Psychosocial needs of children without parental support in a post-conflict-area: A cross section study in the district of Kailahun in Sierra Leone

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

Alice Behrendt
May 2008
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As the author of this report, I am responsible for potential errors in the interpretations of given answers during the interviews and focus group discussions.

Dakar, the 15.04.2008
Alice Behrendt
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# 1. Abbreviations and Acronyms

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ADHD</td>
<td>Attention deficit/ hyperactivity disorder</td>
</tr>
<tr>
<td>CAFF</td>
<td>Child Associated with fighting forces</td>
</tr>
<tr>
<td>CFAFF</td>
<td>Child formerly associated with fighting forces</td>
</tr>
<tr>
<td>CWPS</td>
<td>Child without parental support</td>
</tr>
<tr>
<td>DDR</td>
<td>Disarmament, Demobilization and Reintegration</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual of Mental Disorders, 4th Edition</td>
</tr>
<tr>
<td>ECOMOG</td>
<td>Economic Community of West African States Monitoring Group</td>
</tr>
<tr>
<td>FHI</td>
<td>Family Health International</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Governmental Organization</td>
</tr>
<tr>
<td>NPFL</td>
<td>National Patriotic Front of Liberia</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PSC</td>
<td>Psychosocial Counselor</td>
</tr>
<tr>
<td>PTSD</td>
<td>Posttraumatic Stress Disorder</td>
</tr>
<tr>
<td>RUF</td>
<td>Revolutionary United Front</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nation High Commissioner for Refugees</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations’ Children Fund</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Program</td>
</tr>
<tr>
<td>WPS</td>
<td>without parental support</td>
</tr>
</tbody>
</table>
2. Executive summary

Background and objective: After several decades of political unrest and military coups, civil war broke out in Sierra Leone in 1991. A rebel formation, the Revolutionary United Front, attacked villages in the district of Kailahun close to the Liberian Border. Over the next ten years, tens of thousands of people were killed or mutilated and over two million Sierra Leonean citizens were displaced. The war was declared to be officially over in January 2002. The purpose of this study was to investigate the psychosocial impact of the armed conflict on children in the area of Kailahun, one of the most war affected areas of the country. 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 one rural and three urban communities in the district of Kailahun. The field team, three Sierra Leone psychosocial workers, conducted 11 focus group discussions, 183 individual interviews and nine (9) case studies in Creole language. 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 without parental support compared to a control sample. In the case sample of children without parental support we included children meeting one of the following criteria:

- Children without parents (parents are still missing or deceased);
- Children living with disabled or chronically ill guardians.

The control group was recruited among children who did not meet any of the above listed criteria. 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=78) identified during the study received individual psychosocial support over a period of at least three months after completion of the research project.

Results: The generation of children interviewed in this study was born during or right before the civil war. The majority of them had experienced war atrocities, displacements, family
separation and life in refugee camps during their childhood. About 16% of the interviewed children had lived among rebel groups at one period of their life and another 22% had been held temporarily in captivity by military forces.

Parental death was a particularly traumatizing event for the children if they had to witness how parents were tortured and killed, and if no appropriate funeral ceremony could be organized for the deceased. Due to displacement and high mortality during the war, many family contacts were lost. Children were often too young to know their relatives at the moment of displacement and separation, and were later unable to trace surviving family members.

Most of the children had been repatriated or had returned to Kailahun district by themselves during the past five years. Children of the exposure group were often residing with guardians who were very old, infirm, or chronically ill. Girls living in extreme poverty commonly engaged in transactional sex in order to meet their survival needs. Several of them had become pregnant at a very young age. They were not only extremely vulnerable to sexual transmitted infections, but also had to cope with the stigma of having children born out of wedlock and with the challenge of raising a child on their own. Most of the fathers had disappeared from the community when they learned about the pregnancy, or they refused to recognize the child claiming that the mother had had sexual relationships with several partners.

The comparison of the study group with the control group showed substantial differences between the two groups. The group of children in lack of parental support scored significantly lower on most of the variables indicating wellbeing. They had lower self-esteem and less pro-social skills. While suicide risk was below 10% in the control group, more than 70% of the girls and boys of the study group were assessed to be at high risk for suicide. About 55% of the children without parental support had recently attempted to commit suicide. The methods had included drinking caustic soda or swallowing rat poison. While differences between the study group and the control group were important, gender differences in terms of wellbeing were hardly noteworthy.

The life-time experience for different types of domestic violence as well as the experience of ongoing abuse was elevated among children in both the case and the control group. However, boys and girls who were classified as children without parental support were generally more exposed to physical abuse and neglect. Moreover, girls were more often victims of sexual violence and neglect than boys. Interestingly, domestic violence appeared to have been less prevalent during the war, but the incidence appeared to have risen in the post conflict era.
Mental disorders were widespread among children in both the case and the control group. We found that more than 75% of the study population (including the control group) suffered from post-traumatic stress disorder. Even more worrisome is our finding that more than 80% of the children had the syndrome of a major depressive disorder. This contributed without doubt to the high suicidality we observed. Other disorders, such as conduct disorders, were less common, but did represent a major impairment of day to day life for an important number of children. Our study showed clearly that severe mental illnesses were much more common among the children lacking parental support than among their peers of the control group. The findings also indicated that girls were more vulnerable than boys to certain anxiety disorders and to certain disorders typically diagnosed in adolescence.

**Conclusion and recommendations:** The findings of our study show that the mental health of many children in Kailahun district of Sierra Leone is severely impaired. Loss of family safety nets and extreme poverty of caretakers are the main factors affecting children, particularly orphans, leading to neglect, prostitution, depression and an alarmingly high risk of suicide. The concept of extended families providing for each other has limited applicability in Kailahun district. Taking care of an additional child is considered to be a burden that many families are no longer willing to take on: one additional child may make the difference for a family between poverty and extreme poverty. Although foster families usually do not refuse shelter, they do refuse to take on the responsibility for nourishing additional children and for taking care of their education. Consequently, children without parental care are at risk for an impaired psychosocial development. Another risk factor for the mental health of children is the high prevalence of domestic violence.

Based on our study, we propose to develop a holistic and integrated response to the alarmingly high level of vulnerability among 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 collective and individual psychosocial support to severely affected children, in particular children without parental support and (4) supporting 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 African patterns of psychosocial support for distressed children and their families. Thus, the two organizations recruited a regional research team in order to explore 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 Sierra Leone.

3.1 Objectives

The focus of our study was to assess the mental health of children living in communities affected by armed conflict in the East Region of Sierra Leone. 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 without parental support.
4. Methods

We carried out an extensive literature review and met with representatives of different institutions working with children affected by the war in Sierra Leone for the preparation of the field study. The findings are presented in two parts: firstly, we present a literature review on the situation of children during and after the war in Sierra Leone 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 the district of Kailahun, Sierra Leone. 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 study (including the recruitment of the researchers and their training): 15th October to 6th November 2007;
- Pre-test: The pre-test took place in Kailahun 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 Kailahun 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 Counsellors (PSC) for the Centre of Victims of
Torture (CVT). The research preparation included 16 days of training that took place in Kailahun town, one of the areas for data collection. After the training, we carried out a pre-test of tools, approach 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 Creole language.

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 Sierra Leonean territory. We opted for Kailahun district as it represents one of the most war-affected areas: it is where the war started and where the presence of the rebels persisted until the end of the war. Kailahun district is in the extreme East of the country and has borders with Guinea and Liberia. It is also a program area of Plan Sierra Leone which facilitated the logistical aspects, the selection of the communities as well as the access to our target populations. Plan’s project coordinators in Kailahun and other local and international partners gave useful information on distances between communities, road conditions and the characteristics of different districts. 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 focus group discussion per chiefdom and per community**

<table>
<thead>
<tr>
<th>District</th>
<th>Study area</th>
<th>Number of interviews</th>
<th>Number of focus group discussions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luawa</td>
<td>Kailahun town</td>
<td>66</td>
<td>4</td>
</tr>
<tr>
<td>Upper Bambara</td>
<td>Pendembu town</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>Kissi Teng</td>
<td>Koindu town</td>
<td>59</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Kangama village</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>183</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>
Our original intention was to adopt a methodological approach comparing children formerly associated with the fighting forces to children who had not been directly involved in the war. This approach, however, lacked feasibility as the war ended more than seven years ago. The large majority of children formerly associated with the fighting forces are now older than twenty. Our focus, however, was to assess mental health in children and youth with a maximum age of 20. Hence, we could have only included children recruited by the rebels or governmental forces at a very young age. Children with this profile are not numerous and we considered it too difficult to identify as many as 90 of them in one district within a timeframe of two months. We decided to abandon the specific focus on children involved in fighting forces for the field study in Sierra Leone. This approach was adopted for the study in Liberia where the war has ended more recently.

For the current study, we opted for a comparison of orphans and vulnerable children with a control group. The characteristics of the case and control sample are described in detail in the section below. By contrasting these two groups, we were able to evaluate if children without parents or those growing up in specifically difficult conditions are more vulnerable to impaired mental health than children of the control group.

4.2 Methodological approach for the individual interviews

We conducted individual interviews with 183 children in four communities. Basic prerequisites for the recruitment of the participants were the

- availability,
- age between 8 and 20 years 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 90 children without parental support (WSP). 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. The text box below describes in detail the recruitment criteria for the children without parental support. A child was classified in the control sample on the condition that it did not match any of the criteria in the text box below.
Textbox 1: list of recruitment criteria for the exposure sample (children WSP)

<table>
<thead>
<tr>
<th>A child of the exposure sample needed to match one of the following profiles in order to be considered “without parental support”:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- being a double orphan: a child without biological parents; in most cases both parents have died, but it also includes children with a deceased mother and an unknown father.</td>
</tr>
<tr>
<td>- being still separated from both parents: a child that was separated during the war from both parents and that has never been reunited with them and that has up to now no traces about the parents’ whereabouts.</td>
</tr>
<tr>
<td>- having a deceased parent, while the other parent is still missing or has disappeared several years ago.</td>
</tr>
<tr>
<td>- having one deceased or missing parent while the remaining parent has serious problems: in this category we classified children with one deceased parent while the remaining parent or the currently fostering guardian suffers from a chronic illness, a disability or substance addictions.</td>
</tr>
</tbody>
</table>

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 the children without parental support. 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 that the public gather (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.

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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 Creole, the lingua franca of Sierra Leone 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 Creole respecting the following steps: the three Sierra Leonean consultants discussed each item, wrote it down and registered it on a taperecorder 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 Creole derives from 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:

- Focus group discussions
- Individual interviews
- Case studies
- 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 2: tools used for the individual interviews**

<table>
<thead>
<tr>
<th>Target indicators</th>
<th>Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Introduction of the research to parents and the child as well as signature of written consent</td>
<td>Research introduction and written consent record</td>
</tr>
<tr>
<td>2 Socio-demographic and background information</td>
<td>Semi-structured interview: Socio-demographic data questionnaire</td>
</tr>
<tr>
<td>3 Emotional wellbeing and resilience</td>
<td>Emotional well-being questionnaire of CARE/SCOPE &amp; FHI (Zambia 2003)</td>
</tr>
<tr>
<td>4 Potentially traumatic life experiences (life-time and during the last month); identification of most traumatic life event, assessment of current post-traumatic symptoms</td>
<td>UCLA PTSD Index (DSM IV) (Rodriguez, Steinberg et al. 1999) completed by a domestic violence checklist from Catani, Schauer et al. (Catani submitted)</td>
</tr>
<tr>
<td>5 Pro-social skills and peer relationships of children</td>
<td>2 scales from the Strength and Difficulties Questionnaire (SDQ) (Goodman 1997)</td>
</tr>
<tr>
<td>6 Self-esteem</td>
<td>Rosenberg’s self esteem Scale (Rosenberg 1989)</td>
</tr>
<tr>
<td>7 Axis I mental disorder of the DSM IV-TR</td>
<td>Structured clinical interview : M.I.N.I. KID English version 5.0 (Sheehan, Shytie et al. 2006)</td>
</tr>
<tr>
<td>8 Additional exploration of attitude, feelings and behavior of the child during the interview</td>
<td>Observation sheet</td>
</tr>
</tbody>
</table>
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 provisional 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 to the first part of questionnaire assessing 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 assessing transactional sex (“Have you ever made love to someone for getting money or presents?”). Furthermore, we added another item-list 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 obtain 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 to 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 Kailahun district.

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 drawing on title page) and facilitates the documentation of important life events of the child in a chronological order. The detailed instructions for the implementation of the exercise are outlined in appendix 9.4. 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

Plan obtained authorization for conducting the study from a representative of the Ministry of Education in Kailahun district. Furthermore, 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 \textit{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).

\textbf{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.

\textbf{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 or Mende in order to be able to socialize with the target populations in Kailahun district.

We realized 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 Kailahun district. 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

Kailahun district is a very remote area, about eight hours from the 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 the 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 to find operational profiles for children without parental support, we realized that the criterion “living with a guardian with serious problems” was difficult to apply in the field. Our objective was to focus on ill or disabled caretakers (including substance dependence) in the category of “guardians with serious problems”. We did not include poverty as a condition for having “serious problems” as it is difficult to find an operational definition of “being poor” and we feared that it would take account of too many families. Nonetheless, the reality of the field was that many of the encountered caretakers were not ill, but very old and extremely impoverished. They were neither able to provide convenient shelter and food for the children nor for themselves. Many of these children living with very poor caretakers matched with another category of the exposure group (being an orphan). Several, however, did not and were classified in the control group although they are definitely vulnerable. Furthermore, the number of caretakers classified as being “chronically ill or disabled” and the number of identified children still being separated from their parents are small which means that the majority of the children in the exposure group are orphans.
Our experience with the recruitment criteria for children without parental support taught us that the defined profiles allowed us to identify a group of children at risk, however, that the obligation to find operational definitions made it unavoidable to miss out children that are just as vulnerable, but that are not corresponding to the outlined categories.

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 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.

4.6.5 Limits of the study

The main limitations of this study are the small sample sizes and its geographical restriction to one region of the country. The sample is not representative for the country as we focused only on four communities in the Eastern Region of Sierra Leone. The findings cannot be generalized to the entire Sierra Leonean territory, and certainly not to other countries.

The sample of 180 children has no statistical representativeness for the child population of the Eastern Region. 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 WPS 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 Sierra Leone.

The following chapters are structured as follows: Section 5 provides information about the armed conflict in Sierra Leone 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 civil war in Sierra Leone (1991 – 2002)

After independence in 1961, the country experienced a series of military coups. The armed conflict began in 1991 when the Revolutionary United Front led by Foday Sankoh invaded towns in Kailahun district, near Liberia’s border. The fighting with the Sierra Leone army continued for months and the RUF gained control of the diamond mines in the Kono district and pushed the Sierra Leonean army back towards Freetown. Many civilians approved the political objectives of the RUF at first, however, the accumulation of war atrocities committed by the rebels made favorable opinions for their cause quickly decrease (Wikipedia 2007). The RUF soon became well know for ritual maiming, torture and cruel killings of civilians as well as forceful abductions of young people and children (Dufka 1999). The RUF also made use of indoctrination and drugs to manipulate children to comply during combat (Denov, Kemokai et al. 2004). UNICEF also highlighted the “epidemical dimension” of sexual violence inflicted upon women and girls during the war. It was common practice for members of the fighting forces to rob girls as “bush wives” and to coerce them to provide sexual services for them. Many girls were victims of this form of sexual slavery or of rape, gang rape, forced prostitution and forced pregnancy interruptions (UNICEF 2005).

In 1992, a military coup was launched by a group of military officers of the army and overthrew the government. President Joseph Momoh was sent into exile to Guinea. The interim government put into place, the National Provisional Ruling Council (NPRC) was no more successful than Momoh’s government in holding off the RUF: in 1995, the RUF controlled large areas of the countryside and threatened to invade the capital. In order to regain control of the situation, the NPRC took into service a large number of mercenaries. Their employment enabled the NPRC to fend off the RUF towards the border areas of the country.

In 1996, the NPRC agreed to hand over the power to a civilian government and Ahmad Tejan Kabbah was elected President. Only one year later, however, Kabbah was removed from power by another military coup, initiated by the Armed Forces Revolutionary Council (AFRC), a splinter group of the government’s army. The AFRC invited the RUF to join the government, however, the rebels and the AFRC separated quickly as the RUF refused a disarmament process monitored by the AFRC. President Kabbah was reinstated in 1998 by the ECOMOG forces. Soon after Kabbah’s return, however, the RUF launched new attacks.
as to defeat the government and fighting reached Freetown in the beginning of 1999. The ECOMOG took several weeks to ward off the rebels and to restore peace in the capital. As a result of the mounting international pressure, President Kabbah and rebel leader Sankoh signed the Lomé Peace Accord in summer 1999. As stipulated in the agreement, Sankoh became Vice President and further RUF members took up positions in the government. Furthermore, the United Nations Mission in Sierra Leone (UNAMSIL) was set up and the ECOMOG forces departed in early 2000. The RUF soon started violating the peace accord and took hundreds of UNAMSIL workers hostage. As a consequence, Sankoh was taken into custody and the RUF was expelled from its positions in the government.

In May 2001 a cease fire agreement was signed in Abuja and the DDR process started, disarming in the following years more than 72,000 combatants. In 2002, President Kabbah declared the civil war to be officially over. The UNAMSIL retreated from Sierra Leone by the end of 2005 (Wikipedia 2007). As a result of the war, an estimated number of 50,000 people were killed, over 1 million civilians fled the country and more than 2 million people were internally displaced (Remmert-Fontes, Miketta et al. 2001).

5.2 Psychosocial needs of children in the context of post conflict 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 rehabilitation of affected populations (Murthy and Lakshminarayana 2006). They provide policies and recommendations for general frameworks for work with war affected populations (for example Baingana, Fannon et al.; for example UNICEF 2005). Interestingly, there is little empirical evidence for these reports. Only a very small number of empirical studies have focused on the impact of war and the experiences of children in Africa (Denov, Kemokai et al. 2004; Gupta and Zimmer 2008). Moreover, most of the existing studies 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 the few existing studies focusing primarily on exposure to traumatic life experiences and PTSD assessment, 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).
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, for example, vary from 34% -97% in war affected child populations in Sub-Saharan Africa (Gupta 2000; Derluyn, Broekaert et al. 2004; Karunakara, Neuner et al. 2004; Schaal and Elbert 2006; Bayer, Klasen et al. 2007). It is important to take note, however, that most studies did not assess all diagnostic criteria for PTSD, but used solely symptom-severity- scales that do not allow diagnosing PTSD.

- The existing findings indicate that childhood trauma induced by armed conflict does not only lead 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).

- 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).

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\(^1\) 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.
• A recently conducted study with CFAFF 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).

As highlighted above, the impact of war on children depends largely on the context and nature of the armed conflict. We identified only two studies focusing on the specific Sierra Leonean context during our literature review. In 1999 Plan Sierra Leone initiated a psychosocial support program in two refugee camps and assessed exposure to traumatic events and post-traumatic stress reactions in 306 children before and after the intervention. The assistance project lasted four weeks. It combined trauma healing activities with literacy and numeracy modules. The results implied that almost all children had been exposed to war atrocities and that the majority suffered from symptoms of post-traumatic stress such as intrusions, arousal and avoidance. The post-intervention evaluation showed that symptoms of intrusions and arousal had decreased during the project duration, however, avoidance symptoms had slightly increased (Gupta 2000; Gupta and Zimmer 2008). The second study conducted FGD with CFAFF in order to learn more about their implication in the war, their experiences and coping strategies and the psychosocial impact of their life among the fighting forces. The discussions showed that the children experienced peer support as a significant resource during the time with the fighting forces. The authors underlined the rejection of CFAFF by communities, unwanted pregnancy and physical complaints (injuries, gynecological problems), displacement and feelings of guilt, shame and loss as predominant psychosocial effects of the war on CFAFF (Denov, Kemokai et al. 2004).
6. Results of the field study

6.1 Socio-demographic information of the interviewed sample

We conducted individual interviews with 183 children; 92 boys and 91 girls from 8 - 20 years in four communities in the district of Kailahun. We recruited 94 children without parental support and compared them to 89 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 15.4 years of age. All children enrolled in the study were able to state their age. For most children, the stated age and the estimated age were at the same level (69.2%). The education level of the enrolled children varied from 1 -15 years of schooling. The average number of years of school enrolment was seven years. Boy participants were longer enrolled in school than girls (7.6 years vs. 6.4 years), a difference that is highly significant (t(178) = 2.80; p ≤ 0.01). At the moment of the data collection, about 6% of the boys and girls had definitely dropped out of school. Many other children, however, reported a frequently interrupted school enrolment due to the fact that they are each year temporarily driven out of school for not having paid their fees. The majority of children were enrolled in government (16.7%) and mission schools (77.6%). The remaining 5% of children go either to koranic (4.0%) or vocational schools (1.7%). 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 3: Socio-demographic variables

<table>
<thead>
<tr>
<th>Socio-demographic variables</th>
<th>Total sample (n = 183)</th>
<th>WPS girls (n = 46)</th>
<th>Control group girls (n = 45)</th>
<th>WPS boys (n = 48)</th>
<th>Control group boys (n = 44)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>15.4</td>
<td>15.0</td>
<td>14.8</td>
<td>15.9</td>
<td>15.7</td>
</tr>
<tr>
<td>Standard deviation</td>
<td>2.82</td>
<td>3.30</td>
<td>2.98</td>
<td>2.31</td>
<td>2.56</td>
</tr>
<tr>
<td>Range</td>
<td>8-20</td>
<td>8-20</td>
<td>8-20</td>
<td>10–20</td>
<td>10 – 20</td>
</tr>
<tr>
<td><strong>Average education level (in years)</strong></td>
<td>7.0 (2.76)</td>
<td>6.2 (2.86)</td>
<td>6.7 (2.51)</td>
<td>7.0 (2.99)</td>
<td>7.8 (2.72)</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>57 (31.3%)</td>
<td>14 (30.4%)</td>
<td>11 (25.0%)</td>
<td>14 (29.2%)</td>
<td>28 (40.9%)</td>
</tr>
<tr>
<td>Christian</td>
<td>125 (68.7%)</td>
<td>32 (69.6%)</td>
<td>33 (75.0%)</td>
<td>34 (70.8%)</td>
<td>26 (59.1%)</td>
</tr>
</tbody>
</table>

*standard deviation in parenthesis
Only five girl participants had already started exerting a trade. They were engaged in garden and farm work or were selling fire wood or fruits. One of the participating girls was married. None of the boys reported to have impregnated a girl, on the contrary, 18 of the interviewed girls (20.2%) have already been pregnant and 13% of the girls had at the time of the data collection one child, two girls had two existing children. Four girls were at the moment of the interview without child although they had already been pregnant. They reported miscarriages, abortions or infant death during the first year after delivery.

Many children (50%) had already received assistance from NGOs or governmental institutions. The help was usually related to education related costs (82%): the children received text and exercise books, pens or similar material support and sometimes temporarily the school fees. Several children had not only received school materials, but also been supported with food by the WFP. Most of the help was provided by international NGOs or UN agencies and about 3% by the government. The proportion of children having already benefited from psychological assistance was considerably smaller than the number of children having received help in educational matters: only 7% of the interviewed children had at one point been enrolled in individual or group counseling or other types of psychological assistance.

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 without parental support and their controls do not show significant differences regarding their education level [for girls: ($t(88) = -0.86$; $p > 0.05$) and for boys ($t(90) = -1.30$; $p > 0.05$)]. The case and the control sub-samples were also comparable in terms of religion [for girls ($\chi^2(1) = 0.33$; $p > 0.05$) and for boys ($\chi^2(1) = 1.40$; $p > 0.05$)]. Furthermore, independent t-tests confirmed that the samples do not differ significantly in terms of age: neither for the girl sub-samples ($t(89) = 0.37$; $p > 0.05$), nor for the boy sub-samples ($F(90) = 0.46$; $p > 0.05$). Nonetheless, boys were significantly older than girls ($t(181) = 2.19$; $p \leq 0.05$).

6.1.2 Ethnic groups represented in the interviewed sample

Sierra Leone is native to more than 15 different ethnic groups. Out of this number, six 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 Mende and Kissi.
Figure 1: repartition of represented ethnic groups in the interviewed sample

6.2 Life during the war

6.2.1 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 Kailahun (see also section 6.2.6). All families of the interviewed children were displaced. They fled their homes when the rebels attacked and had to leave all possessions behind to save their lives. Various families went into hiding in the bush and lived in scanty mansions until they were ambushed by rebels or driven out of their hiding places by hunger. Some of the participants were born in camps or in refuge areas.

• “In the same year that I was born, Foday Sankoh entered with his rebels in our hometown. My father and mother went into hiding with me in the bush and we stayed in a hut that we called mansion for nearly three years. At one point, the living conditions at the mansion became unbearable for us and my parents decided to go to Guinea where the UNHCR was providing care for refugees. Unfortunately, we were trapped by the RUF rebels after leaving the mansion. My father was trying to escape, but one of the commanders opened fire on him and shot my father dead. My mother’s hands were cut off with a blunt knife and she was killed soon after. I was left alone on the main road where the rebels had captured us. One stranger, who used to do business with the RUF rebels on both sides of the border, saw me and brought me to Ouende Kenema [Guinea] where we stayed for six good years.” (boy WPS, 16 years, Kailahun)
During the displacements, 70.5% 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. They had to witness forceful abductions, torture and killing, destruction and looting of properties and burning of houses. The Table 4 outlines the incidence of exposure rates to different events in the sample.

Table 4: Exposure to traumatic war related experiences

<table>
<thead>
<tr>
<th>Event</th>
<th>Total sample (n=183)</th>
<th>Girls (n=91)</th>
<th>Boys (n=92)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To witness a landmine explosion</td>
<td>36 (19.7%)</td>
<td>24 (26.4%)</td>
<td>12 (13.0%)</td>
</tr>
<tr>
<td>To witness another child being punished to death</td>
<td>70 (38.3%)</td>
<td>41 (45.1%)</td>
<td>29 (31.5%)</td>
</tr>
<tr>
<td>To be surrounded, lying underneath or stepping on dead bodies</td>
<td>68 (37.2%)</td>
<td>35 (48.1%)</td>
<td>33 (54.1%)</td>
</tr>
<tr>
<td>To have one’s home or properties looted</td>
<td>120 (65.6%)</td>
<td>68 (94.4%)</td>
<td>52 (89.7%)</td>
</tr>
<tr>
<td>To see houses being burnt</td>
<td>108 (59.0%)</td>
<td>58 (80.6%)</td>
<td>50 (89.3%)</td>
</tr>
<tr>
<td>To witness a forced recruitment/ abduction</td>
<td>58 (31.7%)</td>
<td>24 (33.3%)</td>
<td>34 (60.7%)</td>
</tr>
<tr>
<td>To be forced by violence or threat of violence to leave one’s family</td>
<td>96 (52.5%)</td>
<td>55 (76.6%)</td>
<td>41 (73.2%)</td>
</tr>
<tr>
<td>To be recruited by and having lived with the fighting forces</td>
<td>30 (16.4%)</td>
<td>13 (14.3%)</td>
<td>17 (18.5%)</td>
</tr>
<tr>
<td>To see a family member being injured with a weapon</td>
<td>77 (44.0%)</td>
<td>36 (40.4%)</td>
<td>29 (33.7%)</td>
</tr>
<tr>
<td>To see a family member threatened to be killed or being killed</td>
<td>63 (36.0%)</td>
<td>41 (46.1%)</td>
<td>36 (41.9%)</td>
</tr>
</tbody>
</table>

6.2.2 Captivity

After the displacement from home areas, 12% of the girls and 32% of the boys were temporarily held in captivity by armed forces. They were discovered by rebels in their hiding places or caught while traveling towards the Guinean border or towards refugee camps inside Sierra Leone. Many girls experienced sexual violence after being captured. It was also common to separate children forcefully from their parents: while the adults were abducted by the fighting forces for military or sexual services (“for becoming a bush wife”), the children too young to be of use were set free soon after being captured and left by themselves. Some of them were lucky to be reunited with other family members in a refugee camp. Others were taken care of by strangers and lost all traces of their families. The memories of the children of the time in captivity are scattered and painted by images of death threats, sexual violence, torture and killings of relatives.
“During the war, I and my friend were captured by rebels. One day, we were asked to fetch water at the river for them. As we felt alone, we tried to cross the river and to escape. But they saw us and came chasing after us. I managed to run, but my friend got drowned in the river. I cannot forget that and I feel guilty because I suggested to him to run away.” (boy WPS, 16 years, 8 years at the moment of event, Koindu)

“After the death of my father in the war, something terrible happened. I was nine years old when I was captured and forced to have sex with a rebel. I tried to run away and to refuse, but he beat me up very badly and separated me from my mother. Up to now, the whereabouts of my mother are unknown.” (girl WPS, 16 years, Kailahun)

6.2.3 Life among the fighting forces

14.3% of the girls and 18.5% of the interviewed boys have lived among rebel groups during one period of their childhood. The recruiters were the RUF rebels who controlled large parts of Kailahun district during the war and used areas like Kangama as war lord bases. The majority of the children were abducted by force or had to join the rebels because of lack of alternatives, however, 10% of the participants formerly associated with the fighting forces volunteered for serving the rebels, hoping for a better future and protection among their midst. The girls carried out domestic work and sexual services while being with the RUF. Boys were also used for domestic work and additionally as carriers of looted goods in the battlefield. Only one of the 30 participants recruited by the RUF had actively taken part in combats. He was also the only one to be disarmed after the war although he did participate in any reintegration activities. The testimonies of the children illustrate that horror and helplessness were predominant feelings during the time among the rebels. They had to witness irrational killing and torture rituals that RUF members inflicted on family members and strangers.

“During the war, the rebels got hold of us and we had to work for them. After I tried to run away from one of the rebels, they punished me for a long time and my parents were killed. I was threatened to death, but they left me alive. I remained with my uncle who was also seriously beaten and tortured by the rebels. Later they killed him for no reason. One day, they let me go and I was all by myself until I found my grandparents in a refugee camp in Guinea.” (boy WPS, 16 year, Kailahun)

“In 1997, both of my parents were killed by rebels. I was left with my sister who was also killed in the same year and I was left all by myself and not even 10 years old. I was captured by rebels and taken to their base where I was working for them, doing domestic chores like cooking, laundering, fetching water and wood and I was trained to clean their weapons. In 1998, I was trained to fight for them and I was sent to the war front and I killed a lot of people. I was under the influence of drugs so I did not feel much. I also looted, burnt down houses and inflicted pain on many people. One year later, I became scared. The government troops were getting more and more powerful and I refused to fight. I was arrested and the rebels tortured me and send me to a guard room for three days.” (boy WPS, 20 years, Kailahun)
6.2.4 Life in refugee camps

Most of the children (78%) went to live with their families in refugee camps in Guinea. Yet even in refuge, their life continued to be unstable and the greater part of the children lived in 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. A lot of children witnessed rebel and/or military invasions in the refugee camps during spill-over fighting from Liberia from 2000 to 2002. Many families were temporarily captured by dispersed rebel groups or had to witness another time forceful abductions, torture and killings.

- “When the rebels entered Nongoa camp [Guinea], I was captured, beaten and they detained me for several hours and forced me take my clothes of and to have sex with a group of men. What could I do? They threatened to kill me if I only move and they pointed all the time their guns at my head.” (girl WPS, 18 years, Koidu)
- “I was with some of my family members at Katkama Guinea when we were caught by the rebels and they forced me to have sex with them. We managed to get back to the camp, but it was soon after invaded. I tried to run away, but no way out. There were dead bodies everywhere. I had to step on them, there were too many and I could not find my way out.” (girl WPS, 18 years, Kailahun)

A particular danger for the families was the existence of tattoos indicating the membership to a secret society of a specific ethnic group. Just about all ethnic groups practice ritual tattooing ceremonies during the initiation rites in the forest areas of Sierra Leone, Guinea and Liberia. The tattoos given to society members were used by Guinean government forces to detect rebels. Refugees on the move were frequently forced to undress and to lie down on the floor for examination. Guinean military conducted abusive and humiliating body controls for identifying potential rebels in the group. All persons showing suspicious marks on their bodies were suspected to be rebels and often put in detention, tortured or killed.

- “When our camp was invaded, my father was forcefully abducted and was later killed in the war. My mother managed to escape with me to a safer zone. But only shortly later, at Katkama, she was taken by several men and thrown to the ground. They stripped her naked and said that she is carrying rebel marks. They did very bad things to her and she was killed not much later by one of these men. I was left with my uncle.” (boy WPS, 12 years, Kangama)
- “The UNHCR was evacuating us to Borea camp. But then a Guinean military group took hold of us. When they saw a mark on my leg, they accused me of being a rebel. They took me in detention and said that for proving that I am not a rebel wife, I should be with the government forces and become their wife. No one listened to me when I said that I had never been with the rebels. But they left me naked on the floor for a long time. It was in 2000 in Gueckedou town. (girl WPS, 19 years, Kangama)

The living conditions in the refugee camps were difficult, although access to living resources and education was made available by the UNHCR to most children. The majority of the
participants reported access to clean water and food, shelter, freedom to move and education (see figure below). Boys seemed to me more restricted in their movement than girls and were less likely to have access to convenient shelter. Despite the provision of education, shelter and basic living resources, food and firewood were often lacking. Furthermore, more than 22% of the girls had sex with camp workers in order to receive money, clothes, food or material for shelter in return for their services.

- “My whole family fled to Guinea during the rebel war, but we got separated and my father got caught, tortured and killed. I got separated from my mother and I stayed in Guinea with my aunt. I learnt later that my mother had been killed as well. In Guinea, we life was not easy and food was not enough. I was forced to have sex with camp workers in order to get food.” (girl, control group, 19 years, Koidu)

![Figure 2: reported access to basic resources in the refugee camps](image)

6.2.5 Loss of parents

More than 65% of the children have lost a least one parent. Most of the parents died during the war (83.2%) or briefly after the war (12%). The majority (64.2%) 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 were assassinated. In addition to the trauma of witnessing death, 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. 

Furthermore, many children were very young when their parents died. They had been born before or during the situation of displacement, separated from members of the extended family. As a consequence, they never got to know their relatives and some children were never able to trace living relatives after the death of their parents. Others were able to join relatives, but had scarcely known them before. The displacements and high mortality obstructed to a great extent the capacity of family safety and solidarity nets. Numerous children remained without known living relatives and are currently facing extremely difficult life circumstances.

- “I lost both of my parents in one year. My father got poisoned when I was ten and my mother drowned one year later in refuge in Guinea. The day that my mother drowned in the river I was forced to stay by her corpse for two days before the Guinean law could allow her corpse to be buried. We were not allowed to bring her to the grave yard but buried her by the side of the river. I was so frightened. Up to now, my mother has not received a funeral ceremony.” (boy WPS, 14 years, 11 years at the time of event, Koindu)
- “My family and I were captured by the rebels in Sierra Leone. The rebels pushed us around, threatened my father and then brutally killed him in front of our eyes. Then they took away our mother as a bush wife. I learnt later that she died soon after out of discouragement and grief about the loss of my father.” (boy WPS, 18 years, Pendembu)
- “During the NPFL rebel attacks on Monrovia city in 1993, - I was just six years old - my mother and I want to look for food around Sinko [area in Monrovia] where the government forces were defending their positions. Then the rebels of Charles Taylor just opened fire on us. My mother was gun downed and dropped dead. A stranger took care of me until last year when an uncle found me and brought me back to Koindu. I learnt later that my father was also killed when he went to see the corpse of my mother.” (boy WPS, 20 years, Koindu)

6.2.6 Arrival in Kailahun district after the war

The families repatriated gradually from Guinea and other refuge areas, for instance the camps in Bo and Kenema, to their region of origin. More than 85% of the children came back to Kailahun district between 2002 and 2007, only a few children were repatriated before 2002. The following table displays the arrival periods of the children in Kailahun. Those being orphaned during the war came to stay in the district with remaining family members, with friends or lovers, or by themselves.

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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.
Table 5: proportions children for different arrival periods in Kailahun district

<table>
<thead>
<tr>
<th>Period</th>
<th>Total sample</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006-2007</td>
<td>12.5%</td>
<td>9.5%</td>
<td>16.3%</td>
</tr>
<tr>
<td>2002-2005</td>
<td>75.0%</td>
<td>76.2%</td>
<td>73.5%</td>
</tr>
<tr>
<td>2000-2002</td>
<td>10.7%</td>
<td>12.7%</td>
<td>8.2%</td>
</tr>
<tr>
<td>Before 2000</td>
<td>1.8%</td>
<td>1.6%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

6.3 Current household and family situation

More than 35% of the participants lived with one or both parents; 20.9% resided with both parents, 10.4% lived with their mother and 2.7% lived with their father. Another 1.1% of the children stayed with one parent and a new spouse.

Another large proportion (59%) 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: 31% of the children live in their care. Grandparents foster 14.3% of the children. Brothers and sisters of the participants acted as caretakers for 10.4% of the participating children.

The large majority of children (more than 91%) were residing with a closely related family member. However, a child in Sierra Leone 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 (2.2%), with friends (3.3%) or in non-relative foster care (3.3%). The table below shows the living situation of the four sub-samples. As was expected, the rate of children residing in foster care is much higher in the group of children without parental support than in the control group.
Table 6: household situation of children

<table>
<thead>
<tr>
<th>Staying with</th>
<th>WPS girls (n = 46)</th>
<th>Control group (girls) (n = 45)</th>
<th>WPS boys (n = 48)</th>
<th>Control group (boys) (n = 44)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both parents</td>
<td>0 (0%)</td>
<td>16 (35.6%)</td>
<td>0 (0%)</td>
<td>22 (50.0%)</td>
</tr>
<tr>
<td>Mother</td>
<td>1 (2.2%)</td>
<td>14 (31.1%)</td>
<td>0 (0%)</td>
<td>4 (9.1%)</td>
</tr>
<tr>
<td>Father</td>
<td>0 (0%)</td>
<td>3 (6.6%)</td>
<td>0 (0%)</td>
<td>2 (4.5%)</td>
</tr>
<tr>
<td>Brother or sister</td>
<td>4 (8.7%)</td>
<td>1 (2.2%)</td>
<td>6 (12.8%)</td>
<td>8 (18.2%)</td>
</tr>
<tr>
<td>One parent with new spouse</td>
<td>0 (0%)</td>
<td>1 (2.2%)</td>
<td>0 (0%)</td>
<td>1 (2.3%)</td>
</tr>
<tr>
<td>grandparents</td>
<td>14 (30.4%)</td>
<td>2 (4.4%)</td>
<td>10 (21.3%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Aunt or uncle</td>
<td>20 (43.5%)</td>
<td>7 (15.6%)</td>
<td>24 (51.1%)</td>
<td>6 (13.6%)</td>
</tr>
<tr>
<td>Alone</td>
<td>3 (6.5%)</td>
<td>1 (2.2%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Non relative foster care</td>
<td>2 (4.3%)</td>
<td>0 (0%)</td>
<td>3 (6.4%)</td>
<td>1 (2.3%)</td>
</tr>
<tr>
<td>Friends</td>
<td>2 (4.3%)</td>
<td>0 (0%)</td>
<td>4 (8.5%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

As the columns of the control groups of the table indicate, the death of a parent was not the only reason for confiding a child to a member of the extended family. In fact, more than 34% of the children in the control group were fostered by relatives although they have at least one parent. Non-orphans were fostered for diverse reasons such as chronic illness, physical handicaps or migration of a parent, need for domestic labor support in another family or for facilitating the education or socialization of a child. In total, 64.3% of the interviewed children lived in foster care in the extended family and not with one or both of their biological parents.

6.4 Emotional wellbeing

The answer of the children to the question “how happy are you living in your home” showed that slightly over 40% of the children are either “very happy” (9.3%) or “happy” (31.1%). The remaining 60%, however, reported to be sad (36.6%) or very sad (23.0%) at home. The analysis of potentially influencing factors showed that children in the groups without parental support had a significantly lower probability of being happy at home ($F(3) = 29.70; p \leq 0.01$). The post-hoc test Bonferroni showed that boys and girls without parental support were on average highly significantly less happy compared to the control groups (Bonferroni for girls: $p \leq 0.01$; for boys: $p \leq 0.01$). The findings showed no significant differences between girls and boys ($t(181) = 0.54; p > 0.05$).
In spite of the considerable proportion of children unhappy at home, the majority of children (85%) declared to have at least one person in the family offering love and protection. The remaining 15% (23 children) stated to have no attachment figure in their family. All but five of these 23 children belong to the group of children without parental support.

The protecting person was often an aunt or an uncle (25.6%), the mother (14.2%), one of the grandparents (14.2%) or a brother or a sister (13.5%). Although the father was rarely named alone (6.5%), numerous children named both mother and father as important protective figures (16.8%). Only a few children (1.9%) brought forward other relatives than the above named as resources for protection. This might also be due to the fact that commonly every person having somehow a kinship with the child is called “aunt” or “uncle”. Several children (7%) designated non-relatives as protective persons such as their currently fostering guardian, their (boy-) friends or teachers.

6.4.1 What makes you happy?

We classified the responses of the participants to the question “What makes you happy” in seven categories: love and affection in the family (31.5%), school participation (13.3%),
satisfaction of basic needs and reception of gifts (13.3%), playing/be being with peers (29.7%), being alive and in good health (8.5%) and religious activities (1.2%) and “nothing” (2.4%). As the below outlined numbers demonstrate, the most frequent source of happiness was related to situations of affectionate care in the family. The simple fact of receiving encouragement and approval from parents, of spending time with siblings, grandparents or other relatives was a paramount source of well-being for children. The second important source of happiness was leisure time with peers, followed by the categories “school participation” and “receiving gifts and satisfaction of basic needs”, including having enough to eat, receiving new cloths or household material. The answers of boys and girls differed significantly for some categories. Girls evoked considerably more often situations related to care and affection in the family and while boys chose more often situations related to school and satisfaction of their basic needs (see Figure 4).

Figure 4: What makes you happy (proportions in %)?

6.4.2 What worries you most?

A large proportion (95.5%) of the participants answered to be sometimes or most of the time worried. We asked them to share the causes of their anxieties and clustered the responses
of the children in seven categories. The most common source for preoccupation was school (29.2%). Children worried about how to pay their school fees, uniforms and textbooks, about their performances and the outcome of exams. The next important categories were apprehensions about the death of a parent/guardian (22.2%) and health problems of the children or a family member (17.5%). Further common worries were related to the future (9.4%), to lack of basic living resources (food, clothes) (8.2%), separation from parents and lack of support in their foster families (6.4%), domestic violence (3.5) and personal failures and disabilities such as a physical handicap or bedwetting (3.5%).

The comparison of boys and girls showed substantial differences (see figure below). Girls were more often troubled by the loss of a parent than boys. Furthermore, their worries were more often related to domestic violence at home and to family conflicts than the worries of boys. Major concerns of boys were related to school and their health. They were also more often anxious about future than girls.

![Figure 5: Factors that worry children most (proportions in %)](image)
6.4.3 Other factors determining well-being of children

All analyzed factors regarding the emotional wellbeing of children are displayed in Table 9. The samples without parental support scored significantly lower on the greater part of the variables determining emotional wellbeing (see table below).

In general, the percentage of children reporting to be sometimes or often unhappy is at 96% in the study area of Sierra Leone. The proportion of children answering *never to be happy* is at 8% in the interviewed sample which are higher proportion than in Burkina (3.9%) and in Togo (3.3%) and in Cameroon (1.1%). The proportion of children that reported to feel never hopeful about the future is also worrisome: more than 16% of the children reported to feel never hopeful about what their future is going to bring. Moreover, almost 90% of the interviewed children described recurrent sleeping problems.

Approximately 46% of the children feel often or sometimes like running away from home and many of them have already put these thoughts into action: 40% of the interviewed girls and 45% 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 unbearable domestic violence or rejection from caretakers driving children from their homes to seek refuge with relatives or friends.

The comparison of girls and boys indicated that the sexes do not differ for the variables *being angry, being worried, being content, having fear of new situations, trouble sleeping, feeling hopeful about the future* and *wanting to run away from home*. Nevertheless, considerable differences became apparent on the scales of *feeling unhappy* and *having difficulties making new friends* on which girls scored significantly lower than boys.

### Table 7: Analyzed factors regarding the wellbeing of children

<table>
<thead>
<tr>
<th>Factors of wellbeing</th>
<th>Difference between girls WPS and the control group</th>
<th>Difference between boys WPS and the control group</th>
<th>Difference between boys and girls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Being unhappy</strong></td>
<td>(t(89) = 0.73; p &gt; 0.05) No significant differences</td>
<td>(t(90) = 3.08; p \leq 0.01) In disfavor of CWPS</td>
<td>(t(181) = 3.81; p \leq 0.01) In disfavor of girls</td>
</tr>
<tr>
<td><strong>Being worried</strong></td>
<td>(t(82) = 2.06; p \leq 0.05) In disfavor of CWPS</td>
<td>(t(90) = 3.70; p \leq 0.01) In disfavor of CWPS</td>
<td>(t(174) = 1.15; p &gt; 0.05) No significant differences</td>
</tr>
<tr>
<td><strong>Being content</strong></td>
<td>(t(88) = 2.16; p \leq 0.05) In disfavor of CWPS</td>
<td>(t(88) = 5.14; p \leq 0.01) In disfavor of CWPS</td>
<td>(t(176) = 0.83; p &gt; 0.05) No significant differences</td>
</tr>
<tr>
<td><strong>Being angry</strong></td>
<td>(t(89) = 3.13; p \leq 0.01) In disfavor of CWPS</td>
<td>(t(89) = 3.70; p \leq 0.01) In disfavor of CWPS</td>
<td>(t(179) = 1.25; p &gt; 0.05) No significant differences</td>
</tr>
</tbody>
</table>
Fear of new situations  $(t(88)= 1.35; p > 0.05)$  $(t(89)= 3.13; p ≤ 0.01)$  $(t(179)= 0.97; p > 0.05)$
No significant differences  In favor of CWPS  No significant differences

Trouble sleeping  $(t(88)= 2.68; p ≤ 0.01)$  $(t(90)= 3.84; p ≤ 0.01)$  $(t(178)= 0.41; p > 0.05)$
In favor of CWPS  In favor of CWPS  No significant differences

Difficulties making new friends  $(t(88)= 3.54; p ≤ 0.01)$  $(t(88)= 7.52; p ≤ 0.01)$  $(t(178)= 3.45; p ≤ 0.01)$
In favor of CWPS  In favor of CWPS  In favor of girls

Being hopeful  $(t(83)= 3.77; p ≤ 0.01)$  $(t(86)= 4.97; p ≤ 0.01)$  $(t(171)= 1.10; p > 0.05)$
In favor of CWPS  In favor of CWPS  No significant differences

Wanting to run away  $(t(87)= 2.28; p ≤ 0.05)$  $(t(88)= 7.54; p ≤ 0.01)$  $(t(177)= 0.63; p > 0.05)$
In favor of CWPS  In favor of CWPS  No significant differences

6.5 Self esteem and pro-social skills

We evaluated the self-esteem of children with help of the Rosenberg questionnaire. The control groups reported significantly higher self esteem than children without parent support [for girls $(t(89) = -6.94; p ≤ 0.01)$ for boys $(t(90) = -11.63; p ≤ 0.01)$]. As apparent in Figure 6, CWPS of both sexes scored significantly lower on the self esteem dimension than their counterparts of the same sex. Boys seemed to be more self confident than girls though differences are just not significant $(t(181) = -1.79; p > 0.05)$.

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 44% of the girls and 63% 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, 25.3% of the girls and 23.9% 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 30% of the girls and 13% of the boys scored in the lowest category, named “abnormal” by the author, 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”.

Another time, as for the Rosenberg questionnaire, the boys and girls without parental support had significantly less prosocial capacity than the control groups [for girls: $(t(89) = -4.62; p ≤ 0.01)$ and for boys: $(t(90) = -4.56; p ≤ 0.01)$]. Furthermore, girls scored significantly lower than boys on the prosocial scale $(t(181) = 2.81; p ≤ 0.01)$. 
6.5.1 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. Influencing factors were neglect and physical abuse: children subjected to ongoing physical abuse and neglect scored significantly lower on the self esteem scale than non abused and neglected children [for abuse: \(t(181) = -2.59; p \leq 0.01\) and for neglect: \(t(180) = -9.45; p \leq 0.01\)]. Children who had been sexually abused during their life also showed significantly lower self esteem than non sexually abused children \(t(181) = -2.30; p \leq 0.05\).

Furthermore, fostered children had a significantly lower self esteem than children living with one or both parents \(t(180) = -9.04; p \leq 0.01\). In the same line, being happy at home showed a highly significant correlation with a high self esteem score \((Pearson: r = .52; p \leq 0.01)\): children that feel happy at home have a higher self esteem. The number of years of school enrolment also seemed to play a role: children who were longer enrolled in school had a higher self-esteem \((Pearson: r = .17; p \leq 0.05)\).

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 \((Pearson r = .58; p \leq 0.01)\). As was expected, children suffering from major depressive disorders and from PTSD also showed significantly less self confidence than
mentally healthy children [for major depressive disorder: \(t(180) = -4.69; p \leq 0.01\) and for PTSD: \(t(177) = -9.97; p \leq 0.01\)].

6.6 Suicidality

Thoughts about committing suicide were quite common among the children in the sample: more than 76% of the participants 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.

- “Grandfather and my aunt failed to support me when I had a very bad accident in 2002 before our repatriation. I had a compound fracture on my left leg and was hospitalized for over three months. They don’t care what happens to me, even when I told them about the man who did bad things to me [rape]. He is still threatening me and I have no one willing to help me. Sometimes I wish I could just die and disappear.” (girl WPS, 15 years, Koindu town)
- “There is no one I can talk to and I feel so alone, worthless. I have no one to talk to on how to change my situation. I hear often voices of my dead parents wishing me to join them. I feel like dying and wonder how I can kill myself.” (boy WPS, 15 years, Koindu)
- “My parents died in the war after the rebels had burnt our house completely down. My grandmother cannot help me and has to take care of both of us. I got a baby eight months ago, but it has no legal father and it is always sick and cries. I feel like killing myself and the baby with rat poison to end our miserable existence.” (girl WPS, 17 years, Koindu)
- “One morning after we came back to Sierra Leone after war, my eyes started hurting and all the ointments we applied did not help. My eyesight is severely affected ever since and my cousin has no money for a doctor. What makes it even worse, I have a baby without legal father and no one is willing to help us. I am worried to get blind. Who will take care of the child then? I feel like it would be best if I and my child just disappeared.” (girl WPS, 19 years, Koindu)

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 8. The overall rate of suicide risk in the entire sample was 41%, with boys having a higher risk (44.6%) than girls (37.4%). This difference is, however, not statistically significant \(\chi^2(1) = 0.98; p > 0.05\). These findings are alarming: more than four children out of ten are feeling so bad that they express concrete intentions to commit suicide. As shown in the figure.

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Psychosocial needs of children without parental support in Sierra Leone

May 2008
below, the differences between the exposure and the control groups are highly significant [for girls \((\chi^2(1) = 35.84; \ p \leq 0.01)\) and for boys \((\chi^2(1) = 54.67; \ p \leq 0.01)\)]. Suicidality was widespread in the samples of CWPS: more than 70% of the girls without parental support and more than 80% of the boys without parental support stated at the moment of the interview a current risk of suicide. The suicidality rates of the control group were much lower: beneath 10% for girls of the control group and beneath 5% for boy controls.

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 183 interviewed children, 56 (30.6%) had already attempted to commit suicide. Young mothers often attempt to kill their babies along with them. 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 several hours or a night before being released without any follow up.

- “Immediately when the rebels entered Sierra Leone, I was arrested and trained by force to go to war and kill people. And that is what I had to do. I did so many bad things, killing innocent people, looting people’s properties, burning houses. I am a failure and I don’t know what to do now with my life. My parents are dead and I feel often ill, my stomach hurts all the time. I tried once to kill myself by drinking caustic soda, but my cousin threatened to bring me to the police next time I try. I just want to die.” (boy WPS, 20 years, Kailahun)
- “I never had the chance to go to school. Each time, I see other boys of my age going to school, I just hate life and feel like killing myself. The memories of loosing both of my parents in the Liberian rebel war are still the worst for me. The war has taken everything away from me and I see no point why life should continue. So much pain and suffering. When things get too bad, I will mix poison and drink it.” (boy WPS, 20 years, Koindu)
- “I tried to kill myself by preparing caustic soda. But before I could take it I was discovered and taken to the police. They let me go after a couple of hours. I tried another time to cut me with a knife, but I did not die although I lost a lot of blood. I just don’t see any sense in life.” (girl, control group, 18 years, Pendembu)
- “I think a lot about death, I feel that life is so much pain. I know how I can kill yourself. You can just buy caustic soda or rat poison and take it and it is all over. Very often after being beaten or after being chased out of the house, I feel like stealing it from the shop to end my life.” (boy WPS, 17 years, Kailahun)
- “My life was a chain of bad incidents. When I was small, my parents were captured by the rebels close to Guinea, tortured and shot dead. Life in the refugee camp was hard and after we got back to Sierra Leone, one night, an old man caught me at the well, carried me away and had sex with me. There is no one to assist me, my grandmother and my child now. I lost hope. This is beyond what I can bear, we are suffering so much. I recently bought rat poison. While I was trying to swallow it, I was caught by someone and taken to the police.” (girl WPS, 16 years, Koindu)

These testimonies are desperate calls for help. Children expressing firm intentions of killing themselves will not always take action to do so, nor is it certain that they want to die. Still, they are trying to signal to their surrounding that their capacity to cope has reached its limits.
and that they are not ready to go on any more. It is important to be aware that the groups of children in our study who were assessed to be highly suicidal pose considerable risk to seriously harm themselves or others in the near future.

![Figure 7: Prevalence of suicide risk in the different sub-samples](image)

6.6.1 Influencing and correlating factors for high suicidality

Apart from the factor “lack of parental support”, we tried to find out other variables determining the high suicidality of the sample. We identified the following common factors of children with high suicidality:

- living in a foster family ($\chi^2(1) = 41.39; p \leq 0.01$);
- being currently victim of physical abuse ($\chi^2(1) = 10.16; p \leq 0.01$);
- being currently victim of verbal violence ($\chi^2(1) = 4.73; p \leq 0.05$);
- being currently victim of neglect ($\chi^2(1) = 54.35; p \leq 0.01$).
- advanced age: within the interviewed age range (8 -20), there is a positive correlation between advanced age and a high suicidality (Pearson $r = 0.16; p \leq 0.05$).

Education levels measured in the number of years in school had no impact on the suicidality of children. In general, participants with high suicidality had in common that they have lost hope. They observe how other children receive better treatment and feel no need for
themselves to endure any longer the suffering that life has foreseen for them while other children enjoy their lives. High suicidality is often linked to feelings of being rejected from main caretakers or other close relatives. The testimonies of children illustrate the close relationship of domestic violence and an elevated suicidality.

Another reason for the increased suicidality might be that children often hear about and even witness suicide attempts. Within the interviewed sample, 19% of the children had already witnessed someone committing suicide. Furthermore, children in case studies reported to have lost family members through suicide. The apparently high suicide rate in the general population probably incites children to plan, attempt and sometimes to succeed in committing suicide themselves.

6.7 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 6.2) and domestic violence (section 6.8, 6.9 and 6.10), common experiences among the interviewed children included natural disasters (39.2%), motor vehicle accidents (21.9%) and scary hospital treatments (56.3%).

The exposure range for different types of traumatic life experiences was from 1 – 46 events. On average, participants had been exposed to 18 different 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 8.

As visible in the figure below, girls and boys without parental support were exposed to significantly higher numbers of life threatening events than their counterparts from the control group [for girls (t(89) = 3.80, p ≤ 0.01); for boys: (t(86) = 8.09, p ≤ 0.01)]. Furthermore children in the age group from 8 – 15 years had lived noticeably less traumatic life experiences compared to the age group from 16 – 20 (t(177) = 4.56, p ≤ 0.01). They were less often exposed to war related violence and have a lower general exposure rate to difficult experiences due to their younger age.

Additional to the age, the gender factor also seems to be of importance. Girls were significantly more often exposed to different types of life threatening events than boys (t(177) = 3.73; p ≤ 0.01).
6.8 Exposure of children to domestic violence in life-time

Figure 8: number of different types of traumatic life events for the different groups of children

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 9, different forms of physical and verbal abuse were common experiences for most children. The testimonies of the children demonstrate the humiliating and devastating effects of repeated domestic violence.

- “I don’t know what was most horrible in my life. The war experiences were devastating. I lost both parents and our home was burnt down. On our way to Guinea, I witnessed many killings, dead bodies everywhere. Life has not become easier now. My uncle will beat me up for every little mistake I make. His own daughters and sons are kings and queens and I am just not supposed to be there. They will not even let me eat with the others. I wish my parents were not dead. my situation makes me feel hopeless, sad and tired of life.” (boy WPS, 19 years, Kangama)
- “The husband of my aunt makes me work a lot, even when I am very tired he keeps sending me out to do work for him. When he gets mad, he starts beating me very hard, throws things at me and yells at me that he will kill me.” (girl WPS, 15 years, Koidu)
Differences between the case and the control group were evident (see figure below). Boys and girls without parental support are more often subjected to physical abuse [for girls \( \chi^2(1) = 6.35; p \leq 0.01 \) and for boys \( \chi^2(1) = 6.42; p \leq 0.05 \)] and to verbal violence [for girls \( \chi^2(1) = 6.22; p \leq 0.05 \) and for boys \( \chi^2(1) = 4.89; p \leq 0.05 \)], they were more often exposed to neglect [for girls \( \chi^2(1) = 12.70; p \leq 0.01 \) and for boys \( \chi^2(1) = 45.59; p \leq 0.01 \)]. Girls without parental support were also more likely to be exposed to sexual abuse \( \chi^2(1) = 7.39; p \leq 0.01 \).

Gender comparisons indicate that boys and girls were equally exposed to physical abuse and verbal violence [for physical abuse \( \chi^2(1) = 1.81; p > 0.05 \) and for verbal violence \( \chi^2(1) = 0.69; p > 0.05 \)]. Girls were, however, notably more often neglected in life-time than boys \( \chi^2(1) = 9.43; p \leq 0.01 \). Not surprisingly, they were also notably more at risk for sexual abuse \( \chi^2(1) = 34.45; p \leq 0.01 \).

**Figure 9: Exposure to different forms of domestic violence (life-time)**

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 38% of the girls and slightly over 3% of the boys had been subjected to sexual abuse at least one time in their lives. As illustrated in the Figure 9, girls without parental support were the most vulnerable group with an abuse rate above 50%. Rape cases were very common during the war, but girls also reported recent experiences of sexual violence.

• “Two years ago, a man drew me of from the street, covered my mouth and carried me in his room and kept shouting at me. He injected something in my arm and I became unconscious. When I woke up, blood was running down my legs and the man was gone. I ran back home and told my aunt what happened. She reported the man to the police for investigation, but up to now nothing has happened. I am scared that he will do it again.” (girl WPS, 20 years, Kailahun)

Out of the interviewed girls’ sample, more than 40% of the girls had at least one time in their life slept with someone in order to receive money or goods in return. Many of the girls engaged in transactional sex had experienced rape and other forms of sexual abuse during the war.

The girls and their families did not consider them as “prostitutes”: girls simply “go out” at night and sometimes come back pregnant. The girls made themselves available for men in order to be able to cover basic living resources and, in particular, to pay their school fees. Many of the girls were “friends” with several men. As a result, they were not able to know the father of their babies. Others reported that the future and very young fathers left the town as soon as he had learnt about the pregnancy without leaving any traces.

• “The most awful thing that happened to me during the war was when I was taken wife [raped] during the war by gun men. Recently after, my parents died both in a very short period of time. Since then I had nobody to take care of me and I have to sell myself to men to get things I need for living. Now I am living with a friend, but there is still no one caring for me, so I still have to go with men to get money.” (girl WPS, 18 years, Koindu)

• “My parents were killed by the Guinean rebels when I was very young and I lived for the time of the war in the refugee camp of Nongoa [in Guinea]. I am still with my aunt, but she is very hard on me and treats me different than the other children. She locks me up for long times, denies me food, and when she gets angry at me she punches me in the face, throws things at me or takes a stick to hurt me. Two years ago, my aunt gave me to a police officer who made promises to her that he will take care of me. He had sex with me and than disappeared because he was transferred to another area. We don’t know where he is and now I am disgraced. Ever since I feel dirty.” (girl WPS, 14 years, Koindu)

• “During the war, I lived with my grandmother in Guinea, but it was not safe, so we went to Liberia. Unfortunately, the situation in Liberia was also very tense and we were captured by rebels. I was asked to have sex with three rebels, but I denied. They beat me and started putting their fingers into my vagina. They only stopped because a senior commander was coming. Now, I am back in Kailahun, but my grandmother died and I stay with an aunt who does not care about me. No one helped with my school fees and other needs so I became men’s friend for some time. At the age of 15, I was pregnant. My child got born, but it has no father.” (girl WPS, 19 years, Koindu)
6.9 Exposure to domestic violence during the war

Domestic violence was a common experience for many children during the war, however as visible in the figure on ongoing abuse rates (see Figure 10), the numbers were lower during the war than at the present time. The number of children who reported ongoing domestic violence outweighed those naming domestic violence during the period of the war. Parents were probably too busy getting settled after the displacement that the domestic violence became less common. Another possibility is that the children had little memories of domestic violence because their recollections of the war were overshadowed by more life threatening events. Although rates were generally lower during the war; we can still take note of noteworthy differences between children without parental support and the control group. Girls of the exposure group were more often exposed to physical abuse, ($\chi^2(1) = 4.65; p \leq 0.05$) and verbal abuse ($\chi^2(1) = 12.66; p \leq 0.01$). Regarding neglect ($\chi^2(1) = 2.05; p > 0.05$) and sexual abuse ($\chi^2(1) = 1.41; p > 0.05$), however, no significant differences appear. The comparison of the boy sub-samples showed notable differences in terms of physical abuse ($\chi^2(1) = 10.70; p \leq 0.01$), verbal violence ($\chi^2(1) = 15.19; p \leq 0.01$) and neglect ($\chi^2(1) = 17.20; p \leq 0.01$). The gender comparisons showed that girls were more exposed to neglect ($\chi^2(1) = 9.93; p \leq 0.05$) and to sexual violence ($\chi^2(1) = 15.77; p \leq 0.01$) during the periods of armed conflict while boys were more exposed to verbal violence ($\chi^2(1) = 4.29; p \leq 0.05$).

Figure 10: Exposure to different forms of domestic violence during the war
6.10 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 incidence rates of children subjected to different forms of domestic violence are summarized in Figure 11.

The levels of verbal violence and physical abuse were generally quite elevated. Boys and girls, regardless of their group, were exposed to an elevated degree of physical abuse and verbal abuse. Girls without parental support, however, still had significantly higher rates for physical abuse than their control counterparts ($\chi^2(1) = 8.32; p \leq 0.01$). Furthermore, group comparisons showed important differences on the variable evaluating neglect. Both girls and boys without parental support were more neglected than their counterparts of the control group [for girls ($\chi^2(1) = 12.16; p \leq 0.01$) and for boys ($\chi^2(1) = 46.29; p \leq 0.01$)]. Girls WPS had also a higher exposure rate to sexual abuse than girls of the control group ($\chi^2(1) = 8.29; p \leq 0.01$). Furthermore, gender differences became apparent: girls were significantly more often exposed to ongoing neglect ($\chi^2(1) = 9.64; p \leq 0.01$) as well as to ongoing sexual violence ($\chi^2(1) = 25.28; p \leq 0.01$) than boys.

![Figure 11: ongoing exposure to different types of domestic violence](image_url)
6.11 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 in the family. The results of the analysis showed that:

- fostered children were more often exposed to ongoing neglect than children living with one or both parents ($\chi^2(1) = 18.27; p \leq 0.01$), but not more to physical abuse ($\chi^2(1) = 1.41; p > 0.05$);
- girls were more often neglected than boys (see section 6.10);
- being without parental support was a risk factor for being neglected and physically abused [for physical abuse ($\chi^2(3) = 57.09; p \leq 0.01$) and for neglect ($\chi^2(1) = 7.73; p \leq 0.05$)];
- ethnic group affiliations were no indicator: no significant differences are 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;
- age and education level were not representative factors for ongoing domestic violence.

6.12 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. Their narrations were marked by close confrontations with death or perceived death threat against themselves or another person. The responses to this question are clustered in nine categories and summarized in Table 8. 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. Most answers were classified in the categories “death of a family member”, “domestic violence” or a combination of these two categories: “the parents died and the child is at the present time subjected to severe domestic violence by its current guardian”. Children who evoked situations related to domestic violence talked about situations such as

- being maltreated and neglected on a daily basis
- being rejected or driven out of the house by the guardian,
- being severely injured due to inflicted violence
being hurt and humiliated in front of others.

“My parents died during the war, they just got sick and died. I am now with my older sister. Every time something gets missing, I am accused and she takes up a stick and beats up to the moment that I bleed. Last time after she had beaten me, my back hurt so badly, there was white stuff coming out of the wound. I could not sleep any more. A woman put alcohol on it, it burnt a lot, but then it got better.” [she shows her back full of scars to the researcher] (girl WPS, 17 years, Pendembu)

“The wife of my guardian always finds a reason to punish me. She always tells people how bad I am, how stubborn I am. She has humiliated me so many times and threatens to chase me out of the house. I don’t know what is worse: the beating or the threats to be thrown out of the house.” (boy WPS, 16 years, Kailahun)

“When I got pregnant, my mother was extremely mad at me. She started beating me and then chased me out of the house and told me never to come back. I was so scared. I tried to get rid of the pregnancy with chemical products, and I became sick, but the baby survived.” (girl, control group, 18 years, Kailahun)

“I don’t know why, but I pee in bed. It happens when I am asleep. Every time it happens, the wife of uncles strips me naked and sends me like that out of the house. The she asks other children to sing about me and to humiliate me, throw things at me. Every time it happens, I am not getting food for the entire day. I wish I could just disappear.” (boy WPS, 15 years, Kangama)

The loss of the parents was also often a highly traumatic situation for the children. They witnessed how their parents were tortured before being killed in front of their eyes (see also 6.2.5). For many orphans, the loss of the parents and the later inflicted ongoing violence were connected. They had drawn conclusions such as “I have no parents which means that no one will protect me from violence and assist me in my life” out of their life trajectory. Further important categories include “war atrocities”, (witnessing torture and killings, forceful abduction, looted properties and burnt houses). Sexual violence was for 12 of the interviewed girls and for two of the boys the most terrifying life experience.

“My older brother used to protect me. He loved me so much. But then, the rebels captured us, they killed him and I had to watch it. He used to do everything for me, he even supported my father for getting food. Since he is gone, daily life is difficult and from time to time I go and see men for having money for me and my children. But no one wants us.” (girl WPS, 20 years, two children, Pendembu)

“I was a very small boy when the RUF attacked my village in the early morning hours. My parents took me to Foya in Liberia. After a year, NPFL rebels violently invaded the town. They killed my father in a big ceremony and ate his raw body. My mother escaped that night and went into hiding. I was left in the bush. When she came to search for me the next day, she was taken away by rebels and made a bush wife. She moved with me later to Guinea to Fallango camp in Nongoa. A few years later, she was killed by rebels in Guinea. No one cares about me now and I have no family left.” (boy WPS, 17 years, 7 years at the incidence, Koidu)

“My parents were captured by the RUF rebels. They were beaten, tortured and put in the sun for long hours without drinking or food. One day, the rebels killed them. I was in refuge in Guinea with an aunt. But the rebel war came over there one day. I was captured and put into an empty room where a group of men did lots of harm to me. They raped me over and over.” (girl WPS, 10 years at the incidence, 18 years, Kailahun)
Table 8: categories of the most disturbing events ever lived by the children

<table>
<thead>
<tr>
<th>Event category</th>
<th>Total sample</th>
<th>Girls</th>
<th>Boys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape/ abortion</td>
<td>14 (7.8%)</td>
<td>12 (13.5%)</td>
<td>2 (2.2%)</td>
</tr>
<tr>
<td>War atrocity</td>
<td>20 (11.2%)</td>
<td>9 (10.1%)</td>
<td>11 (12.4%)</td>
</tr>
<tr>
<td>Family members died/ were killed or threatened to be killed during the war</td>
<td>52 (29.1%)</td>
<td>29 (32.6%)</td>
<td>22 (24.7%)</td>
</tr>
<tr>
<td>Domestic violence (other than sexual abuse)</td>
<td>45 (25.1%)</td>
<td>23 (25.8%)</td>
<td>22 (24.7%)</td>
</tr>
<tr>
<td>Parents died, child currently subjected to maltreatment</td>
<td>32 (17.9%)</td>
<td>10 (11.2%)</td>
<td>22 (24.7%)</td>
</tr>
<tr>
<td>Separation from parents during the war</td>
<td>3 (1.7%)</td>
<td>0 (0%)</td>
<td>3 (3.4%)</td>
</tr>
<tr>
<td>Illness</td>
<td>7 (3.9%)</td>
<td>2 (2.2%)</td>
<td>5 (5.6%)</td>
</tr>
<tr>
<td>Others</td>
<td>6 (3.4%)</td>
<td>4 (4.5%)</td>
<td>2 (2.2%)</td>
</tr>
</tbody>
</table>

6.13 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 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 socially non-acceptable behavior, reported that they were stigmatized, mocked and sometimes punished.

- “I have bad, bad dreams. About the killings of my parents. How can life continue if in your head awful things go on and on? Every time I wake up it is as if my parents have just been killed another time and me, watching, not able to move.” (boy WPS, 15 years, Kangama, suffering from PTSD)
- “Since my mother drowned in the river, I am afraid of water. I cannot get close to them; it scares me and brings back all the memories on how I sat next to the dead body of my mother. I am not going to places where I have to cross a river. Unfortunately, there are many around Koindu. When my grandma brought me over from Guinea she had to tie a piece of cloth around my head so I could not see the river.” (boy WPS, 14 years, Koindu, suffering from specific phobia and PTSD)
- “I keep thinking of my friend drowning in the river while I survived. I feel guilty. I am tired all the time and I feel like I cannot move easily like other people, my body is so heavy. Sometimes I think about death. I wish to die as life is of no interest to me.” (boy WPS, 16 years, Koindu, suffering from Major depressive disorder and post-traumatic stress disorder)
6.13.1 Mood and anxiety disorders

In the following 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 80% in the interviewed sample; PTSD rates were almost equally high at 76.5%. These numbers are highly alarming and show the long lasting consequences of the war: even more than seven years after the war ended, the mental health of the countless children was still severely impaired. As visible in the figure below, girls and boys WPS were significantly more impaired by major depressive disorder [for girls: \( \chi^2(1) = 10.00; p \leq 0.01 \); for boys: \( \chi^2(1) = 19.49; p \leq 0.01 \)]. Regarding the PTSD prevalence, difference between girls WPS and their counterparts of the control group were not significant \( \chi^2(1) = 3.09; p > 0.05 \). Both groups are very highly attained by this disorder. For the boy sub-sample, however, we assessed a considerably higher PTSD prevalence rate in the sample of children WPS \( \chi^2(1) = 46.72; p \leq 0.01 \). Moreover, the comparison of boys and girls indicated that girls are more vulnerable to PTSD than boys \( \chi^2(1) = 18.27; p \leq 0.01 \).

![Bar chart showing prevalence of mood and anxiety disorders in different sub-samples](image-url)

*Figure 12: prevalence of mood and anxiety disorders in the different sub-samples*
6.13.2 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). We differentiated in the assessment between alcohol related disorders and substance related disorders. In general, substance related disorders were rare in the exposure and the control group. There was no case of alcohol dependence. Two boys reported alcohol abuse and two other boys substance abuse. None of the interviewed girls testified excessive alcohol consumption. Substance dependence was confirmed by two girls and substance abuse by one girl. The excessively consumed substance was locally grown marijuana that was sold at the same price as ordinary cigarettes. The boys indexed with alcohol abuse used a locally distilled liqueur “pega pack” that is sold in plastic bags at the price of 1000 Le (~ 0.3 US$). As incident rates for substance related disorders were generally very low, there were neither significant differences between the exposure and the control group nor differences between boys and girls.

6.13.3 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.

We identified conduct disorders in 20.2% of the children. The highest rates were found in the group of girls WPS. Although both groups WPS displayed higher conduct disorder rates than the control group (see figure below), there were no significant differences between the case and the control sample. Amazingly, conduct disorders were significantly more common in girls than in boys ($\chi^2(1) = 18.24; p \leq 0.01$): 33% of the interviewed girls put on view conduct disorders while this was only the case for 7.6% of the boys. In most studies, conduct disorders during adolescence were more common in boys than in girls (Moffitt, Caspi et al. 2001). Indicators that were common for conduct disorders were

- running away from home,
- preference to sleep in market places instead of coming home,
- disobedience to basic rules,
- refusal to assist in household chores,
- stealing and
- brutalizing smaller children and animals.

We also observed that children, who experienced in their own childhood severe physical and verbal abuse, started at an advanced age of adolescence to abuse in return younger siblings. Many of them also projected anger and frustration on creatures with little defense such as chickens or goats. As a part of their refusal to obey their parents, girls also stay out late at night to engage in sexual relationships.

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, was significantly stronger represented in girls than it was in boys ($\chi^2(1) = 31.10; p \leq 0.01$). Furthermore, another time we saw higher rates in the sample of children WPS than in the control group, however, as for conduct disorders, differences were not significant. The children with ADHD encountered difficulties in staying 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: being incapable of following classes and getting punished by teachers for
forgetting assignments or for hyperactive and impulsive behavior in class such as fidgeting on the chair or interrupting other children or the teacher.

![Bar chart showing rates of conduct disorder and ADHD]

**Figure 13: Rates of conduct disorder and attention deficit/ hyperactivity disorder (ADHD)**

### 6.14 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 aim 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, 11 focus group discussions were conducted in three 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 bad war memories like the experience of a girl having lost her parents reminded them of their own painful experiences, similar to those experienced by the story character.

The children singled out without difficulty a large scale of feelings for the stories’ character:

- feelings of fear and terror: confusion, feelings of insecurity, helplessness, horror, feelings of becoming mad;
- feelings of sadness and depression: feeling rejected, hopelessness, anger, discouragement, shame and guilt.
The children did not only name the feelings, but also brought forward direct consequences of their emotions: difficulties sleeping and concentrating, constant worrying, isolation and loneliness. The different solutions proposed by the children on how to ease the suffering of the story’s characters can be grouped in five answer categories that are listed in decreasing importance:

I. Peer support: the most frequent answers to the problems depicted in the five stories were suggestions related to peer support systems. The participants proposed to ease the suffering by talking with friends, getting encouragement from friends and being introduced to a friend’s parents in order to receive food.

II. Advice: the children suggested providing advice to the suffering child in order to help him or her to overcome the difficulties. They recommended, for instance, integrating the suffering child in study/homework groups or skill trainings. For the epileptic crisis, they advised the child to stay away from fire and streams and to avoid being alone and to consult the hospital or a native traditional healer. As a resource person for advice, they named family members, particularly caretakers.

III. Faith: The third most significant group of answers was associated with finding consolation in faith: praying, asking other people to perform prayers and regularly visiting the mosque or the church.

IV. Escaping the area of abuse: Several answers put forward were to run away from the abusive household situation.

V. Report problems to an external structure for support: some of children proposed for the story on domestic violence to turn to community elders, to the child welfare committee chairman, to the Ministry of Social Welfare, Gender and Child Affairs (MSWGCA) or to go to an international NGO such as Save the children.

The answer categories indicate that children refer more to their peers, family and their faith than to an external support structures (governmental and NGO structures). Only a minority of children had it in mind to consult the state or international child protection institutions for situations of distress and violence. A more important resource seems to be religious establishments where people can socialize, sing, dance 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 Sierra Leone. The data collection was carried out in the district of Kailahun, 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 without parental support 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 Kailahun district. The dynamic currently affecting the development of children is complex and sustained by multiple factors. In the following sections, we will outline the most alarming effects and recapitulate the results of the comparison of the exposure and the control group (7.1). In a second step, we will try to shed light on the dynamic of underlying causes and sub-causes and discuss the interaction of their various effects (7.2). Within the paragraphs, we will also highlight the differences between boys and girls.

7.1 Mental health of children without parental support in Kailahun district

The long exposure to war related violence and loss has been a highly traumatic for many children and adults. The trauma of the war is amplified at the present time by a widespread and genuine domestic violence. As a result, even seven years after the war, the majority of children display signs of impaired wellbeing. What is more, we found a high prevalence of mental disorders in the exposure as well as in the control sample. Syndromes of depression and post-traumatic stress were particularly common and were more than twice as prominent as in our assessments in Togo, Burkina and Cameroon (Behrendt and Mbaye 2007; Behrendt and Mbaye 2008; Behrendt and Mbaye 2008). The Children also reported manifold behavioral disturbances (non-organic bedwetting, suicidal behavior, chronic grief). Although there was an undeniable vulnerability of all children to impaired mental health, we found substantial differences between the children without parental support and the participants of the control group.
Children without parental support had been exposed to more life-threatening experiences than the control group and they were more likely to be subjected to different types of domestic violence. Girls without parental support were twice as often victims of sexual abuse than their female counterparts of the control group and many of them were, at the time of the data collection, involved in transactional sex in order to sustain their living.

Many children without parental support experienced their right to protection to be violated on a daily basis. Only very few participants of the exposure group had the chance to be fostered in a family offering affection, protection and assistance for educational and nutritional needs. As a result of the lack of the protection, the great majority of indicators assessing mental health (well being, resilience, self esteem, suicidality and mental disorders) showed that children without parental support were largely disadvantaged compared to their counterparts of the control group: They had less coping capacity and prosocial skills, a lower self-esteem and were, as a consequence, often isolated and with little peer support. While suicidal behavior in the control sample pertained to approximately 5% of the sample, for the children without parental support, the rate was above 70%. Many of them had already attempted to kill themselves.

The children without parental support were also more vulnerable to mental disorders and behavioral disturbances than the control group and were more often severely impaired in interpersonal functioning and learning and participation skills. The results clearly exemplify that children without parental support in Kailahun district were in particular need for assistance. Moreover, gender comparisons pointed out that girls were more exposed to neglect and sexual violence than boys. The elevated levels of these forms of domestic violence in girls probably contribute to the fact that girls are more prone to develop mental disorders than boys. It is very important that psychosocial support programs offer services addressing the particular needs of girls (see also section 8.4).

7.2 Explanative factors for the impaired mental health status of children in Kailahun district

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

- Displacement and separation of families: All families encountered during the current study were displaced during the war. The rebel attacks in Kailahun forced an entire civilian population to flee the area for safer areas. 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.

- **Looting and destruction of infrastructures and properties**: the rebel invasions in Kailahun district 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. Power houses and supply lines were annihilated. The road conditions degraded to an extent that import and export activities are up to now encumbered. The entire region has been deprived of power which impedes both the poor infrastructure and the economical development of the region. Investors are discouraged by the strenuous working conditions and the problematical accessibility of the area. 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. The permanent poverty related stress and the high amount of time that caregivers need to invest in livelihood activities certainly contributes to the high rates of physical abuse and neglect of children.

- **Exposure to highly traumatizing, inhuman and life-threatening events**: in Kailahun district, only a few children of the study population were spared from war atrocities. Most children have witnessed 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 Sierra Leone. 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 Sierra Leone. Entire population groups were exposed to violations of most fundamental norms of humankind: people had to witness torture, rape and killing of family members; they were forced to eat human flesh and they were subjected to worst forms of sexual, verbal and physical abuse. Many people were dismembered by cutlasses. Children were converted into “assassins” and “bush wives”. The repercussions of these experiences are visible in the high prevalence of mental illness, suicide risk and domestic violence.

- **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 the years have lead to chronic symptoms of post-traumatic stress not only among children, but among adults as well.
• High general mortality rate during the war: Many civilians were killed during the war. Others died prematurely in refuge due to lack of availability of health care or lack of financial means for paying the treatment. 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 could not be re-constructed after the war.

7.2.1 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 children in Kailahun district. 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 orphan rates. Many of these orphans are currently either staying with second or third degree relatives, with very old and frail grandparents or other vulnerable caregivers without any kinship tie.

At the present time, the communities have to provide foster care for more children than ever before although their economic resources have greatly decreased. Before the war, it was tradition to raise children with the support of the extended families. Fostering relatives did not make the difference between their biological children and the children of relatives. Children living together under the same roof were all considered the same and caregivers provided as much support to the fostered children as to their own. This perception, however, has changed. Although there are still guardians that provide sufficient amount of affection and care to fostered children, this is clearly not the case for the majority of children without parental support. 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. In addition to that, fostered children are more likely to be exploited and neglected: it is a sad reality that fostering has become a catalyst for child abuse and exploitation in the post-war context of the Kailahun district.

The deteriorated traditional foster care system is one of the main factors affecting many children in Kailahun. 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, seven years after the war, we find a very elevated rate of mental disorders in children.

7.2.2 Vicious circles of “normalized” violence

The results of the current study imply that the levels of different forms of domestic violence were lower during the war, but have increased considerably in recent years. Caregivers are overstrained with their own traumatic experiences, losses and the constant struggle for surviving. In order to cope with their emotions, they project their own distress onto the children. The results of the study indicate that the amount and severity of the punishments are often disproportioned to the mischief committed by the child. A child is often subjected to severe forms of physical abuse for minor mistakes (such as losing small amounts of money or limited performance in household chores). Furthermore, caretakers feel vindicated to inflict harsh punishment on the children due to their “unacceptable” conduct. Truly, many children have developed deviant behavior due to emotional distress: bedwetting during adolescence, misbehavior or chronic apathy are widespread among children and particularly among those without parental support. Caretakers, unaware of alternatives, attempt to correct these “abnormalities” by recurrent maltreatment. The dynamic between conduct problems and domestic violence results in many cases in a vicious circle: the inflicted maltreatment affects the mental health of the children, leading to more deviant conduct, which induces the caretaker to increase the physical or verbal abuse which results another time in the relapse of mental health of the child. Rapidly, both, the domestic violence and the conduct deviances become chronic: the caretaker inflicts violence on the child even if the child is behaving correctly and the child misbehaves even if he or she is not maltreated.

Another dangerous consequence of the domestic violence is that children fail to learn non-violent ways of addressing conflicts than abuse of power and inflicting violence on others. Children observe on a daily basis how people use violence as a means to tone down negative feelings and for imposing their choices. It is very likely that the current generation of children will reproduce this “normalized” violence on their progeny. This second vicious circle of intergenerational violence represents a severe danger for the mental health of the upcoming population and even for the future stability of the country.

In fact, the current ongoing domestic violence is not only putting the mental health of individuals at stake. Violence in families and lack of prosocial and conflict resolution skills are
transferred to entire population groups. Endemic domestic violence and power abuse at community level can endanger the peace building process that the country is currently undergoing. The study findings lead to the hypothesis that the two vicious circles described above are likely to create a third vicious circle: the impact and consequences of the armed conflict will generate a degree of violence and mental illness at community level that are likely to precipitate another armed conflict. Thus, prevention of domestic violence and promotion of mental health represent major peace building assets.

7.2.3 Proliferation of transactional sex

Over 40% of the interviewed girls are involved in sexual relationships where sexual services are offered in return for presents, goods or money. More precisely, 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 Kailahun district.

7.2.4 Teenage pregnancy and children “without a 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 extremely vulnerable. Girls informing their caregivers about the pregnancy, are often driven out of the house. It is considered to be a shame for a family to have a child born out of wedlock. Family members punish the pregnant girl for harming their reputation by limiting or cutting off the support to her. The rejection of their families pushes many girls to desperate acts: they attempt to
commit suicide or they abort the baby by swallowing traditional medication (potion including herbs and the bark of the mango tree) or chemical products. 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 are forced to continue transactional sexual relationship as soon as they have delivered in order to be able to provide basic living resources for themselves and their child. This results, of course, quite often in a new pregnancy and a young non-supported mother of two children will be 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.
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 women and children. The results of the current study are startling/disquieting and contribute to the existing evidence that it is an imperative to provide psychosocial support to children directly affected by decades of armed conflict in Africa.

The foundation to our recommendations is to develop 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 collective and individual psychosocial support to severely affected children, in particular children without parental support and (4) supporting girls enrolled in transactional sex.

8.1 Strengthening the capacity of caregivers to support children

As emphasized in the conclusion, 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 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 without parental support

The project module proposed for the implementation of this recommendation is based on two sections: (1) the creation of a network for identifying vulnerable children and (2) the set up of specifically trained mobile psychosocial support and protection unit. The study has revealed a significant vulnerability of children without parental support. Many of them are in such desperate situations 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 without parental support 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 without parental support;
• 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 reach a large number of children. In Kailahun district, 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 actions 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 Sierra Leone.
9. Annex

Bibliography


Psychosocial needs of children without parental support in Sierra Leone


