, inhuman and life-threatening events: in Lofa County, only a few children of the study population were spared from war atrocities. Most children have witnessed or committed themselves torture and assassinations, sexual violence as well as looting and destruction of properties. At this point we would like to highlight the particularly revolting nature of the armed conflict in Liberia. The rebel powers reversed society values and rules in order to humiliate and control their victims. This reversal of society rules became a powerful tactical weapon in the armed conflict of Liberia. Entire population groups were exposed to violations of most fundamental norms of humankind: children were separated by

force from their parents. They were converted into “assassins” and “bush wives” and lived over long period under permanent death threat and had to witness many people dying. Many of them had to witness torture, rape and killing of family members; they were forced commit themselves atrocities and they were subjected to worst forms of sexual, verbal and physical abuse. The repercussions of these experiences are visible in the high rates of mental illness and suicidality.

- Displacement and separation of families: All families encountered during the current study were displaced during the war. The repeated rebel attacks and fighting between dissident and government troops in Lofa County forced an entire civilian population to flee the area. During the long period of displacement, children were separated from caregivers, and families as a whole were disunited. Events like captures by fighting forces, camp invasions and forced recruitments contributed as well to the disconnection of families.
- High general mortality rate during the war: Many civilians and rebels were killed during the war or died prematurely due to straining living conditions and lack of availability of health care. As a result, many children lost parents and other relatives. Thus, family resources and safety nets for child care, education and protection have been largely decreased and have not been re-constructed since the war ended.
- Looting and destruction of infrastructures and properties: the rebel invasions in Lofa County lead to demolition of trading, communication and farming facilities. Properties were pillaged and destroyed and many families lost from one day to the other all their savings and economic resources. At the present time, most families sustain their living with small scale agriculture. They maintain small farms that enable them to survive, but not to escape poverty and malnutrition.
- Life in refuge: Most children spent significant periods of their lives in refuge where socio-economical constraints, persistent insecurity, repeated relocations and camp invasions overshadowed their childhood. The instable living conditions and recurrent exposure to life-threatening experiences *over years* have lead to chronic symptoms of post-traumatic stress not among children.

### 7.1.1 Break down of family support systems and poverty of caregivers

The dynamic of the above listed features has generated a multitude of negative consequences and sub-consequences for the development of all children in Lofa

County. We would like to particularly highlight the consequence of the weakened support and solidarity of family and community systems. The daily strive for basic living resources, influences of globalization and the emotional recovery from the war have changed the perceptions on responsibility and family solidarities in many households. The disconnection of families and the high mortality during the war have resulted in high rates of children without parental support. At the present time, the communities have to provide foster care for more children than ever before although their economic resources have greatly decreased. Many caregivers seem to have adopted the attitude “my own children first” and provide only educational and nutritional support to their own children while the only support given to the fostered children is the mere provision of shelter. Others are reluctant to support children who had been associated with the fighting forces because they fear that their negative stigma will be of disadvantage to the reputation of their family. The deteriorated traditional foster care system is one of the main factors affecting many children in Lofa County. Another factor is the extreme poverty of many caregivers: every day many guardians are facing the challenge of nourishing and supporting several children with little income. In many cases, they cannot afford the most basic supplies such as dry shelter, proper clothes and food. The combination of circumstances – exposure to violence and life-threatening events, poverty and the destruction of family safety nets – have lead to pathological coping mechanisms among adults and children. As a result, three years after the war, we find a very elevated rate of mental disorders in children.

## 7.2 Mental health of children formerly associated with the fighting forces in Lofa County

As described in the section above, many children were exposed to a multitude of war related violence and other life-threatening experiences. The majority of children have been exposed to different forms of domestic violence. Although the general exposure to life threatening events was elevated, children formerly associated with the fighting forces represented a particularly vulnerable group: they were notably more exposed to events such as being surrounded by dead bodies, witnessing torture and killings or burning and looting of houses. The rates of sexual violence were generally high during the war, but girls formerly associated with the fighting forces were significantly more often sexually abused than their peers of the control group.

The experiences of the children during the war and their current living situation have a considerable impact on the mental health of former child soldiers. Compared to the control group, they had

- less indicators of resilience and emotional well being,
- a higher suicidality and
- a higher rate of PTSD and major depressive disorder.

In addition, girls formerly associated with the fighting forces were more likely to be involved in transactional sex than girl participants of the control group. There were no noteworthy differences regarding self-esteem and pro-social skills between the children formerly associated with the fighting forces and the control group. However, there was not a single variable on which the exposure group scored *better* than the control sample. We will discuss in the following sections what factors contribute to the impaired mental health of child soldiers.

### 7.2.1 Building block effect and less parental support

The analysis of the impact of traumatic life experience showed that the quantity and the intensity of exposure to adversity play a role. No matter how strong the resilience of a child is, if distressing events keep accumulating, the defense mechanisms will break and the child will develop severe mental disorders and/ or a high suicidality. This conclusion is in line with previous research results and is known under the term of “building block effect” or “dose effect relationship”: the higher the number of traumatic life event, the higher the probability of an individual to be severely mentally ill (Schauer, Neuner et al. 2003). As children formerly associated with the fighting forces had a notably higher exposure rate to traumatic life experiences, it can be to some extent expected that they are more prone to mental illness than children with a lower exposure rate. Furthermore, former child soldiers were more likely to have lost a parent during the war. As a consequence, they are more likely to be affected by grief and by lack of support in day to day life.

### 7.2.2 Limited reach of DDRR activities

Only seven of the participating former boy child soldiers and none of the girl participants had participated in DDRR activities. Many of them were excluded from the activities due to the fact that they were not able to hand in ammunition or weapons at the end of the

war. Others deliberately chose *not* to participate due to fear of stigmatization. It seems like many children did not want or did not have access to the projects providing assistance for the rehabilitation and reintegration of former child soldiers. The findings generate the hypothesis that DDRR and assistance project primarily targeted children who have carried weapons and who participated in combat. Children, on the contrary, who had been predominantly recruited for domestic and sexual services, rarely received assistance. As a consequence, most girls, who have been forcefully abducted as "bush wives", were not benefiting from support and have to overcome the trauma of multiple sexual abuses and death threats without any help.

### 7.2.3 Being judged as a perpetrator

Children who have taken actively part in combat, torture and "punishments" of civilians are often perceived by community members as perpetrators. Since the end of the war perpetrators and victims have to live next to each other. Thus, feelings of revenge and dislike are likely to be projected on former child combatants. They are blamed and thought to be guilty for the loss and destruction that happened during the war. The former child perpetrators, on the other hand, feel often guilty and confused about the stigmatizing treatment that they receive. Lacking appropriate coping mechanisms, they react with aggressive and insulting conducts that reinforce their rejection from other community members. The resulting dynamic had lead to marginalization of former child soldiers which affected negatively their mental health and their reintegration. This observation, however, was only valid for children who were implicated in war atrocities and cannot be generalized to the large number of children who were part of a fighting force, but predominantly used for other services than combat.

### 7.2.4 Correlation between life-time sexual abuse and engagement in transactional sex

The study findings generate the hypothesis that sexually abused girls are more likely to become engaged in transactional sex. Former girl combatants had the highest rate of sexual abuse and they were also the most likely to be found in transactional sex relationships in the post war context. Almost 30% of the interviewed girls had offered sexual services in return for presents, goods or money. Girls become a "men's friend" in order to pay their school fees, other educational needs as well as basic living resources. Girls engaged in transactional sex are not necessarily living in extreme poverty. They

need sometimes simply supplementary external support in order to achieve their goals in their professional life or for their socialization (clothes, jewelry, and perfume). The majority of girls, however, perceive transactional sex as their only option to sustain a life for themselves and their family.

Although transactional sex enables girls to find short-term solutions to their problems, the results of the current study illustrate to what extent it puts the future of the girls and their progeny at risk. First of all, condom use is unusual for transactional sex: most men are unwilling to pay or give less if obliged to use a condom. As a consequence, girls engaged in transactional sex are at high risk of STI including HIV. The follow-up project gave an idea about the spread of STI among girls engaged in transactional sex. As a matter of fact, many of the girls participating in the follow-up project were diagnosed and received medical assistance for the treatment of STI. Evidently, the high prevalence of transactional sex is a catalyst for the spread of STI including HIV in Lofa County. The findings of the study indicate that girls formerly associated with the fighting forces are especially vulnerable to STI.

### 7.2.5 Teenage pregnancy, abortions and progeny without father

Another side-effect of the transactional sex is a high rate of teenage pregnancy. As soon as a non-married girl turns out to be pregnant, she becomes very vulnerable: her needs increase, but she has less possibilities to earn money and family members often punish the pregnant girl for harming their reputation by refusing to assist her. Girls in lack of support often opt for illegal abortions without professional assistance and suffer afterwards from gynecological problems.

Furthermore, once the baby is born, the majority of girls cannot count on the father's support. The girls are either unable to determine the identity of the father as they had relationships with multiple partners or are abandoned by the man responsible for the pregnancy. All of the young mothers enrolled in the follow up have no father to support their babies. They have to raise their children on their own with little assistance from their families and often drop out of school lacking means to continue their education with the new financial burden of supporting a child. Many girls were forced to continue transactional sexual relationship as soon as they had delivered in order to be able to provide basic living resources for themselves and their child. This resulted, of course, quite often in a new pregnancy and the young non-supported mother of two children was

obliged more than ever to sustain her living through transactional sex. The only way to break out of the vicious circle of steadily increasing needs due to the growing number of children is if the mother finds a husband that accepts to marry her and to support her and her children.

Teenage pregnancy and motherhood are not problems unique to girls formerly associated with the fighting forces. It is a general problem of the post war context in Lofa country. Our findings implied, however, that girls formerly associated with the fighting forces are particularly likely to be found in the group of young and non supported mothers.

# 8. Conclusion et recommendations

Armed conflicts have largely inhibited the development of Sub-Saharan Africa. The consequences are manifold. Yet, the impact on well being and mental health is one of the most significant, and affects in particular vulnerable groups, such as children formerly associated with the fighting forces. The results of the current study are startling/ disquieting and contribute to the existing evidence that it is imperative to provide psychosocial support to children directly affected by decades of armed conflict in Africa.
In order to avoid further stigmatization of former child soldiers and to enhance their reintegration, we recommend developing a holistic and integrated project approach to vulnerable children, with particular components taking into account the specific needs of girls. We have divided the recommendations for such a multisectoral approach in four sections: (1) Strengthening the capacity of caregivers to support their children, (2) Building up the resilience of children and protecting them from violence, (3) Providing individual psychosocial support to severely affected children, in particular children formerly associated with the fighting forces and (4) supporting girls enrolled in transactional sex and teenage mothers.

## 8.1 Strengthening the capacity of caregivers to support children

Parents and guardians are overstrained by livelihood activities, by their own trauma and by tasks related to education and child care. Assistance programs are needed to help the parents and guardians to fulfill their responsibilities. As children's difficulties are intertwined with the difficulties and coping capacity of their caregivers, we recommend focusing a principal part of assistance activities on caregivers and not directly on children. By accompanying guardians in their daily educative and care giving tasks, the well-being of the children can be significantly improved. We propose to create dialogue spaces for parents and guardians at community level where information on child care can be delivered and discussed. Guardians can exchange about problems, identify solutions together and construct solidarity systems. For the creation of these exchange spaces, we recommend to train and support local NGOs, present and appreciated at community level, to organize and facilitate meetings with guardians and to make use of

this space to provide psycho-education to parents about the needs of children. Important aspects to address with guardians/ parents will be, for example,

- how to provide and establish better supporting systems for fostered children;
- how to help children to overcome the loss of their parents and how to support grief processes;
- how to support children who are ostracized due to their implication in the war;
- how to help and talk to a child reporting sexual abuse and what measures to take;
- the devastating impact of neglect and other severe forms of domestic violence;
- how to address behavioral disturbances such as bedwetting and sleeping problems;
- symptoms of neurological and other severe illnesses;
- socio-professional reintegration of school drop outs.

It is important that caregivers receive and discuss information on how to respond to the psychosocial needs of children of different age groups. The goal is to help caregivers to understand in which way children express themselves and to show them how to support children when they are distressed, how to answer questions kindly and simply and how to communicate to children that they are safe and appreciated.

### 8.2 Building up the resilience of children and protecting them from violence

The first strategy *"Strengthening the capacity of caregivers to support children"* contains already important elements for assisting parents in educative tasks and for decreasing domestic violence. In the scope of the current strategy, we would like to propose further activities to support affected children to cope with their difficulties and to reinforce child protection at community level. In order to reach large numbers of children, we recommend collective activities targeting groups of children in different communities. The goal of the strategy is, as a first step, to identify and to create protective spaces where children can express themselves and are listened to and, as a second step, to organize and facilitate activities in these spaces. The following sites are examples for potential protective spaces where children can meet without creating stigmatization.

- Children clubs and networks;
- Small and large group games as well as sport events (soccer games etc.);
- Theater and drawing sessions;

- Child radio programs;
- Religious group gatherings.

Once an adequate framework for protective spaces is identified, key actors for child protection, namely local NGOs and community based organizations, are suggested to be trained on how to provide collective psychosocial support in the scope of these protective spaces. Recommended activities could be, for example,

- Games stimulating expression and listening to each other,
- Fairy tale sessions for encouragement and transmission of values,
- Group reflections for identifying solutions for common problems in order to reinforce peer support mechanisms (difficulties in school performances, household chores etc.),
- Exercises to build up self confidence,
- Role plays about difficult situations for comprehending the distress of peers,
- Social games for decreasing stigmatization associated with certain types of illnesses (like epilepsy, HIV), with the family status (e.g. a mentally ill mother) or implication in the war (children formerly associated with the fighting forces).

It is important to encourage in the scope of these different activities different modes of expressions, such as singing, dancing, praying or organization of traditional rituals. The community members should be involved as much as possible in the implementation of these activities. Recurrent collective activities with children will allow the facilitators to identify severely affected children who need more specific and intense support than the majority of their peers. They can be referred, as outlined in the next section, to psychosocial mobile units for severely affected children.

### 8.3 Providing individual psychosocial support to severely affected children, in particular children formerly associated with the fighting forces

The project module proposed for the implementation of this recommendation is based on two sections: (1) the creation of a network for the identification of vulnerable children and (2) the set up of specifically trained mobile psychosocial support and protection unit. The study has revealed increased needs of psychosocial support among children formerly associated with the fighting forces. Many of them have been chronically traumatized and have developed such maladaptive coping strategies that individual support is needed in order to provide sustainable and efficient assistance. However, there is no doubt that

there are also other groups of vulnerable children that require specific and individual support. The strategy outlined in the following paragraph is meant to identify and assist the most severely affected children. We recommend that children formerly associated with the fighting forces and other vulnerable groups (such as teenage mothers) are systematically screened. If they show certain indicators of severe distress (e.g. ongoing relentless domestic or sexual violence, high suicidality), they are to be integrated in the project module for individual support.

Key actors to involve in the identification of severely affected children are community based organizations and development committees, teachers and religious leaders. We propose the elaboration of a training module to enable the above named actors to

- screen particular vulnerable groups such as children formerly associated with the fighting forces;
- recognize signs of distress and abuse in children;
- set up and accompany family mediations;
- address sensitive issues with children and know how to formulate questions;
- refer the child to an adequate assistance institution;
- follow-up on the well-being of referred children (home visits) on a regular basis and
- raise awareness about the devastating consequences of domestic violence.

It is important to mobilize a combination of actors associated with modern and traditional assistance institutions in order to reach a large number of children. In Lofa County, the church has a very strong capacity for youth and adult mobilization. We suggest assisting pastors and other church actors to transfer key messages about child protection. Another powerful tool for transmitting messages on psychosocial needs of children is the community radio.

Alongside to an operational network for child protection at community level, we propose to set up psychosocial mobile units specially trained for assisting severely affected children. All identified to be severely affected can be referred to these psychosocial mobile units. The mobile units should be permanently available. Their training level and commitment is a key factor for their success. It is recommended that the members are either clinical psychologists or specially trained social workers. The specific objectives for assisting particularly affected children are to:

- Ease the emotional suffering of the identified children and help them to build up hope;
- Take appropriate action to reduce danger and harm that the identified children are exposed to;
- Empower the children to develop new perspectives;
- Build up livelihood perspectives for these children;
- Identify and collaborate with local child protections partners for ensuring medical, judicial and social support to the identified children.

The following activities will be needed in order to provide psychosocial support:

- Counseling, trauma healing and crisis intervention;
- Family mediations and regular home visits in case of conflict and ongoing domestic violence;
- Identification of family members or other care givers that are disposed to ensure the protection of the children and to work out supporting strategies for the best interest of the child;
- Relocation of children to a safer environment in case that this represents the only solution to protect a child's life;
- Enhancing of livelihood perspectives for the child;
- Facilitating and following up on social, judicial and medical assistance.

### 8.4 Supporting girls enrolled in transactional sex

The widespread phenomenon of transactional sex represents a severe danger for the health and development of girls and their progeny. We suggest integrating a module comprising activities such as

- assistance of young mothers in child care, reproductive health, family planning and socio-professional reintegration;
- integration of an educational module on family planning, reproductive health and STI including HIV in primary and secondary schools;
- Raising awareness on HIV/ AIDS targeting particularly men: girls have little possibility to negotiate condom use in transactional sex; however, if men are aware of the risks, condom use might become more frequent;
- set up of family planning facilities that are accessible for young girls.

Finally, we would like to stress the importance for a regular project monitoring and evaluation of such a psychosocial support intervention. It is indispensable to support frontline workers, to supervise and provide regular training for all partners. Programs should not be limited to short time slots, but at least be conceptualized for at least five years.

Apart from programmatic recommendations, we would also like to highlight the importance of more research. Even though the current study makes available precious information for project development, we have to take into consideration that the small sample size represents a limitation for the reliability of the findings. Further studies investigating larger samples with a longitudinal approach are recommended to explore further the psychosocial impact of war on specific groups of children in Liberia.

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