

**Culture and Mental Health in Liberia:
A Primer**

2017

Culture and Mental Health in Liberia: A Primer

WHO/MSD/MER/17.3

© World Health Organization 2017

Some rights reserved. This work is available under the CC BY-NC-SA 3.0 IGO licence.

Publications of the World Health Organization are available on the WHO website (www.who.int) or can be purchased from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int).

Requests for permission to reproduce or translate WHO publications – whether for sale or for non-commercial distribution – should be addressed to WHO Press through the WHO website (www.who.int/about/licensing/copyright_form/en/index.html).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Contact for feedback and communication: Department of Mental Health and Substance Abuse at WHO (mhgap-info@who.int) or Sharon Abramowitz (saabramowitz@gmail.com).

Suggested citation: World Health Organization. *Culture and Mental Health in Liberia: A Primer*. Geneva, WHO, 2017.

Culture and Mental Health in Liberia: A Primer

Preface

At the request of the Liberia Country Office of the World Health Organization (WHO), we have prepared a narrative review of the literature on mental health and psychosocial programs (MHPSS) in Liberia. This review focuses on relevant beliefs, help-seeking behavior, service utilization and both formal and informal resources for mental health. This report can provide some useful background for those unfamiliar with the local situation that hope to contribute to improving mental health services in the country.

In 2015, a team was assembled specifically for this task through the Health in Africa Working Group of the University of Florida. We would like to thank the many people who generously contributed their time and expertise: Patricia Omidian, Amara Fazal, Alexis Boulter, Michael Dehalt, Chelsea Lutz, and Heejin Ahn, who helped locate and review the literature, and draft, refine, and edit the text.

One year later, the WHO commissioned an update of the report to reflect the changes wrought by the Ebola epidemic and to capture relevant research published from 2014-2016, and to include new initiatives in Liberian mental health and psychosocial services. Special credit goes to Patricia Omidian (WHO Liberia) for commissioning the initial phases of this project and to Mark van Ommeren and Edith van 't Hof (WHO Geneva) for supporting the finalization of this document. A special thanks to Patricia Omidian, Ruth Kutalek, Cora Passanisi, and Darren L. Domah for their valuable insights from the field. Amanda Gbaromo-Ndorbor of the Ministry of Health as well as John Mahoney and R Kesavan (WHO Liberia) kindly reviewed the pre-final draft.

In addition to coordinating the project, I reviewed the literature and edited the drafts and final manuscript. Producing this report has required a communal effort and all of the contributors worked intensively in the hope of making a contribution to the ongoing relief efforts and the long-term challenge of strengthening mental health services in Liberia.

Sharon Abramowitz, Ph.D.
Boston, December 14, 2016

Table of Contents

Executive Summary	7
1. INTRODUCTION.....	8
1.1. Background.....	8
1.2. Methodology	9
2. SOCIOCULTURAL CONTEXT	9
2.1. Geography of Liberia.....	9
2.2. Demography and Diversity	9
2.3. History of Liberia, Conflict, and Humanitarian Aid.....	10
2.4. Political aspects (organization of state/government), distribution of power, contesting sub-groups/parties)	13
2.5. Religious aspects (religious groups, beliefs and practices)	13
2.6. Economic Context and Social Structure	14
2.7. Marriage, Family, and Gender Relations	14
2.8. General health aspects.....	18
2.8.1. Mortality, threats to mortality, and common diseases.....	18
2.8.2. Overview of structure of formal, general health system.....	19
3. MENTAL HEALTH AND PSYCHOSOCIAL CONTEXT	21
3.1. Epidemiological studies of mental disorders and risk/protective factors conducted in the country	21
3.1.2. Local expressions (idioms) for distress and folk diagnoses.....	24
3.1.3. Explanatory models for mental and psychosocial problems.....	25
3.1.4. Concepts of the self/person (latent or explicit ideas about the relations between body, soul, spirit).....	26
3.1.5. Major sources of distress.....	29
3.1.6. Role of the formal and informal educational sector in psychosocial support.....	29
3.1.7. Role of the formal social sector in psychosocial support	30
3.1.8. Role of the informal social sector (community protection systems, neighborhood systems, other community resources) in psychosocial support	32
3.1.9. Help-seeking patterns (where people go for help and for what problems).....	33
3.2. The mental health system.....	34
3.2.1. Mental Health Policy and Legislative Framework	34
3.2.2. Description of Formal Mental Health Services (primary, secondary, and tertiary care).....	37

Culture and Mental Health in Liberia: A Primer

3.2.3. Relative Roles of Government, Private Sector, NGOs, and Traditional Healers in Providing Mental Healthcare	37
4. HUMANITARIAN CONTEXT	40
4.1. Experiences with past humanitarian aid involving mental health and psychosocial support.....	40
5. REFERENCES	42

Culture and Mental Health in Liberia: A Primer

Executive Summary

This primer to “Culture and Mental Health in Liberia” has been designed to provide to interested agencies and practitioners an accessible summary of the relevant literature on mental health and psychosocial support (MHPSS) in the Liberia context. It also helps establish a “history of the present,” or a recent history of international and Liberian national activities and challenges in the MHPSS domain in Liberia.

The report builds upon the framework for a literature review set forth in the WHO-UNHCR (2012) publication *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings*, which includes a template for desk reviews to summarize MHPSS information about an emergency-affected region or country.

Liberia is in the midst of profound social and cultural changes that are creating a complex environment for mental health and psychosocial needs and services. Since the end of the Liberian Civil War in 2003, a decade of post-conflict development has transpired which has seen an extraordinary investment in community-based mental health in some of the most resource-poor contexts in the world. It is impossible, to date, to know the impact of the recent West African Ebola epidemic’s powerful and tragic impact on Liberian lives, or how post-Ebola mental health and psychosocial support will change in the near future in the context of shifting trends. This report, however, should give interested agencies and practitioners a foundation for understanding the context.

This report reviews and summarizes the available literature on Liberian mental health and mental health services. During two study intervals from 2015-2016, searches were conducted of academic monographs, databases, and the expert technical literature for state-of-the art research relevant to mental health in Liberia across a range of subfields, including public health, psychology, psychiatry, epidemiology, humanitarian studies, anthropology, political science, economics, and regional and gender studies. No time limit or restriction of content was placed on the review. A wide range of topics were considered, from ethnic, social and cultural attitudes towards mental illness, to “post-Ebola syndrome.” The study was augmented through consultation with key informant interviews.

The first part of the review describes the general context with a focus on historical, geographical, demographical, economic, political, religious, gender and cultural factors essential to a basic understanding of Liberia and its people. The second part of the review focuses on mental health and psychosocial context. This includes a review of factors such as basic epidemiology of mental illness, common beliefs about mental illness, sources of distress, concepts of self, explanatory models, idioms of distress, help-seeking behavior, as well as the roles of different sectors in MHPSS and the formal mental health system. The third part of the review describes the humanitarian context, including experiences with past aid in the area of MHPSS.

There is a need for increased attention to mental health and psychosocial support (MHPSS) in Liberia. While Liberian mental health actors will know their country and cultural well, outsiders getting involved in Liberia’s mental health system need to have basic knowledge about the country, the people, and sociocultural aspects of mental health and psychosocial support in Liberia. Reading this primer will help ensure that new stakeholders in MHPSS will have a basic understanding of context to be more effective in their work.

1. INTRODUCTION

1.1. Background

Less than 1% of Liberians have access to appropriate mental health services. In 2014-2015, Liberia and its regional neighbors Sierra Leone and Guinea struggled to contain the largest epidemic outbreak of Ebola Virus Disease (EVD) in known human history. As of 26 May 2016, there have been 28,616 reported cases of Ebola, with an estimate of 11,310 fatalities. The tragic toll of the Ebola outbreak has weakened many of Liberia's post-conflict reconstruction gains in health and economic development achieved since the end of the Liberian war in 2003.

Prior to the West African Ebola epidemic, the Republic of Liberia was ranked 175 out of 189 countries in the 2014 UNDP *Human Development Index*, and struggled with extreme poverty, a lack of access to basic healthcare, governance and transparency issues, economic underdevelopment, widespread exposure to potentially traumatic events, a lack of infrastructure, and persistent societal violence. After years of governmental and NGO efforts to expand basic mental health and psychosocial services into primary health care in all fifteen of Liberia's counties, the Liberian health sector has been particularly hard hit; of the 372 reported cases among Liberian health workers, nearly half (n=180) have died of EVD—one of whom was a recently trained mental health clinician. The disruption in the healthcare sector undermined significant gains in training, staffing, and supporting mental health-trained health professionals. The loss of these clinicians is likely to undermine significant gains achieved in training, staffing, and supporting clinicians.

With the onset of new demands like post-Ebola syndrome (Kutalek 2014, Grady 2015), children orphaned due to Ebola, Ebola survivors' reintegration, and the losses and potential traumatic events experienced in local communities during the epidemic, the impact of Ebola on local mental health needs and services is likely to be significant. Governments, NGOs, and international organizations such as the World Health Organization are collaborating to "Build Back Better" mental health systems in Liberia (WHO 2013, 2016a) after the Ebola epidemic. The challenges are great, but commitment has been demonstrated by the government and international partners. Strengthening Liberia's health systems capacities while meeting the immediate challenges of a still incomplete post-conflict transition requires the creation of health systems capacity at each level of the mental health system, from psychosocial support in the community to clinical treatment, from case reporting to epidemiological surveillance, to updated and expanded mental health policy and legislation, to mental health financing mechanisms that are sufficient to meet emergency-related and routine needs.

This report is intended to contribute by summarizing what is known about Liberian mental health/psychosocial support and Liberian mental health services and informal supports before and during outbreak. This includes a review of the literature and background information on basic epidemiology (where data is available), common beliefs about mental illness, explanatory models, idioms of distress, help-seeking behaviors, configuration of mental health services and the relationship between religion and mental health. This review is intended to inform short-term, medium and long-term efforts to improve mental health care and mental health services in

Culture and Mental Health in Liberia: A Primer

Liberia by outlining social and cultural issues relevant to Liberian mental health care, identifying systemic gaps, and identifying recent and past innovations in the field of mental health and psychosocial intervention.

1.2. Methodology

The report builds upon the framework for a literature review set forth in the WHO-UNHCR (2012) publication *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings*, which includes a template for desk reviews to summarize MHPSS information about an emergency-affected region or country. This paper reviews and summarizes the available literature on Liberian mental health and mental health services and was conducted in light of the West African Ebola epidemic from 2014-2015. The authors searched Medline, Google Scholar, and other available databases to gather scholarly literature relevant to mental health in Liberia using a range of keywords in different configurations. Keywords included, but were not limited to: Liberia, Ebola, EVD, post-conflict, conflict, education, depression, anxiety, psychosis, schizophrenia, learning disability/disorder, MHPSS, mental health, mental illness, mental disorder, psych*, conflict resolution, community healing strategies, drug abuse, substance abuse, counseling, gender-based violence, epilepsy, neuro*, brain*, trauma, PTSD, psychosocial, psychiatric. This review was supplemented by consultation of key books and grey literature relevant to Liberia and consultation with key informants in 2016 who had been involved with MHPSS in Liberia from 2014-2016. The first part of the review describes historical, economic, sociological, and anthropological factors essential to a basic understanding of Liberia and its people. This includes discussion of demography, family structure, economics, and religion. The second part focuses on mental health and mental health services, with a review of factors such as basic epidemiology of mental illness, common beliefs about mental illness, explanatory models, idioms of distress, help-seeking behaviors, configuration of mental health services and the relationship between religion and mental health.

2. SOCIOCULTURAL CONTEXT

2.1. Geography of Liberia

Liberia is a sub-Saharan nation in West Africa spanning 110,000 square kilometers (43,000 square miles), of which approximately 87% is land. It is located on the North Atlantic Coast of Africa and is bordered by Guinea to the north, Cote d'Ivoire to the east, and Sierra Leone to the northwest. Coastal mangrove swamps, lagoons, and sandbars characterize the terrain. The interior is dominated by dense tropical rainforests covering rolling plains and a rolling plateau, with low mountains in the northeast. The climate in Liberia is tropical and humid. There are high precipitation levels, making the region uniquely suitable for intensive latex rubber, cocoa, and coffee cultivation, while territorial resources include mining reserves of gold, alluvial diamonds, iron, and most recently – offshore coastal oil reserves.

2.2. Demography and Diversity

Liberia has a population of nearly 4.1 million. Approximately 60% live in urban areas, and 43% of the population is under 15 years of age. Prior to the Ebola outbreak, the median age of the

Culture and Mental Health in Liberia: A Primer

population is 19 years old, and life expectancy is 60 among women) and 63 among men, but the immediate impact of the Ebola outbreak may have affected these estimates (Helleringer and Noymer 2015). The largest ethnic groups in Liberia include the Kpelle, Bassa, Grebo, Gio, Mano, Kru, Loma, Kissi, and Gola. Linguistic groups are typically correlated with “tribes” of the same name, and tribal identities are important aspects of social affiliation. English is the official language of Liberia, but 15 indigenous languages are officially recognized. Estimates of literacy among Liberians over the age of fifteen vary from 20-60%. Recent research suggests that some of Liberia’s linguistic diversity may be in decline due to urbanization, migration, and changes in formal and informal education systems (Childs 2015).

Liberia has a strong ethos of “Liberia for Liberians.” There are some large non-citizen permanent resident populations, like the Lebanese community, that have resided in Liberia for over a century, and are critical of constitutional legislation that prohibits their citizenship. Article V, Section 13 of the 1847 Constitution prohibited citizenship to all but “persons of colour.” In 1955, clause was changed to “Negroes or persons of Negro descent.” This clause likely also impacts the treatment of other minorities of non-African descent.

2.3. History of Liberia, Conflict, and Humanitarian Aid

The modern state of Liberia emerged in the 19th century amidst concern from white Americans about the legal and social status of free people of African descent. They were convinced that post-slavery racial integration was an unrealizable goal in the United States, and founded the colony of Liberia as a free settler society that would exemplify the possibility of black self-governance. At its independence on July 26, 1847, Liberia was known as the second “Black state,” following Haiti, which gained independence in 1804. Early coastal settlements like Monrovia (named after the 5th US President, James Monroe) were populated by freed American black slaves, and the settlements were linked together in a loose chain of commerce and exchange. Liberian settlements were dependent upon the American Colonization Society for food, equipment, weapons, and medical support, and the naval support of the United States government. For these reasons, Liberians colloquially refer to Liberia as “America’s stepchild.”

From 1808-1866, the United Kingdom established the Blockade of Africa, which intercepted slaving vessels and returned captured slaves to nearby African coastal regions. The population of Liberia expanded when British naval vessels intercepted slaving ships from central Africa and deposited the slaves in Liberian settlements. Settlers and their descendants were called Americo-Liberians, and new arrivals were called “Congoes.” Together, they formed an elite political, economic, and social class that ruled over the indigenous tribal groups that comprised 95% of the population of Liberia. Americo-Liberian social, religious, legal and political institutions formed the basis for the contemporary government of Liberia, and ethnic and religious competition for resources continues to function as a source of conflict. During the first 150 years of Liberia’s existence, the state gradually expanded through an assemblage of legal doctrines (*The Laws and Regulations of the Liberian Hinterland*), military actions (*The Frontier Forces*), missionary campaigns, and international territorial leasing agreements (e.g. with *Firestone Corporation*). Social unrest grew under the rule of a self-serving oligarchy of Americo-Liberians.

Culture and Mental Health in Liberia: A Primer

After a long period of authoritarian rule under President William Tubman funded by resource extraction arrangements and the financial patronage of other governments, conflict broke out under his successor, William Tolbert. The beginning of Liberia's political and military destabilization began in April 1980, when Sergeant Samuel Doe launched a military coup d'état to topple the government of the First Republic, and install himself as President. The Liberian civil war officially began on December 24, 1989, when Charles Taylor, a former member of the Liberian government, began to seize much of the territory of greater Liberia with Libyan support. During the subsequent thirteen-year conflict, the United Nations, the Economic Community of West African States (ECOWAS), and the neighboring states of Guinea, Sierra Leone, and Cote d'Ivoire became involved in the conflict. The Liberian war continued intermittently for thirteen years, and is estimated to have caused the deaths of 200,000-300,000 people, and to have displaced millions more across the region. In 1997, the international community, anxious about regional destabilization, secured a partial cease-fire among Liberia's warring factions and installed the Interim Government of National Unity (IGNU). Soon after, Charles Taylor won a presidential election with a wide margin. Conflict resurged under Taylor's despotic rule, and in 2003, the conflict was brought to an end through a negotiated peace settlement and the installation of a temporary government, the National Transitional Government of Liberia (NTGL) (McGovern 2005, Reno 2008).

From 2003 to the present day, the Government of Liberia (GOL) has worked in partnership with the United Nations Mission for Liberia (UNMIL), a peacekeeping and humanitarian assistance operation established by UN Security Council resolution 1509. At the outset of the partnership, UNMIL and its bilateral, multilateral, and NGO partners took a lead role in consolidating the territory of Liberia under UNMIL authority on behalf of the government of Liberia. UNMIL also took a lead role collaborating with the GOL to manage affairs of state, rebuild Liberia's foreign relations, restore democratic elections in 2005, addressing national indebtedness issues, and delivering emergency humanitarian assistance to an impoverished, food insecure, and largely displaced population. From the period 2003-2007, nearly half of Liberia's population was repatriated from refugee and IDP camps to largely destroyed urban centers and rural villages through a massive campaign that used the slogan "Home is best." This massive period of displacement required the direct support of the population through humanitarian food, medical, housing, and cash disbursements in order to avert recurring public health crises, violence and instability, and a reversion to war.

The period of 2003-2005 also witnessed the repatriation of more than 120,000 combatants who had participated in all aspects of the Liberian war through the Disarmament, Demobilization, Rehabilitation, and Reintegration (DDRR) process, which exchanged cash and tuition or vocational training waivers in exchange for arms and the enlistment of individuals in an ex-combatant registry. In principle, all DDRR activities were required to include psychiatric and other mental health components, but in reality, the inability to identify a Liberian psychiatrist to lead the initiative resulted in the absence of any mental health or psychosocial screening during the DDRR process (Abramowitz 2014). Later, many ex-combatant initiatives hosted by international organizations or NGOs did include mental health and psychosocial components, but these initiatives cannot currently be traced through monitoring and evaluation documents that might speak to their utilization and efficacy.

Culture and Mental Health in Liberia: A Primer

In 2005, the first national election since Charles Taylor's 1997 election resulted in the election of Ellen Johnson Sirleaf, who campaigned on a platform of re-engaging with Europe, North America, and Asia; addressing Liberia's critical debt burden; combatting gender-based violence; and fighting corruption. This augured the onset of a rapid effort to shift authority from UNMIL to the Government of Liberia, despite many Ministries' lack of management experience and uncertain mandates. The Liberian national army, police forces, and political parties had been temporarily disbanded for retraining; the international embargoes on Liberia's leading cash exports (timber, diamonds, mining) as a result of wartime trade and ethics violations were in place; and the government was, essentially, broke.

Over the next eight years, from 2005-2013, President Sirleaf worked in partnership with the international community to negotiate large-scale debt forgiveness, re-equip various governmental ministries (Health and Social Welfare, Education, Gender), and bring peace and stability. As Liberia gradually assumed a greater burden of responsibility for managing its internal and external affairs with the continued strong support of UNMIL, and by extension, the UN Security Council, general conditions in the population slowly improved, but corruption remained a significant problem. However, at the end of this period, the majority of social services, food assistance, education services, and medical services were still provided by third-party humanitarian and development actors working in lieu of government service delivery.

During this time, many hundreds of Liberians were employed by international NGOs as "trauma healers" or "psychosocial agents" –a low-level staff or volunteer role for conducting recruitment, evaluation, counseling and community-based psycho-education. The training included empathic listening, basic education about post-traumatic stress disorder, anxiety disorders, and depressive disorders, basic counseling skills, and community outreach (Abramowitz 2014). Training processes for trauma healers and psychosocial agents have been criticized for their highly variable training, duration, supervision, and certification criteria. In some cases, personnel received ongoing training and supervision over many years from licensed mental health professionals. In most other cases, however, "trauma healers" and "psychosocial workers" were effectively unregulated and unsupervised; but were empowered by NGOs to conduct community-based education, outreach, and counseling after one-off brief (e.g. one-day, three-day, or one-week) training of trainers (TOT) initiatives.

Despite overall improvement, Liberia remained nearly at the bottom (175/187) on the Human Development Index in 2013. The inability of the healthcare sector to meet the pressing health needs of the general population was known to medical humanitarian programs; and the health sector was subject to recurring shocks, or epidemic outbreaks, throughout every year from 2003-2014. The Ebola outbreak was by far the most severe of many epidemic shocks that destabilized the Liberian health sector. Its catastrophic impact upon the Liberian economy, health system, transportation, education system, and national and local revenues eclipsed previous crises. The Ebola outbreak also resulted in a temporary surge in humanitarian response to end the current outbreak, and repair the systemic gaps in the health sector that had allowed the outbreak to occur in the first place.

With the 2017 national elections on the horizon, and the pending closure of the United Nations Mission in Liberia, the key concerns for all Liberians are political and social stability, continuity

Culture and Mental Health in Liberia: A Primer

of governance, economic revitalization, and the strengthening of the national health system, including national-level coordination and local access to care.

2.4. Political aspects (organization of state/government), distribution of power, contesting sub-groups/parties)

Liberia is centrally administered by a national government based in the coastal capital, Monrovia. At the local level, Liberia is divided into fifteen counties. Each county is administered by a superintendent appointed by the president and is further divided into districts, chiefdoms, and clans. The basic unit of local government is the town chief or committee of elders. The system of “native” administration retains much of the older system of indirect rule in which local chiefs collect taxes and judge minor cases, but the legal framework for this system is in flux.

Since 2005, Liberia has functioned as a constitutional democracy under the presidency of Ellen Johnson Sirleaf, winner of the 2011 Nobel Peace Prize, and the first female elected African president. An intensive international effort to support Liberia’s post-conflict reconstruction has been engaged in by the Liberian government in partnership with the United Nations Mission in Liberia (UNMIL), bilateral aid, and NGO-supported humanitarian assistance. The period of post-conflict reconstruction has seen marked improvements in life expectancy, maternal-infant health, economic and infrastructure development, and political stabilization, but institutions in Liberia remain highly dependent on foreign assistance and imported commodities, and highly vulnerable to shocks like the West African Ebola outbreak. The expatriate Liberian population living in North America and Europe contributes a high level of remittances and plays an important role in Liberian politics.

2.5. Religious aspects (religious groups, beliefs and practices)

Liberia is predominantly Christian, with approximately 85.6% of the population adhering to various sects of Christianity. Prominent denominations include: Lutheran, Baptist, Episcopal, Presbyterian, Roman Catholic, United Methodist, African Methodist Episcopal (AME), AME Zion, and a variety of Pentecostal and Seventh-Day Adventist congregations. Different sects of Christianity are known to correspond to different spheres of political influence and economic resources. An additional 12.2% of the population adheres to Islam, of whom a majority is Malikite Sunni, with Shia and Ahmadiyya minorities. Muslim populations are closely associated with Vai and Mandingo tribes, but are also known to be prevalent among Gbandi, Kpelle, and other ethnic groups. In addition, 1.5% claims no religion, and 0.6% follows indigenous religious beliefs. The remaining population identifies as Baha’i, Buddhist, Hindu, and Sikh (IRFR, 2014). Sociocultural beliefs have intermixed with religious and indigenous practices in Liberia, blurring the distinction between religion and culture.

Despite the predominance of common religions, many Liberians incorporate aspects of indigenous religion – including secret societies, warrior cults, witchcraft, sacrifices to ancestors, reincarnation, and evil spirits – into their daily practices (Tolerance and Tension, 2010). Traditional animistic cosmology holds that there are powerful spiritual forces that are neither good nor evil, but can be harnessed for political, economic, or social power, and harm or restore physical and mental health. Traditional forces must be engaged with carefully by following the

Culture and Mental Health in Liberia: A Primer

rules of centuries-old men's and women's secret societies called *Poro* and *Sande*, or specific cults like Leopard or Snake societies, which are also responsible for religious initiation, circumcision, bush schools, and the administration of religious and spiritual rituals. Spiritual forces are considered powerful, but dangerous to tamper with, and can cause infertility, madness, or death, as can the commission of murder or theft, or being the victim of witchcraft or sorcery (Geschiere 1997). Many consult traditional religious healers, keep sacred objects in homes, and believe in the power of juju, all without asserting claim to traditional religions. Most Liberians believe that political and economic power is obtained, at least in part, through the manipulation of occult forces (Ellis and Ter Haar 2004). Traditional religious practices have been implicated in several murders associated with organ or body-part theft over the last two decades.

Liberia has no official religion, and its state constitution and laws generally affirm religious freedom. Public businesses and markets are encouraged to close on Sundays and Christmas (IRFR, 2014). Some Muslims report discrimination (Freedom House, 2014). Roughly 76% of Liberians in a survey believed that people of other faiths were free to practice their religion. However, almost half of all Liberians surveyed believed that conflict between religious groups was a very big problem in Liberia (Tolerance and Tension, 2010). Specific religious beliefs and practices played a prominent role in community-based responses to the Ebola epidemic, especially around the issue of burials.

2.6. Economic Context and Social Structure

Liberia is one of the poorest countries in the world, with a per capita GDP of US\$410 in 2013. As of 2007, 88% of Liberians live on less than \$1.25 per day, indicating high levels of absolute poverty (The World Bank Group 2015a). Liberia has the official World Bank status of a Heavily Indebted Poor Country and a United Nations classification as a Least Developed Country (The World Bank Group 2015b, United Nations 2015). Although official economic growth rates in 2014 were projected at 5.8% (The World Bank Group 2015c), the impact of the Ebola crisis has resulted in an economic collapse and food insecurity, and capital flight.

Liberia has rich natural resources and a climate that favors agriculture, but civil war has depleted the country's human capital and infrastructure, creating a heavy dependence on imports and foreign aid. Access to electricity, improved sanitation facilities, clean water supply, and year-round passable roads remains low. Current barriers to economic growth include inadequate infrastructure, poorly defined legal frameworks governing land administration, conflict between different ethnic groups, and low financial sector development. Liberians mainly find employment in the agriculture sector, which includes subsistence farming and industrial rubber, coffee, cocoa, and rice production. Employment is also found in trade and services, and a small sector of the economy is manufacturing and industry. The merchant marine industry is responsible for a significant allotment of both employment and revenue in Liberia (Government of Liberia 2015).

2.7. Marriage, Family, and Gender Relations

Households and communities in Liberia are highly organized by age and gender. From childhood through old age, men and women are socially organized into age cohorts. Older age cohorts have

Culture and Mental Health in Liberia: A Primer

considerable authority over youth, and have the ability to make binding decisions about youth labor, education, marital choices, and healthcare. Youth are expected to be obedient and deferential to elders in an extensive kin network of obligation. A culture of “hypermasculinity” likely contributes to a cultural context in which gender-based violence is highly prevalent, even pervasive (Jones et al. 2014).

Prior to the Liberian war, this paradigm governed marriage and family (Dunn-Marcos et al. 2005). According to Moran (1990), Liberian marriage customs, family life, and gender roles are closely associated with kin group classification as ‘civilized,’ ‘kwi,’ and Americo-Liberian; or ‘country,’ ‘uncivilized,’ ‘traditional,’ or ‘native.’ This informal classification has a substantial impact on how people organize households, families, economic responsibilities, and educational attainment, but there is considerable diversity between ethnic and religious groups, and across regions.

In the post-war period, social changes have undermined this system, leading to greater independence among youth, especially in urban areas. Today, in Liberia, 28% of women and 30% of men are married, and 30% of women and 24% of men are living together in informal unions (DHS 2013). Most households are multi-generational, and there is a widespread practice of child fosterage (22% of children were in household fosterage arrangements in the Liberian Demographic and Health Survey). Birth rates are rising rapidly in a context where children are highly valued, but infant and childhood mortality rates are high, and women have limited capacity to regulate family size. The process of childbirth itself is often handled by locally trusted traditional healers and midwives (Modarres and Berg 2016).

There has been a significant trend towards urbanization, with more than 50% of the Liberian population living in urban centers. The high levels of mobility, violence, and urbanization have shifted social relations within households, but domestic and sexual violence has reportedly substantially increased, even as households have consolidated and people have reentered schools and reassumed agricultural roles or other professions. In the course of this transition there appears to have been a gradual shift towards nuclear families, Christianization, and cultural urbanization, including the adoption of urban values, dress, lifestyles, and occupations, but many retain close connections to rural patterns of kinship, language, and dress. Status can be achieved through education, marriage, and professional attainment, but a dominant elite system makes upward mobility difficult. As a result, youth unrest is widespread, and youth movements and strikes occur frequently to bring attention to the lack of jobs, educational opportunities, and upward mobility for young men and women. Formal marriages are often monogamous, featuring nuclear family arrangements, and tend to occur late. Informal or “traditional” marriages are also widespread, and one may have serial traditional marriages in one’s life. People who self-identify as “traditional” live in rural areas, participate in a traditional gendered division of labor, are polygamous, and are often closely associated with specific market and agricultural practices (Moran 1990). In both ‘civilized’ modern households and traditional households, men and women contract informal extramarital unions with ‘girlfriends’ (also called ‘country wives’) or ‘boyfriends.’ Among Western-educated Liberians, marriage is contracted through legal and church-based ceremonies. Girls tend to socialize, date, and become involved with boyfriends prior to marriage. Marriage usually happens at a young age, between the ages of 16-18, but girls who receive higher education tend to defer marriage for longer periods of time due to policies

Culture and Mental Health in Liberia: A Primer

that prohibit pregnancy within schools. In rural Liberia, polygamy is considered an ideal, and women may marry soon after menarche. The state recognizes both traditional marriages and “modern”. Both are legal but rules are not the same for both and it is important, particularly for women, to understand that rights vary.

Among indigenous populations, marriage is to an extent a socio-economic venture in which the husband must pay the wife’s family a bride price and must perform bride service, or labor (Dunn-Marcos et al. 2005), but romantic love is becoming an increasingly important motivation for marriage in both rural and urban areas. In the event of divorce, the woman’s family is responsible for repaying the bride price and the husband receives custodial rights of their children, hence the Vai saying *kai watamudengnda* – a child belongs to his father (Olukoju 2006). Traditional custom dictates that the children of marriage belong to the husband and his family, but post-war Liberian legal reforms now grant custody to both parents. Relatedly, traditional custom mandated that upon the death of a male, all his assets (including children) revert to his family. Post-war legal reforms now mandate an equitable distribution of the deceased’s assets to spouse and children. These are seen as important legal reforms to advance gender equity.

While historically, gender roles are clearly defined within families and are associated with expected economic contributions, gender roles are in a state of radical flux in the aftermath of the Liberian war (Abramowitz and Moran 2012). Men are responsible for providing land, houses, and cash, and for clearing the land for agriculture and harvesting, along with performing hard labor activities such as making furniture or porting loads (Moran 1988, Dunn-Marcos et al. 2005, Fuest 2008). Since the end of the war, traditional women have become the dominant labor force in food production, responsible for 70% of cross-border trade (Diggins and Mills 2015). Urban women have assumed a greater role in politics, education, the NGO sector, and professional services (Fuest 2008). Across the board, women’s critical role has earned them the title of “breadwinner” (Moran 1988). Prior to the war, however, women’s primary roles included food production, child rearing, and domestic work. The economic distribution of labor within households also varied by ‘civilized’ and ‘traditional’ status. In traditional households, women are more likely to participate in market activities, hold a certain degree of autonomy, and assume a relationship of *gender complementarity* within households. This contrasts with urban households, which feature *gender dependency*. Kwi women are often financially dependent upon men for cash, gifts, and support, and have less autonomy. They are also socially dependent on their husbands for status. A shift in economic activity, (e.g. from professional labor to market labor) could rapidly change a woman’s status from modern to traditional, and male family members (fathers, sons, brothers, and husbands) readily claim the products of her labor (Moran, 1986).

Many taboos, or cultural prohibitions, function to maintain social order and have positive health and social effects, and are heavily socially policed. General sexual taboos include those barring having sex with a pregnant woman or a woman who is still breastfeeding (Dunn-Marcos et al. 2005). Social taboos include using one’s left hand to greet people and hand over items, or selling food that has not been covered (Olukoju 2006). Some individuals and groups have specific rules regarding clothing that can be worn or food that can be eaten; and some medicines are believed to only work so long as individuals and family members observe specific rules.

Culture and Mental Health in Liberia: A Primer

Because of changing social expectations within the household, domestic labor issues are a source of friction and can result in violence. Women are becoming increasingly resistant to husbands', fathers', brothers', boyfriends', and community leaders' efforts to lay claim to their cash, labor, and other earnings, and this is an important cause of domestic disputes. Men may accuse women of being unfaithful with other boyfriends, and women may protest men's spending of household cash on girlfriends or other family members. Women are expected to prepare food for their husband and children, and food is often withheld as a sign of displeasure with the marriage or as a suggestion of infidelity (Schroder 1974, Moran 1988).

The formal and informal education of children has also undergone major social changes. Girls are given household, cooking, and child-rearing tasks in order to prepare them for married life. Boys are encouraged to seek labor or apprenticeships from an early age. School is difficult to access for both girls and boys, and school fees are a barrier to entry. With many men and women returning to high school and university education in the post-war period, access to financial resources for items like books, uniforms, school fees, and food is low, and demand is high. Men and women regularly have domestic conflicts over how limited financial resources are to be distributed for food, clothing, and educational expenditures for themselves and their children; and who has the right to make these determinations. These conflicts are known to result in violence, and community leaders may have limited ability to intervene due to changing social expectations surrounding leadership and authority (Abramowitz and Moran 2012).

Parents and elders are closely involved in the upbringing of children, and strict disciplinary methods are used. Mothers and siblings play lead roles in disciplining younger children, and practices like beating, 'peppering,' and depriving of food are common disciplinary tactics. Sibling 'parenting' responsibilities and expectations intensified in the context of conflict and life in refugee camps (Dunn-Marcos et al. 2005). Children conceived out of wedlock are not stigmatized; and a father may bring a child conceived out-of-wedlock into the household to be raised. However, children conceived during the war, especially as a consequence of rape, may be stigmatized by their own parents and by community members, and may be seen as having inherited 'bad characters' from combatant parents. Maternal-child attachment, postpartum depression, social rejection of the mother, and social rejection of the child have all been issues that have arisen for women who conceived children during the war.

'Fosterage,' or the practice of transferring children out of their parents' households into family or community members' households for childrearing, education, and labor, is a common practice in Liberian society, and it draws upon the belief that children are a shared resource, and that communities help to provide for families in times of trouble. Fosterage traditions provided important social supports during the Liberian War and during the Ebola epidemic. The practice of fosterage has been practiced in the region for many centuries, and it was most commonly known to occur when a family had more children than they were able to feed, and a relative or friend was childless. In this situation, the move of the child to a friend, neighbor, or family member was seen as contributing to the well-being of the child, the child's parents, and the childless family (Moran 1992).

The practice of fosterage has ambiguous implications for physical and mental wellbeing. During the Sierra Leone and Liberian conflicts, child fosterage was used to accommodate major

Culture and Mental Health in Liberia: A Primer

population displacement and instability issues (Shepler 2005), and it was also used as a model for child recruitment into armed forces (Coulter 2009, Utas 2008, for mental health implications see (Behrendt 2008)). While communities have been known to pool resources to send children to school, and fosterage can provide children with safe and loving homes where they have access to education, serious concerns are emerging around the use of child fosterage as a social coping mechanism. Before Ebola, fosterage was increasingly being recognized as a way to facilitate extreme uses of child labor in household, mercantile, and agricultural work, and there is a growing recognition that girls and boys are at a high risk for physical and sexual violence in fosterage situations. When the household needs for fosterage exceed available food, clothing, space, and labor resources, children may also be shifted between households many times, leading to instability and a lack of continuity in caregiving, access to health services, and educational access (Bledsoe, Ewbank, and Isugo-Abanihe 1988). Since the Ebola outbreak, communities have worried that the widespread demand for child fosterage was economically unsustainable, and they have demanded financial, psychosocial, and maintenance support for the fostered children of Ebola victims and Ebola child survivors (Abramowitz et al. 2015)

Elders are referred to as *Uncle, Aunt, Mister, Mrs., Old Man, Papaye, Old Pop, or Old Lady*, and are traditionally afforded great prestige. Respect for one's elders is a core cultural value and as such elders are often cared for by children and may reside in the same home. If more than one generation lives in one house, the eldest male is considered the central authority figure. These extended family homes are often seen among traditional families, whereas nuclear families are more common among Western-educated homes. It is disrespectful for a child to shake hands with an elder (Dunn-Marcos et al. 2005). However, elder authority is often a source of community friction because elders may be seen as hoarding wealth, information, and resources from youth (Ellis 2001, Rowlands 2008); as using their authority illegitimately (Murphy 1980); or as having been made irrelevant by recent post-war social changes (Sawyer 2005). New sources of authority are emerging through growing exposure to Western media, telecommunications, rising urbanization, and an increased value upon western education and urban employment. Practices in international development continue to call for consultation with community elders as a strategy for engaging community support in development projects in Liberia (Fearon, Humphreys, Weinstein 2009, Flomoko and Reeves 2012).

2.8. General health aspects

2.8.1. Mortality, threats to mortality, and common diseases

Health conditions are regarded as poor in Liberia, but in recent years, most measures of population-based health have been steadily improving, with continual improvements in the under-five mortality rate, maternal mortality ratios, and deaths due to HIV/AIDS and tuberculosis. Prior to the Ebola outbreak, life expectancy had reached 60-63 years from a postwar low of 43 years, but the probability of dying between the ages of fifteen and sixty is high (262/1000), suggesting that high mortality rates are not just ascribable to high infant and children under 5 mortality rates. Leading causes of death are acute respiratory infections, malaria, tuberculosis, HIV/AIDS, stroke, diarrheal diseases, maternal, neonatal, and nutritional causes, heart disease, chronic respiratory disease, and suicide, homicide, and conflict. There has been a steady improvement noted in all causes of mortality from 2000-2012. It is anticipated that many

Culture and Mental Health in Liberia: A Primer

of these gains will have been temporarily reversed by the recent Ebola outbreak's death toll and its resulting impact of diminished access to health services

2.8.2. Overview of structure of formal, general health system

The Liberian war destroyed the physical, logistical, and human resource infrastructure of the Liberian health system, and placed the Government of Liberia in a position of dependency on medical humanitarian aid. Since 2006, health systems strengthening has been a key priority for Liberia's MoHSW, but Liberia remains dependent upon foreign aid for the delivery of primary and tertiary healthcare (WHO 2015). The Ebola epidemic revealed that health systems strengthening requires a greater investment in all aspects of health systems functioning (healthcare worker (HCW) training, surveillance, reporting, analysis, policy, financing), and that post-conflict investments focused on primary healthcare to the exclusion of all other factors. This has prompted a major structural overhaul that included a planned comprehensive restructuring of the Liberian health sector bureaucracy. This restructuring would be largely funded through extramural funds.

The Liberian health sector is funded through the Liberian national budget and direct bilateral and multilateral grants, all of which is funneled through the Pool Fund, a financing mechanism established under the 2007 National Health Plan to centralize international fund allocations and facilitate the nationalization of healthcare priorities. The National Health Plan called for the decentralization of the Liberian health sector. The purpose of the innovation of The Pool Fund is to allow the MoHSW to realize efficiencies by bypassing the need for multiple parallel grants and projects, allow the MOHSW to direct the allocation of funds in direct partnership with international NGOs, and allocate resources to nationally identified priorities (Lee et al. 2011). It provided a blueprint for the development of primary, secondary, and tertiary levels of healthcare; and legislated the suspension of user fees. It also committed the Liberian government to increasing total national budgetary commitments to health expenditures to 15% of the national budget (Lee et al. 2011). The official policy for health sector redevelopment has been to expand primary health care access and to decentralize health care administration to County Health Teams (CHTs) lead by a County Health Officer, who reports to the Minister of Health.

Current policy indicates that mental health care is to be fully integrated into the Liberian primary healthcare system. Funding for mental health is a legislative mandate, but it has taken a low priority relative to other health expenditures. Mental health financing has a low priority. In a 2009 policy exercise designed to develop realistic financial cost estimates for the basic package of health services, mental health services were allocated US \$0 (RBHS 2009). However, significant steps have been taken to build a 'Coordinated Care' approach that integrates mental health into primary health care (c.f. collaborative care). (Patel et al. 2013)

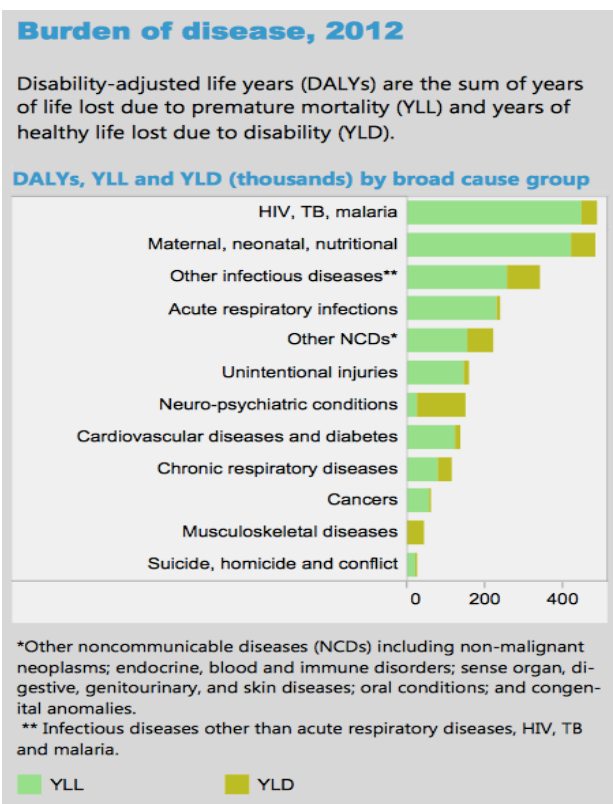
A central component of Liberia's health policy is the Basic Package of Health Services (BPHS), which assures maternal and newborn health, child health, reproductive and adolescent health, communicable disease control, mental health, and emergency care (MOHSW 2008). However, the BPHS explicitly notes that "Several major areas of concern, even those of particular concern in the post-conflict environment such as mental health, were either excluded for the time being, or have been accorded lesser priority" because they do not advance MOHSW priorities of

Culture and Mental Health in Liberia: A Primer

decreasing morbidity and mortality; deploying safe, effective, and available interventions; are not feasible given Liberia's resources and constraints; or lack the potential for medium- to long-term sustainability (MOHSW 2008, 5). The main focus of the Liberian MoHSW has been the training and expansion of a health professional workforce in mental health diagnosis, treatment, and referral; and the expansion of diagnosis and mental health referral best practices. Local and international NGOs have been working with the MoHSW to secure a regular supply of commonly needed psychiatric medications on the Essential Drug List. A 2011 report on the basic package of essential services also prioritizes the growing need for mental health and substance abuse services, but as of 2011, access remains low (MOHSW 2011a, 2011b), with just 18% of clinics offering any form of mental health services. Most primary healthcare facilities run by international NGOs do not include mental health in their programming.

Figure 1: Liberia Burden of Disease (WHO 2015)

Compared to other countries in the region, healthcare service utilization is relatively low due to a lack of access to supplies, equipment, and staff in healthcare facilities—recent analyses from Liberia's MoHSW suggest that 41% of all households (15% urban and 61% rural) did not have access to a health facility. Recent evaluations of healthcare access further indicate that local populations have lowered health facility utilization and low confidence in the formal healthcare sector due to a fee-for-service system implemented during the health sector transition. Even so, in recent years, the Liberian government had made significant strides in primary health care delivery. In 2010, 80% of government facilities were ready to provide the Basic Package of Health Services, and the healthcare workforce had tripled from 3,107 in 2003 to 9,196 in 2009 (Lee et al. 2011). The MoHSW has also revitalized nursing and midwifery training through the Martha Tubman School of Midwifery in Grand Gedeh County, the Esther Bacon School of Nursing and Midwifery in Lofa County, and the Tubman Institute of Medical Arts in Monrovia. The largest hospital in Liberia is John F. Kennedy (JFK) Hospital in Monrovia, which is financed and administered by the MoHSW.



The majority of the primary and secondary healthcare facilities in the country continue to be administered by foreign aid organizations. Clinics and hospitals administered by the state are seen as providing an inferior standard of care, often due to the imposition of a pay-for-service or cost-offset system that discourages utilization, even in cases of emergency. Access to healthcare in Liberia is understudied, but one 2008 study of essential health services in Nimba County reports on barriers to healthcare and healthcare utilization practices in a region where

Culture and Mental Health in Liberia: A Primer

humanitarian health services have been made available to offset limited public health sector services. In Nimba County, a densely populated region on the border of Cote d'Ivoire and Guinea, Kruk et al. (2010) found that residents had to travel an average of more than two hours to reach any health facility, while in each village, there was an average of 2.3 village healers (Kruk et al. 2011). Another study of confidence in healthcare in Nimba County found low rates of confidence in access to healthcare among rural populations (Svoronos, Macauley, and Kruk 2014). Respondents who used health services used *both* traditional healers and available primary and secondary health services. All respondents could access malaria treatment at that facility, but only 55% could access HIV testing, 26.8% could access emergency obstetric care, 14.5% could access care for pediatric illnesses, and 12% were able to access mental health services. Essential infrastructure investment has been focused on primary clinics, but substantial underinvestment in public health, epidemiological and emergency response capabilities has been identified as a factor in the inability of the health system to manage the 2014-2015 epidemic outbreak.

A recent study of over 100 Liberians with physical and mental disabilities found that individuals confronted major challenges obtaining support through informal networks (Cooper and Libanora 2016). Community-based rehabilitation services are not integrated with mental health services, and mental health services tend to be concentrated in highly populated areas like Montserrado County, where the capital city Monrovia is located. The study also found that 62% of all respondents had difficulty accessing mental services when they needed them. While a relatively high proportion of respondents in this study's sample were taking medications--respondents with mental health (76%) or epilepsy (97%) disabilities were taking medications--it also found that these individuals had difficulty accessing medications.

Traditional healers include herbalists, bonesetters, midwives, diviners, and other types of religious healers (Schoepf and Guannu, 1981). In a context of rising Pentecostalism in Liberia, they may also include faith healers, pastors and prosperity gospel preachers. In the formal healthcare sector, access to care is limited and inconsistent. This problem is exacerbated by the fact that the majority of public health care services are funded through international funds, which are subject to external pressures, timeline and allocation restrictions, and fluctuations in the global demand for humanitarian health services. Some researchers believe that the traditional healing sector is frequently characterized by secrecy, authority, and distrust of the healthcare system (Lori and Boyle, 2011), while others suggest that traditional healers and local midwives are highly trained and experienced and much more caring than nurses and doctors at hospitals and clinics, but are unfairly excluded from the formal healthcare sector by specific training and educational barriers (Modarres and Berg 2016).

3. MENTAL HEALTH AND PSYCHOSOCIAL CONTEXT

3.1. Epidemiological studies of mental disorders and risk/protective factors conducted in the country

Mental illness has been long studied in Liberia, but little past medical or anthropological literature is available for review (Nolan 1972, Thébaud 1982). The medical anthropological and transcultural psychiatric study of Liberian culture and mental illness seems to have been effectively disrupted from 1985-2007. Even with the resumption of research activities in Liberia

Culture and Mental Health in Liberia: A Primer

post-war, there has been little research on the distribution of severe psychopathology, mental disorders, and risk/protective factors in Liberia, and there was an absence of reliable public health data to inform the Global Burden of Disease (GBD) Report.

Research on mental illness in Liberia has focused on the burden of post-traumatic stress disorder (PTSD) and other common mental disorders (e.g. depression, anxiety disorders, suicidality) in populations most affected by conflict, and on exposure to traumatic events like combat or sexual violence.¹ In one study of an area highly affected by violence, murder, or battle, 48% of respondents reported symptoms of PTSD (Galea et al. 2010), which tracked closely along the geographic path of battle. This estimate is in line with a previous study that found that 44% of respondents met symptom criteria for PTSD, 40% met criteria for major depressive disorder, 10% reported suicidal ideation, and 8% met criteria for social dysfunction (Johnson et al. 2008). A study of Liberian refugees in the Oru refugee camp in Nigeria found that among a fairly small sample of 200 refugees, 60% reported a sufficient number and severity of symptoms consistent with PTSD (Olubunmi and Dogbahgeen 2013). Two studies of PTSD among Liberian refugees identified minor variations in expected PTSD symptom structure (Rasmussen, Smith, and Keller 2007, Vinson and Chang 2012).

A more recent study of youth mental health needs in Monrovia predictably found that war exposure and post-conflict sexual violence, poverty, infectious disease, and parental death negatively impacted youth mental health and functionality in education, employment, and positive social relationships (Borba et al. 2016).

There are also very few studies of substance abuse among Liberian populations. A study of substance abuse among Liberian adolescents found that 50% of respondents had used alcohol, 9% had used marijuana, and that all adolescent substance users were more likely to engage in risky sexual behaviors (Harris et al. 2012). One study of frequent alcohol users found that frequent alcohol use was correlated with decreased healthcare seeking behaviors and extreme poverty (Weil et al. 2014); and another found that ex-combatants were more likely to abuse alcohol, suggesting a possible attempt to self-medicate mental illness (Johnson et al. 2008). Abramowitz's (2014) ethnography describes the use of marijuana and diazepam by war-affected youth to manage symptoms of PTSD and depression.

Severe psychiatric morbidity issues were found among ex-combatants (Johnson et al. 2008) and among children formerly associated combatant groups in Nimba County (Behrendt 2008). The persistence of PTSD may be associated with continued exposure to extreme stress in a context of chronic stressors like post-conflict instability, poverty, food insecurity, and sickness (Galea et al. 2010). Johnson et al. also identified traumatic brain injury as a possible widespread complication among ex-combatant populations and may confound efforts to diagnose mental illness at the community level (Johnson 2012). There are almost no resources across Liberia to address what may be a high burden of neurological disorders, including traumatic brain injury.

According to the UNDP, almost everyone experienced or witnessed atrocities during the war (UNDP 2004), including murder, rape, and physical abuse. Sexual violence, rape, and atrocities

¹These data are largely derived from population-based psychiatric epidemiological research using self-report symptom checklists. Trained diagnosticians have not clinically validated these reports.

Culture and Mental Health in Liberia: A Primer

during the war and post-war period have reportedly, been rampant, fueled by a culture of ‘hypermasculinity’ (Vinck and Pham 2013, Lekskes, van Hooren, de Beus 2007). High rates of sexual violence, transactional sex, and “chronic exposure to sexual violence” persist, are worsened by poverty and instability, and are believed to impact women’s risk of sexually transmitted infections (Callands et al. 2013, LISGIS 2008). These risk factors are likely to create vulnerabilities to long-term mental disorders (Jones et al. 2014). Swiss et al (1998) found a high rate of reported incidences of sexual violence, coercion, and torture, with 49% of all participants reporting at least one act of physical or sexual violence (Swiss 1998). Wartime statistics on rape have been the subject of methodological critique (Palermo and Peterman 2011), but high levels of wartime and post conflict sexual violence rates have been confirmed in subsequent studies (Johnson et al. 2008), as have persistent/chronic PTSD over time. In Johnson et al.’s study, both male and female ex-combatants were many times more likely to have been exposed to sexual violence and to experience PTSD. The mental health legacies of wartime sexual violence across the region have been qualitatively described (Liebling-Kalifani et al. 2011, Coulter 2009).

The mental health and psychosocial burdens caused by the recent Ebola epidemic remain unstudied, but are presumed to be high enough to warrant serious policy attention (Van Bortel et al. 2016, Schutz et al. 2015). Studies conducted in Nigeria during the recent Ebola outbreak found that the psychosocial effects of the Ebola epidemic included adjustment disorders, symptoms of anxiety, and depression (Mohammed et al 2015a, 2015b, 2015c). In Ebola patients, delirium was common at the end-stage of the disease, creating complications for containment of highly infectious patients. Some mental health experts have observed mental disorders like depression, anxiety, and post-traumatic stress disorder, vision problems, blindness, chronic joint pain, and possible neurological complications in Ebola survivors which may be part of an emerging discussion on “post-Ebola syndrome” (Kutalek 2014, Grady 2015).

Baseline mental healthcare, including psychosocial counseling, was integrated into Ebola case management, requiring a major scale up of Liberia’s mental health and psychosocial response systems capacities. The integration of psychosocial counseling into Ebola case management had important effects. It reduced conflict, facilitated behavior change, helped families and communities respond to quarantines and deaths, strengthened reporting systems, and created important bridges to survivor reintegration. However, case management plans may have failed to take into account two key issues that have had import for post-Ebola mental health: (1) how to respond to the specific (and overwhelming) mental health needs of survivors; and (2) how to respond to fear as a social contagion effect (Thomas 2015, Cheung 2015) during a major epidemic. Anti-stigma activities were likely effective – a national Knowledge, Attitudes, and Practices study conducted in November 2014 found that close 100% of respondents believed that Ebola was real and found that 90% of respondents would welcome Ebola survivors back into their communities—but it also found that 50-60% were concerned that they could still be infected by a survivor. As indicated earlier, communities that were highly affected by Ebola in Monrovia reported a need for psychosocial support for child Ebola survivors and were certain that children would need counseling and trauma-healing (Abramowitz et al. 2015).

Culture and Mental Health in Liberia: A Primer

3.1.2. Local expressions (idioms) for distress and folk diagnoses

There are few identified local idioms of distress in Liberia, but there has been some documentation of the local expressions, symptoms, and psychosocial consequences of epilepsy and PTSD over the last four decades. Goudsmit et al. (1983) identified the term *See-ee* to describe epilepsy in Grand Bassa County, and others have noted the distinct psychosocial consequences of epilepsy among the Bassa and Kpelle tribes (Jilek-Aall et al. 1997).

Open Mole is a local term to characterize a syndrome associated with depression, anxiety, insomnia, malaise, neck pain, and dizziness (Abramowitz, 2010). It is used in both urban and rural areas, and it is believed to be caused by a softening of the skull, similar to sunken fontanel in infant dehydration, but it is believed to occur in adults. Archival records also indicate the use of the term *Open Mole* among the Gola tribes in Liberia fifty years ago, and among individuals in urban Monrovia in the present day. *Open Mole* can be initiated by a sudden fright or experience of loss, so in recent years, people experiencing symptoms of traumatic stress, anxiety, and depression related to conflict, death, desertion, or other forms of suffering have characterized their symptoms as *Open Mole*. Some NGOs providing mental health services in Liberia have integrated the term *Open Mole* into psychiatric classification. However, the use of *Open Mole* into psychiatric classification practices may have induced Liberian populations to report experiencing the condition in order to obtain psychotropic medications.

Commonly reported symptoms of *Open Mole* include:

- Headache
- Fast Heartbeat
- Insomnia/Difficulty Sleeping
- Worry
- Loss of Appetite/Weight Loss
- Nightmares
- General sense of fear
- Feeling cold
- Eyes swinging
- Cries a lot
- Weakness in the body
- Sitting by self, not talking to no one
- Trembling
- Neck pain
- Body pain
- Confused
- Sadness
- Didn't understand what life held for me
- Thoughts of ending life
- Heat in the body
- Flashbacks
- Fatigue
- Poor memory/forgetfulness
- Hearing voices
- Running into the bush
- "Going off"
- Aggressive behavior
- "Just talking, talking anyhow"
- Chest pain
- Seeing things
- Feeling of insects or worms crawling in body or head
- Poor concentration
- Back pain

Culture and Mental Health in Liberia: A Primer

With respect to psychoses, terms used to describe people with mental illnesses are “walking talkers – people who absentmindedly soliloquize in the streets,” “mentally abnormal,” “crazy,” and “wild” (Maximore 2011). In urban areas, signs of severe mental illness (likely psychosis) include hearing voices, talking to oneself, eating garbage, torn clothing, deep sores, not shaving, malnutrition and eventual starvation, and exposure to the elements. In rural areas, people are described as “going off,” “tearing their clothes and running into the bush,” or as self-isolating. The western concept of trauma is well known and well-understood in Liberian contexts, and is a frequently used term in local discourse.

3.1.3. Explanatory models for mental and psychosocial problems

Severe mental illness and neurological disorders like epilepsy are highly stigmatized among Liberians, and untreated mentally ill persons are likely to suffer from extreme abuse. People believe that mental illness is contagious, that it is caused by witchcraft, and that it is retribution for misdeeds caused during the war (Downie 2012). In order to manage the physical movements and behaviors of people with mental illness, community members may resort to extreme physical punishment like tying people down by their wrists and ankles, binding them to a tree or a house (Downie 2012), or quieting them with alcohol. People with serious mental illnesses are often beaten, subject to witchcraft trials, and raped. Mental health clinicians and psychosocial workers have found that family education and community outreach can effectively persuading Liberians that individuals are suffering from a disorder, encourage medication adherence if necessary, and support behavior changes between mentally individuals, families, and communities (Abramowitz 2014, Betancourt 2008, 2010).

Mental illness continues to be regarded by many Liberians as a punishment or effect of having committed evil deeds, like rape or murder; as evidence that one has been a victim of sorcery or witchcraft; as a consequence of engaging in sorcery, African sign, African magic, black magic; or as a consequence of having violating religious totems and taboos (Abramowitz 2014, Maximore 2011). Liberians observe taboos and totems as part of animistic practices that are closely tied to places of origin, kin groups, religious practices, and cultural traditions. The violation of ordinary taboos and other cultural rules are also seen as causes of mental illness, or madness (Olukoju 2006).

In many ways, like in other societies, traumatic stress poses an exception to the rule of stigma towards mental illness. Liberians possess a rich cosmology of explanations for wellness and illness (see Figure 2) and shift between explanatory models rather freely, with the introduction of new problems or new information. The western concept of *trauma* is well known and well-understood in Liberian contexts, and is a frequently used term in local discourse. Liberian populations self-identify as having a need for trauma healing and counseling services in many contexts, and in a recent study of vulnerable youth (orphans, homeless children, ex-combatants, children of ex-combatants, street children, children with mental illnesses, criminals, and children with epilepsy) they actively appealed for counseling, medication, and in some cases, institutionalization (Levey et al. 2013). This level of cultural adoption of the concept of trauma is likely an outcome of long-term exposure to mental health and psychosocial public awareness campaigns during and after the war. It possibly also reflects a specifically Liberian awareness of the extreme experiences of violence, impoverishment, and vulnerability that Liberians experience in their everyday lives.

Exposure to trauma is also seen as a cause for drug abuse, interpersonal violence, poor self-care, promiscuity, and psychosis. The use of the term trauma is often situated in the context

Culture and Mental Health in Liberia: A Primer

of a demand for external counseling support services (as, for example, when community leaders call for trauma counseling for children who have been affected by Ebola as a result of the deaths of family members, community stigma, or the experience of having survived the disease). The concept of trauma, for Liberians, references mental health and psychosocial struggles, including depression, PTSD symptoms, anxiety, social withdrawal, or compulsive or reactive behaviors. Liberians tend to see traumatic stress as a progressive health problem that involves rumination, worry, anger, anxiety, and stress, but poses a risk of total deterioration and destabilization into insanity and death (Maximore 2011, Abramowitz 2014). It is also seen as contributing to social disorder and petty criminality issues that disrupt public life.

Wider events can complicate this relatively simplistic discussion of explanatory models. Based on studies published to date, it appears that emotional disorders (anxiety, depression, PTSD) among patients with Ebola, family members, survivors, or “contacts” are not stigmatized for manifesting a mental health problem (although they may be subject to stigma for EVD). Additionally, discussions of mental health and psychosocial care under conditions of war or major epidemics seem to include the problems and concerns of the collective. For example, during both the Liberian War and the Ebola epidemic “social contagions” of panic, fear, paranoia, and stigmatization circulated through the Liberian population in response to volatile events, frightening news reports about changing health, social, political, or economic conditions, and perceived social and political emergencies (Mohammed et al. 2015). According to a Centers for Disease Control ethnographic research study, fear, anger, and distrust of governmental and international authorities (Moran 2015) was directly associated with decisions to evade Ebola reporting, containment, and clinical measures. Additional factors like the dysfunction of Ebola reporting hotlines, fears of quarantine, adopting a “wait and see” approach also resulted in running away, hiding, and other forms of resistance when signs of Ebola were detected (Roth and Lacson 2015).

3.1.4. Concepts of the self/person (latent or explicit ideas about the relations between body, soul, spirit)

	Liberian Traditional View	Western View
Ways of Being (Worldview)	Supernatural forces and powers largely shape human experiences. The physical and spiritual realms are interdependent. A supreme Great Spirit creates all life. Spirits and forces are neither evil nor good --- they are simply powerful. The human spirit transcends the barrier of death and exists in both mortal and spiritual worlds.	Humans exist at the center of a random and inequitable universe. It is their responsibility to discern and transform the environment for the improvement of lives. Spiritual forces are seen as being aligned with either goodness or evil, following Judeo-Christian religious thought and worldviews. These views are latent, and not explicit in Western biomedicine.
Concepts of the Person	A person is composed of both body and spirit, which are interdependent and inseparable	A person is composed of a body and a mind that co-exist, but are often regarded as separate

Culture and Mental Health in Liberia: A Primer

	<p>during life. The separation of the spirit and the body occurs at death, but it can also occur during life as a result of tampering with powerful spiritual forces during life through witchcraft or sorcery. This can cause infertility, madness, and death.</p>	<p>(Cartesian dualism). Concepts of the mind are often associated with concepts like morality, will, virtue, and weakness; while understandings of the body are often grounded in a biological understanding of human corporeality that is affected by disease, injury, and aging.</p>
Health	<p>Health is a holistic concept that suggests a harmony between all aspects of life:</p> <ul style="list-style-type: none"> • The natural, non-human environment (forests, animals, etc.) • The human environment (nuclear and extended family, community, village) • The invisible realm (ancestors, spirits, gods) <p>Health and wellbeing is present when there is a balance of social relations, morals and conduct, wealth, and physical well-being.</p>	<p>Health is associated with the optimal functioning of human biological systems defined by physiological and biochemical parameters and psychological well-being. Environmental factors influence health via physical impacts (i.e. access to food, environmental pollution). Social well-being is seen as an important part of one's well-being, but it is not recognized as being a central aspect of human health. Health and wellbeing is assessed by individual performance in physical, psychological, and social functioning.</p>
Illness	<p>Illness results from a disruption between the individual and elements of the environment (see below). Social separation or a violation of spiritual or natural laws is cited as the source of illness.</p>	<p>Illness occurs when there is a disruption of normal functioning in biological or psychological systems.</p>
Origins of Illness	<p>Illnesses result from disturbances in the relationships between individuals and their environments may include:</p> <ul style="list-style-type: none"> • Conflict in social relationships • Violation of religious and spiritual community, family, and individual taboos • Affliction or possession by 'African sign,' sorcery, malevolent spirits, or dark magic 	<p>Illnesses are caused by genetic or hereditary predisposition, infection, injury, or neglect of chronic conditions.</p> <p>External factors causing illness or injury result from the introduction of foreign bodies into the organism. They may include:</p> <ul style="list-style-type: none"> • Exposure to environmental toxins (e.g. carcinogens) • Behavioral habits (e.g.

Culture and Mental Health in Liberia: A Primer

	<ul style="list-style-type: none"> • Hexes, curses, or poisons sent by others • Retribution by ancestor or spirit for wrongdoing • Guilt for past or present misdeeds <p>Violations of communal taboos may result in infertility, madness, or death.</p>	<p>overeating)</p> <ul style="list-style-type: none"> • Poor hygiene and sanitation practices and conditions • Acute, external factors (e.g. sexual assault, war)
Classification of Illness	<p>Physical illnesses that can be cured through Western medicine or traditional healer</p> <p><i>Juju</i>: Illness with supernatural source, usually black magic that requires “country” healing interventions</p> <p>Complicated bone injury requires the healing of a <i>Bilite</i></p>	<p>Physical illness</p> <p>Mental illness</p> <p>All require biomedical physicians, health officers or nurses to treat and improve the condition.</p>
Death	<p>Death involves separation of soul from body before movement into the spirit world; and it is considered to be a normal part of the natural progression of life. Upon death, one gains the status of “ancestor,” a role with considerable spiritual power. Children who die do not become ancestors.</p>	<p>Death is seen to result from biological dysfunction or disequilibrium. Failures in biological systems require maximum intervention in order to prevent death. Death is considered permanent and unchangeable via medical intervention.</p>
Experience of Illness	<p>When people experience illness, they characterize their illnesses in general terms, without reference to specific anatomical terms. Definitions of illness include both physical complaints and the psychosocial and spiritual experiences of the person.</p> <p>Kin and community are closely involved with practices of healthcare seeking, diagnosis, and treatment; and youth (up to age 35) may not be seen as being capable of making their own healthcare decisions.</p>	<p>When people experience illness, they define their experience by describing disease and syndromes, describing symptoms with a high degree of specificity, and reference to anatomy. In biomedical treatment contexts, the emphasis continues to be on physiological ailments.</p> <p>Patients are approached individually and are regarded as having final authority over healthcare decisions, in partnership with their medical provider. Information about patient illness is seen as a private matter that has legal protections.</p>

Culture and Mental Health in Liberia: A Primer

Mode of Healing Intervention	<p>To assess the cause of illness, healers may use massage, divination, and extensive interviewing and questioning of family members and community in order to determine nature and meaning of the illness.</p> <p>Treatment may require:</p> <ul style="list-style-type: none">• Cleansing rituals or the confessions of offenses in order to purge the spirit or identify maleficent forces.• Consultation with ancestors or spirits• Consumption or anointment of herbal remedies and roots• Resolution of conflict in social relationships• Appeasement for violations of cultural taboos• Sacrifice of animals	<p>Assessing the cause of illness involves a clinical interview, and is supported by imaging or pathology tests in order to specify issues with systemic functioning.</p> <p>Treatments may require:</p> <ul style="list-style-type: none">• Curative medications• Palliative medications• Palliative care• Patient behaviors change• Supportive therapy (physical therapy, occupational therapy, psychotherapy) <p>Treatments are rationally designed to achieve goals that are based on a biomedical understanding of the body. They are developed to focus exclusively on resolving or eradicating physical and mental suffering and its perceived causes.</p>
-------------------------------------	--	---

Sources: Conteh 1990, Jones 2004, Olukoju 2006, Buseh 2008.

3.1.5. Major sources of distress

Like many developing and post-conflict countries, suffering in Liberia is associated with underdevelopment in every sector. Financial burdens include extreme poverty, medical and housing costs, food insecurity, unemployment, low access to education, and high school fees. Hunger, social conflict, instability, low-level communal violence, drug addiction, and a lack of opportunities for youth are well-known social problems. Additional social causes of distress include marital infidelity, petty theft, disobedient children, sickness, STIs, HIV/AIDs, and changing moral codes. These factors are aggravated by Liberia's political instability, a widespread perception of political and economic corruption and impunity. Agricultural barriers include a lack of access to seeds, tools, fertilizer, pesticide, agricultural labor, and cash.

3.1.6. Role of the formal and informal educational sector in psychosocial support

It remains unclear how the year-long school closures during the Ebola epidemic will impact social trends among youth (although there were informal complaints about increases in promiscuity and teenage pregnancy because children were home from school.)

During the Liberian War, UNICEF and its partners prioritized the integration of psychosocial services in schools in order to affirm the role of schools, and education more broadly, as a safe space for normal childhood growth and development (UNICEF and MOE 2003, Winthrop and Kirk 2006). In the aftermath of the Liberian War, the education sector has increasingly become divorced from the great demand and need for psychosocial services,

Culture and Mental Health in Liberia: A Primer

despite the efforts of UNICEF and the International Rescue Committee (IRC) to mainstream psychosocial curricula through the Liberian Ministry of Education (Beleli et al. 2007). The Liberian education system continues to lack the major attributes of good schooling, such as well trained teachers. Both teachers and students suffer from mental health and psychosocial issues (Shriberg 2008), and continue to experience symptoms of mental disorder resulting from wartime experiences, continued poverty, and vulnerability (Shriberg 2009). Research suggests that the Liberian population and educational experts regard the integration of mental health, psychosocial, and general social services in schools as essential for post-conflict reconstruction (Williams 2011). The Ebola epidemic prompted a reintegration of short-term psychosocial training curricula in teacher-training activities.

Formal education is seen as an important strategy for promoting ex-combatant rehabilitation through professional reintegration. Several institutions of higher education, including the University of Liberia and Cuttington University, hosted large classes of ex-combatants over the last decade. Targeted groups like ex-combatant youth (categorized as “children associated with the fighting forces”) were provided with psychosocial support to address their emotional needs and to participate in the broader reintegration process (Awodola 2012). The psychosocial needs of the student population remain largely unsupported in the formal educational sector.

The informal educational sector overlaps closely with traditional knowledge systems and secret societies like Sande societies for women and Poro societies for men. There also exists a closely guarded set of secret societies affiliated with natural forces like leopard societies, snake societies, and water societies. Leaders of Sande and Poro societies enjoy great prestige in traditional Liberian culture. Especially in rural areas, children are not allowed to participate as adults in traditional practices until they have completed bush school trainings. The Sande and the Poro are the most important traditional organizations in Liberia, responsible for both female and male circumcision initiation ceremonies and for the training of youth in *bush schools*.

Although the practices of bush school attendance and female circumcision are beginning to wane, as of 2011, 72% of rural and 39% of urban women belong to the Sande Society (GIZ, 2011). The Sande, which has experienced a revival since the war, traditionally performed trainings to young girls in order to prepare them for womanhood and marriage, which culminated in the ancient ritual of female circumcision. Despite the known physical and psychosocial risks associated with female circumcision, 13 of the 16 tribes in Liberia still participate in this practice (Batha 2014). Bush schools were originally meant to ensure a girl’s marriageability, chastity, health, beauty, and family honor (Goldberg 2014, Batha 2014).

3.1.7. Role of the formal social sector in psychosocial support

After the Liberian war, mental health service delivery was intensively targeted towards addressing wartime social problems like gender-based violence, ex-combatant rehabilitation and reintegration, and trauma-healing and psychosocial services, leading to considerable innovation (for an example of a video-based intervention, see Gurman et al. 2014) but in sectors like gender-based violence, evidence of impact through meaningful evaluations are lacking (for an integrated review, see Landis and Stark 2014). During this period, routine resources for youth and adults at risk of mental disorders were largely neglected. However, a recent key study assessing the needs of vulnerable youth populations in post-conflict Liberia

Culture and Mental Health in Liberia: A Primer

found that at risk-youth—homeless children, children with epilepsy, mental illnesses, ex-combatants, criminals, children of ex-combatants and others—desired access to formal medical care, treatment, counseling, and institutional assistance and support, and health policy has shifted in this direction (Levey 2013).

Due to a recurring lack of resources dedicated to Liberian mental health, the formal social sector in psychosocial support reflects a disjointed mobilization of community-based rehabilitation efforts involving psychosocial counseling, peacebuilding, and conflict resolution. These efforts are often facilitated by psychosocial workers, trauma healers, health workers, social workers, NGO workers, faith-based and community-based organizations, and rapidly trained clinical staff and volunteers, and they have their roots in humanitarian post-conflict assistance.

In 2015, the WHO introduced a Community Healing Dialogues (CHD) program to improve the psychosocial well-being and community relationships of individuals affected by Ebola, support communities' abilities to cope with conflicts and distress, and help restore social solidarity. CHD was inspired by the experience of sociotherapy in Rwanda and Democratic Republic of Congo (Jansen et al. 2015, Richters, Rutayisire, and Slegh 2013). A final program evaluation of the CHD program suggest that community rehabilitation efforts helped improve participants' problems, decreased stigma, increased healthy and supportive relationships within the community (Passanisi 2016). The same report noted that although Community Healing Dialogues targeted Ebola-affected communities to address Ebola related problems, communities wanted access to the same or similar services for a wider range of MHPSS issues (conflict, gender violence, and other psychosocial stressors). Despite the acceptability and feasibility of CHD programs, such programs confront major systemic and structural barriers to being scaled to wider populations; and thus pose challenges for sustainability.

The postwar period has also seen the establishment of formal grassroots organizations and support groups for individuals with mental or physical disabilities. This tracks closely with the distribution of post-conflict humanitarian assistance, with high rates of participation in DPOs and support groups in Montserrado, Lofa, Bong, and Nimba Counties. For example, the AIFO/Carter Center report indicates that “Bong and Nimba counties had higher rates of participation in self-help groups by persons with mental disabilities than all the counties as a whole (Cooper and Libanora 2016, 8).” Individuals with mental illness are less likely than individuals with physical disabilities to participate in DPOs and support groups.

While some programs training mental health and psychosocial workers focus intensively on providing training and mental health counseling to program counselors (Stepakoff et al. 2006, Abramowitz 2014), others prepared counselors insufficiently, leading to training inconsistencies across the NGO counseling sector. One evaluation noted a heightened risk of vicarious traumatization (Passanisi 2016) and a lack of psychosocial resources for psychosocial workers. Lekskes and colleagues, for example, noted, “Counselors may not be able to provide professionally warranted counseling and are restricted to the level of ‘good neighbors’ advice. In addition, the counselors are often very young and sexually traumatized themselves. Some of the counselors had not yet overcome their own trauma-related problems and that made it difficult for them to help others” (Lekskes, van Hooren, de Beus 2007, p.24). The impact of ineffective or incomplete psychosocial counseling training remains under-researched.

3.1.8. Role of the informal social sector (community protection systems, neighborhood systems, other community resources) in psychosocial support

Stigma against individuals with mental illness remains widespread in Liberia, and individuals with mental disorders are often blamed for their illness, refused care, or experience physical

“All [100] respondents [with physical and mental disabilities] reported that community attitudes and behaviors towards persons with mental health disorders included discriminatory and abusive behaviors ranging from sexual and physical abuse, to forced labor and chaining or holding persons with mental disabilities against their will. All respondents believed that persons with mental disabilities were entitled to the same rights as other individuals in the society. Users in particular reported that the individuals with mental disabilities were often blamed for their condition. While all respondents reported that persons with mental illness who were violent were often chained or locked up only community health and social workers endorsed the practice. Age, gender and economic status were cited across the groups as contributing factors to abuse, neglect and lack of access to care. Females, especially younger females, were reported by respondents to be more likely to be raped. Males, especially young males, were reported to be more likely to be forced to work and age was also a factor in physical beatings. According to the respondents, economic status was also associated with access to treatment with well-off and wealthy individuals either being more likely to be shut in the house and or more likely to get formal mental health services in Liberia or abroad (Cooper and Libonara 2016, 3).”

Figure 2: Community-Based Attitudes and Behaviors Towards Individuals with Mental Illness, Findings from AIFO/Carter Center Report on Community-Based Rehabilitation (CBR) and Access to Mental Health Services

and psychological violence and social exclusion (see Figure 2).

In general, Liberians are strongly rooted in family ties and community-based social networks within and beyond Liberia. Liberian families and communities serve as protective resources under conditions of extreme stress or social transition. Social goods like adequate finances for basic needs, language proficiency, social support networks, engaged parenting, family cohesion, cultural adherence, educational support, and faith and religious involvement are all associated with qualitative reports of positive psychosocial outcomes (e.g. Weine et al. 2013). With regard to mental health and psychosocial support, however, family and community-based networks can be a knife that cuts both ways.

A lack of family and community support for individuals with mental disorders can undermine their ability to access healthcare, inhibit social acceptance, create poverty and undermine economic well-being, allow family and community members to violate basic human rights, and expose these individuals to extreme violence. Social pressure within communities is known to create significant psychological distress. Churches and religious institutions play a central organizing in Liberian lives, and can be regarded as a key—but complicated--resource for mental health. They offer a space for the negotiation of conflict, and the spiritual redress of experienced wrongs; but there have also been reports of physical and psychological abuse, social control, and financial exploitation (Heaner 2011).

On the other hand, the lessons of both the post-Ebola WHO Community Healing Dialogues program and more than a decade of post-conflict community-based reconciliation activities demonstrates that investments in improving community relationships and understandings of mental disorders can have outsized effects for improving the health and well-being of individuals and communities. Past studies have found important kinship and community-based protective effects on mental health outcomes; and CBR activities support kinship and

Culture and Mental Health in Liberia: A Primer

community-based engagements. Indeed, marriage was found to be a protective factor against symptoms of PTSD among Liberian refugees in Nigeria (Olubunmi and Dogbahgeen 2013).

3.1.9. Help-seeking patterns (where people go for help and for what problems)

Liberians draw upon the formal and informal medical sectors in a complementary way; they are *medically pluralistic* (Janzen and Arkininstall 1978, Leslie 1980) and use formal care and traditional healing practices at high rates. Research suggests that Liberians draw upon the formal health sectors, informal drug markets, and traditional healers in order to seek resolution for healthcare maladies. A study by Kruk et al. (2011) surveyed the healthcare seeking behaviors of a large sample of Liberians in Nimba County. They found that people were more likely to seek healthcare at formal healthcare facilities when there was a drug dispensary present, but distance to the healthcare facility discouraged utilization. Most significantly, they found that people with a traditional healer in a village were *more* likely to seek formal healthcare, rather than less. This finding, however, contrasts with a later finding by the same researchers that respondents preferred clinics that offered a thorough exam to clinics that offered available medications (Kruk, Rockers, Varpilah, Macauley 2011). Formal healthcare facilities are used for health checkups, health-related education, vaccinations, family planning, antenatal care, childbirth, and at times as a community center or training facility at times (Kruk et al. 2011). Women were also likely to use informal care, but older people, people with worse physical and mental health, and poorer people were the most likely groups to seek informal care.

During the Ebola epidemic, cooperation between the international and national Ebola clinical response and traditional healers was severely curtailed, although traditional healers were seen by some as “the front line” in the Ebola response (Platform for Dialogue and Peace 2015). Although traditional healers are used in complementary ways with western biomedicine, Liberian newspaper articles and radio reports over the last decade have narrated significant problems with traditional healing practices, and growing widespread distrust. The war caused a disruption in traditional education systems that have led to downstream effects on the intergenerational transmission of knowledge about traditional forms of healing practices. As a consequence, traditional medicine is known to be a cause of hospitalizations and deaths due to accidental poisoning, infection, hemorrhaging, and cirrhosis; as well as injury and sexual assault. Widespread public support for traditional healing practices should not be presumed; and traditional healers should not be regarded as uniformly trained and equally competent. While some hold regional, national, and international reputations as expert healers, others are seen as charlatans or frauds that financially benefit from the ignorance and desperation of local populations who lack healthcare access. As one study noted, “Between the Bureau of Culture and Customs and the Ministry of Health Department of Complementary Medicine, there has been a long-standing disagreement over the right to issue licenses to traditional healers” (Platform for Dialogue and Peace 2015).

In the context of the Ebola outbreak, the closure of primary care clinics and hospitals resulted in healthcare-seeking behavior changes. Rather than seeking healthcare from formal or informal healthcare networks, one WHO study found that nearly 60% of sampled Monrovia residents sought their first medical intervention through private drug markets and drug vendors (Abramowitz et al. 2014), also called “black baggers,” referring to the suitcases used to move drugs across the region.

Culture and Mental Health in Liberia: A Primer

Since the Ebola epidemic, there have been some reports of attitudinal changes from healthcare workers towards patient populations, with healthcare workers acting colder, feeling more fearful of patients, being more reluctant to provide care, or demanding higher fees for healthcare services (ex. Oliphant 2015). One possible result is that local populations are becoming discouraged from using the formal healthcare system, and are once again seeking care from traditional healers, or providing home-based care using medication obtained through local markets and “black-baggers” (see Modarres and Berg 2016) but these may be incidental or context-specific rather than an overall trend. Some quotations in the same report indicated great satisfaction and trust in local healthcare workers. This requires further investigation. One study that examined the impact of Ebola on local attitudes towards mass drug administration to control and eliminate neglected tropical diseases found trust in vaccination campaigns, despite locals’ expectation of resistance (Bogus et al. 2015).

3.2. The mental health system

3.2.1. Mental Health Policy and Legislative Framework

In the Ministry of Health’s Mental Health Policy and Strategic Plan for 2016-2021, key areas are targeted for improvement and expansion (see Figure 3). The new plan builds upon Liberia’s efforts to ‘Build Back Better’ strengthen the Liberian health sector target key mental health initiatives, including strengthening national mental health legislation, expanding pilot programs in regional hospitals, expanding healthcare worker trainings, and promoting stigma reduction (Liberia Ministry of Health 2015). The new plan is ambitious, and targets critical vulnerabilities in the existing mental health system. A National Technical Coordinating Committee facilitates collaboration between key national and international actors on mental health policy and practice in Liberia, and helps to sustain an effective political and advocacy alliance.

Specific Policy Priorities for 2016-2021
<ul style="list-style-type: none">• Enact the Mental Health Act for Liberia.• Expand availability of mental health clinicians.• Train 1,312 registered nurses, physicians assistants, and hospital health workers in mhGAP to increase mental health capacity.• Train all general community health volunteers in urban areas in basic identification, referral, and psychosocial interventions.• Train all community health workers in rural and remote areas in basic identification, referral, and psychosocial interventions.• Train teachers, village leaders, traditional healers, and religious healers in basic identification, referral, and psychosocial interventions.• Mental health promotion and anti-stigma and anti-discrimination efforts.• Open new wellness units.• Develop drug and alcohol rehabilitation/step down and addiction treatment services in all regions.• Develop systems to ensure supply of psychotropic medicines.
Strategic Objectives for 2016-2021
<ul style="list-style-type: none">• Increase the clinical capacity of mental health professionals.• Increase in-patient mental health capacity through the establishment of wellness unit’s at all county hospitals.

Culture and Mental Health in Liberia: A Primer

- Train selected professionals in identification, management and referral of patients with mental health and substance use disorders at the Primary level.
- Provide the necessary psychotropic drugs at all facilities in order to expand the availability and access of mental health services in primary care.
- Train community-based workers to recognize signs of mental illness and make referrals to the appropriate health facilities.
Sensitize communities about mental health and illness and modify negative perceptions about the mentally ill, thereby minimizing stigma and negative behaviours toward persons with neuropsychiatric disorders including epilepsy, mental health and substance use disorders.
- Encourage families of persons with neuropsychiatric disorders (epilepsy, mental health and substance use disorders) to be involved in the care and management of their loved ones.
- Build the new Catherine Mills Mental Health Center.

Figure 3: Summary of the Mental Health Strategy and Policy (2016-2021), (Ministry of Health 2016)

Culture and Mental Health in Liberia: A Primer

Benchmark events in the Republic of Liberia's recent mental health policy history are indicated in Figure 4.

<i>Year</i>	<i>Benchmark</i>
2016	Mental Health Policy and Strategic Plan for Liberia (2016-2021)
2015	Post-Ebola mental health and anti-stigma programs introduced
2015	Ministry of Health restructuring shifts social welfare issues to Ministry of Gender, Women, and Social Protection, retains authority over Mental Health
2014	Ebola epidemic surges in Liberia
2012	mhGAP roll out in Liberia starts
2012	National Mental Health Act drafted, but not adopted by Liberian Legislature
2010	Carter Center establishes Clinician Mental Health Training Program
2010	National Mental Health Strategic Plan developed, National Technical Coordinating Committee is established
2009	National Mental Health Policy

Figure 4: Benchmark Events in Republic of Liberia Mental Health Policy and Legislative Framework

A recurring gap in Liberia's mental health policy framework is the division of labor between mental health clinicians and psychosocial workers, which results in referral gaps. Pilot programs in Montserrado and Maryland counties integrate clinicians and psychosocial counselors into Ebola response teams. Prior to the Ebola epidemic, there were few efforts to coordinate the activities of mental health clinicians and psychosocial workers or to require that they collaborate on MHPSS response activities. The Ebola epidemic marked a turning point in collaboration between rival psychosocial and clinical mental health workers. In 2015, a decade of tension between the clinical and psychosocial counseling professional communities over the licensure and certification of mental health clinicians and psychosocial counselors were resolved with the rollout of Government of Liberia licensure standards. Today, there are governmental and higher education training pathways to receive licensure as a mental health clinician or as a psychosocial worker. However, outside of Montserrado County, community-based rehabilitation workers continue to report that they have no involvement with mental health professionals.

Despite these strides, the mental health system in Liberia remains under-resourced and fragile. Financially, Liberia remains wholly dependent upon external donors for the financing of mental health services and psychiatric training, and no effective strategy for mental health financing has been realized, nor has the Liberian government secured international commitments to support Liberian mental health (see Dixon, McDaid, Knapp, and Curran 2006). Psychiatric medications are principally obtained through The Global Fund, or through the private/informal pharmaceutical markets. Public support for mental health services is high, and public outcry regularly calls for the improved provision of mental health and psychiatric services and medical training (Maximore 2011).

3.2.2. Description of Formal Mental Health Services (primary, secondary, and tertiary care).

Presently, there is one psychiatrist in Liberia, and one in-patient psychiatric hospital--the E.S. Grant Mental Health Hospital, with 80 beds and outpatient services in Monrovia. Across the country, there is a broad but inconsistent network of trauma-healing, gender-based violence counseling, and psychosocial services included in NGO development, gender, and health programs.

Two training programs have sought to expand mental health services in Liberia. The Harvard/MGH/University of Liberia program has been partnering with E.S. Grant Mental Health Hospital to provide psychiatric residencies to medical students in Liberia. Separately, as of 2015, more than 150 nurses have graduated from The Carter Center Mental Health Program (TCC-MHP) with certifications in mental health nursing. The objective of the program is to place trained primary care nurses with mental health diagnosis and treatment skills in public health facilities with 'wellness' centers, thereby fully integrating mental health into primary healthcare at the community level. The training has been completed, yet nurses' ability to practice psychiatric nursing in public health facilities is impeded by a lack of resources. It is unknown how many trained nurses have been impacted by the Ebola crisis, but the program also established an in-service training module that was used in training clinical workers. Additional outpatient psychiatric care, and psychosocial and mental health counseling services are offered by several dozen humanitarian aid and development NGOs, church-based organizations (CBOs), and third-party run health facilities, and are of variable quality.

3.2.3. Relative Roles of Government, Private Sector, NGOs, and Traditional Healers in Providing Mental Healthcare

The structure of post-war mental health services in Liberia has emerged from a legacy of war and post-war prioritization of trauma healing and psychosocial support. Today, international and local NGOs play a leading role in advancing mental health in Liberia (McDaid, Knapp, and Raja 2008) and work in close collaboration with the Ministry of Health and the World Health Organization. Surveillance and reporting by mental health clinicians is in its early phases, but is rapidly expanding due to data reporting technological innovations introduced by the Carter Center (Zegura, Derkits, and Cooper 2015).

Due to recurrences of regional violence, epidemic outbreaks, and substantial systems limitations, shifting from humanitarian medical care to a post-conflict development system of healthcare has been a non-linear process, requiring repeated returns to humanitarian healthcare systems (Derderian 2014). Throughout the wartime, post-war, and Ebola epidemic periods, international NGOs provided training-of-trainer (TOT) workshops in counseling, trauma healing, and psychosocial support to Liberian paraprofessionals in order to develop community-based mental health and psychosocial support (MHPSS) programs, gender-based violence counseling initiatives, and other psychosocial activities (Lekskes, van Hooren, de Beus 2007). Through these institutions, and through an unknown number of TOTs, social workers and paraprofessionals received diverse trainings in MHPSS. The variability in the quality and duration of training, however, created a permanent post-war challenge for paraprofessionals seeking professional certification, as MHPSS TOTs in Liberia and neighboring countries were not grounded in minimum standards. Their haphazard character

Culture and Mental Health in Liberia: A Primer

also generated a sharp critique from academics and practitioners involved in the reconstruction of the Liberian medical and mental health infrastructure (Abramowitz 2014).

From 2008-2014, close psychiatric care and mental health nursing succeeded psychosocial intervention for humanitarian-designated vulnerable populations as a priority. In 2008, the Carter Center and Harvard/Massachusetts General Hospital's (MGH) Liberia Working Group accelerated progress towards the drafting of a national mental health policy and mental health legislation. The NGO-administered Grant Mental Health Hospital was absorbed into the Liberian state healthcare system and was placed under the administrative rubric of the JFK Hospital. This merger facilitated the establishment of medical psychiatric residency training programs in partnership with the University of Liberia's A.M. Dogliotti College of Medicine and MGH, and an ambitious training program in mental health nursing through the Mother Patern School of Health Sciences, in partnership with The Carter Center. Liberia is also a member of the Mental Health Leadership and Advocacy Program (mhLAP), an Anglophone West Africa initiative to promote mental health policy and practice (Abdulmalik et al. 2014).

Community-based mental health and psychosocial support interventions are well regarded and welcome in local communities, and Liberians have a long experience and familiarity with mental health counseling services (Stepakoff et al. 2006, Abramowitz 2010, 2014). Kruk et al. (2011) found a correlation between mental health and healthcare utilization among informal healthcare providers. Women, younger people, and people with traumatic experiences were more likely to seek formal healthcare than others.

Community-based mental health services are welcomed, but Liberians have specific preferences regarding the location where mental health services should be delivered, and those sites differ by age. A recent study of community preferences for the location of delivery of mental health services suggested that community-based sites were preferable to clinic-based sites. Gray et al. (2013) found that elders preferred for *young adults* to receive mental health services in a church or a mosque, for *adolescents* to receive services in volunteer programs, and for *children* to receive services through sports and recreation programs.

During the post-conflict period, community-based mental health programs used two approaches to engage with local communities. In the first approach, mental health and psychosocial services are integrated into education, agriculture, vocational training, or development initiatives by placing psychosocial workers in community contexts to provide trauma-healing, counseling, and conflict resolution through group and individual therapy (Lekskes, van Hooren, de Beus 2007). This approach continues to be widespread, and is a prominent feature of at-risk youth, ex-combatant reintegration, and CBO activities. The second approach involves the integration of mental health and psychosocial counseling into primary health care to provide outpatient psychiatric treatment and group and individual therapy to urban and hard-to-reach rural areas (ex. Last Mile Health). In both approaches, the target of the programs is the alleviation of common mental disorders like depression, anxiety, and low to moderate post-traumatic stress disorder, and some studies have demonstrated a moderate improvement in PTSD-related symptoms through treatment (Lekskes, van Hooren, and de Beus 2007). Additional goals are to help clients reduce stress and traumatic stress symptoms, identify social resources, promote peace building, and emphasize individual and community resilience (Stepakoff et al. 2006).

Throughout the Ebola response, psychosocial and mental health workers were expected to play a double role— they were expected to act mental health and psychological counselors and

Culture and Mental Health in Liberia: A Primer

as cultural translators or interlocutors, conflict resolution brokers, and behavior change and communications liaisons (Cheung 2015). An important part of their work focused on working with communities through issues of stigma. Social contagions often spread through social media, word of mouth, and print and radio news outlets and gain legitimacy quickly, if they are not dispelled (Carey 2014). A study conducted by Omidian, Tehoungue, and Monger (2014), however, found in looking at high-risk behaviors, “denial,” and fear reactions to the Ebola response that community resistance was over-stated, communities’ efforts to comply with Ebola containment were under-reported, and the empirical and psychological foundations for community distrust were misunderstood by aid workers. In 2014, *Time Magazine* ranked “A lack of cultural sensitivity” among “The 5 Biggest Mistakes of the Ebola Response” (Sifferlin 2014). It may be that in the context of social contagions, “listening to communities” is instrumental in containing both group and individual psychological distress (Kutalek 2015).

The Ebola epidemic recovery period has marked the introduction of a WHO initiative, an alternative called “Community Healing Dialogues,” which built upon culturally-accepted practices of communal engagement around controversial issues to address Ebola-related dilemmas that were impacting post-Ebola rebuilding. Community-based conflict resolution mechanisms have historically been used to help regulate conflict, negotiate disputes, and validate grievances—all aspects of stress that are exacerbated by conditions of legal and judicial instability (Abramowitz and Moran 2012). Through The Carter Center Mental Health Program, steps have been taken to train the Liberian National Police to work with mental health crisis responders in order to improve police treatment of Liberians with mental illnesses and prisoners (Kohrt et al. 2015), and steps have been taken to provide mental health care in Liberian prisons.

Gender-based violence counseling services count among the most available form of mental health and psychosocial support in Liberia, but they are not closely associated with trained mental health clinicians. The quality of these services is contingent upon training. As Lekskes and colleagues noted,

“The main problem ... is that the counselors do not have a clear idea what kinds of intervention can be carried out, and in what way. Some of the counselors advise clients to forget what happened to them, and tell them not to blame themselves. This diminishes the experience of the client and is not particularly helpful (Lekskes, van Hooren, de Beus 2007, p.24; see also Abramowitz 2010).”

4. HUMANITARIAN CONTEXT

4.1. Experiences with past humanitarian aid involving mental health and psychosocial support

Despite the significant traumatic stress, bereavement, fear, stigma, and loss that the Ebola outbreak caused (Cheung 2015), mental health and psychosocial services (MHPSS) were initially under-utilized in the Ebola response, but were ultimately comprehensively integrated into key aspects of the Ebola response strategy through clinical healthcare worker training, psychological counseling, and the establishment of community healing dialogues as indicated below. Some accounts from Liberia reported that MHPSS was not seen as essential to the emergency response, relative to epidemiology, contact tracing, and case management. When cases of mental disorder appeared in Ebola Treatment Units (ETU), staffs were unprepared (Cooper 2015). Several reports indicate that agencies providing frontline Ebola outreach and clinical services were not ready to respond to the emerging mental health needs of their own expatriate and national staff employees coping with the personal and professional stresses of the Ebola response (Greenberg, Wessely, and Wykes 2015, Cheung 2015), including the experience of stigma or social and economic exclusion for national staff. This research suggests that at the intersection of mental health and humanitarian aid, an emerging issue regarding humanitarian agencies' "duty to protect" their employees' mental health may be looming ahead.

MHPSS counseling programs, community education initiatives, leadership training seminars, and psychosocial support and rehabilitation initiatives have been used with Liberian populations nearly continuously for more than 20 years, from Liberians' first exposure to Disarmament, Demobilization, Rehabilitation and Reintegration (DDRR) and trauma-healing activities in 1995, through Sierra Leonean, Guinean, and Ghanaian refugee camps in 2003, and into the present day. One comparative study of the utilization of formal medical services for mental, neurological, and substance abuse (MNS) among distinct refugee populations around the world found that Liberian refugees were more likely than other African, Asian, and Middle Eastern refugee groups to seek MNS services (Kane et al. 2014).

Ex-combatant populations in Liberia have received substantial programming in mental health and psychosocial support over the last decade. Early efforts to integrate mental health and psychosocial services into the DDRR process failed due to poor funding, lack of preparation of staff, and unanticipated resistance from demobilizing ex-combatants, many simultaneously undergoing withdrawal from narcotics. Later efforts to integrate MHPSS into ex-combatant educational and vocational training programs were well-received, and may have played an important role in re-socialization (Abramowitz 2014). Some efforts to integrate participants' goals and priorities in MHPSS program design through participatory action research have been documented as having positive effects, from acting as a liaison between ex-combatants and community leaders and families in problem-solving reintegration issues, and in promoting social support, basic needs assistance, and social acceptance (World Bank 2014, see also Betancourt 2008, 2010). Reintegration models established for ex-combatant populations in Liberia, Sierra Leone, and other post-conflict contexts were adapted for the Ebola epidemic to help reintegrate Ebola survivors into their home communities and mitigate stigma. Even so, many observers note that survivors' mental distress does not receive sufficient attention or support (Yadav and Rawal 2015). These observations are neither supported nor disproved with systematic research, but it is a common theme in commentaries on post-Ebola survivorship.

Culture and Mental Health in Liberia: A Primer

“Trauma-healing,” a category derived from humanitarian programs targeted towards mental disorders commonly seen in populations affected by extreme stressors occupies an important place in Liberian populations’ understanding of mental health service provision. Most recently, during a WHO study of community-based attitudes to Ebola conducted in Monrovia in September 2014, Liberians have called for trauma healing for communities affected by Ebola, counseling support for orphans due to Ebola, and public memorialization for those who have died of Ebola (Abramowitz et al., 2015).

In late 2014 through 2015, the Government, WHO, and key MHPSS partners achieved the following key milestones for integration of MHPSS into a humanitarian response:

- In 2015, Liberia hosted a three-country meeting (with Sierra Leone and Guinea) on Mental Health and Ebola during the epidemic outbreak.
- They maintained the visibility of mental health and psychosocial issues by ensuring that local MHPSS were present at Ebola-related medication reviews, protocols development, and healthcare worker trainings.
- They provided support to the Government of Liberia/Carter Center rollout of standardized Government of Liberia licensure activities for psychosocial counselors and mental health clinicians.
- They expanded surveillance and reporting on MHPSS issues in all Liberian counties.
- They ensured that the Ebola Health Management Information Services expanded tracking of mental health issues related to Ebola, Ebola survivors, and post-Ebola syndrome.
- They advocated for mental health issues in Ebola and post-Ebola planning and policy activities and meetings.
- They integrated a psychiatrist into the development of Ebola Treatment Unit protocols.
- They expanded direct MHPSS training to Ebola clinical staff.

Further guidance for integrating mental health and psychosocial support into epidemic response codifies these activities as priorities that must be implemented during epidemic responses, even despite possible resistance from emergency responders.

In a context where community-based resistance to Ebola interventions was identified by the international community as a “psychosocial” issue, each of these contributions served to prepare field workers to address local populations with sensitivity, destigmatize the vast social changes that were produced by Ebola, and advocate for newly vulnerable populations (orphans, survivors) created by the epidemic. Important insights about battling the stigma of Ebola can be learned from global efforts to combat HIV/AIDS-related stigma (Davtyan, Brown, and Folayan 2014). Despite these key contributions, however, MHPSS remains an under-recognized facet of epidemic response in Ebola response analyses and in post-Ebola health system recovery efforts.

5. REFERENCES

- Abramowitz, S. A. Trauma and humanitarian translation in Liberia: the tale of open mole. *Culture, Medicine, and Psychiatry*. 34(2): 353-379. 2010.
- Abramowitz, Sharon Alane. *Searching for Normal in the Wake of the Liberian War*. University of Pennsylvania Press, 2014.
- Abramowitz, Sharon Alane, Kristen E. McLean, Sarah Lindley McKune, Kevin Louis Bardosh, Mosoka Fallah, Josephine Monger, Kodjo Tehoungue, and Patricia A. Omidian. Community-Centered Responses to Ebola in Urban Liberia: The View from Below. *PLOS Neglected Tropical Diseases*. 2015: e0003706.
- Abramowitz, SA, McLean, K. McKune SL, Fallah, M., Monger, J., Tehoungue, K., Omidian, PA. *Preliminary Report on Community-based Accounts of Co-Morbidity, Co-mortality, and Health-Seeking Behaviors in Four Monrovia Communities during the West African Ebola Epidemic*. Working Paper from WHO data. Submitted to U.N. Mission Emergency Ebola Response, 2014. <https://www.academia.edu/9585650>. Last accessed March 25, 2015.
- Abramowitz, Sharon, and Mary H. Moran. *International Human Rights, Gender-Based Violence, and Local Discourses of Abuse in Postconflict Liberia: A Problem of "Culture"?* *African Studies Review* 55, no. 02 (2012): 119-146.
- Abdulmalik, Jibril, Woye Fadahunsi, Lola Kola, Emeka Nwefoh, Harry Minas, Julian Eaton, and Oye Gureje. "The Mental Health Leadership and Advocacy Program (mhLAP): a pioneering response to the neglect of mental health in Anglophone West Africa." *International Journal of Mental Health Systems* 8, no. 1 (2014): 5.
- Allen, Denise Roth, Romel Lacson, Amos Gborle, Manisha Patel, and Michael Beach. *Understanding Why Ebola Deaths Occur at Home in Urban Montserrado County, Liberia: Report on the Findings from a Rapid Anthropological Assessment December 22-31, 2014*. Monrovia, Liberia: Centers for Disease Control (CDC), 2015.
- Aloysi, Amy S., Diana Samuel, Jan Schuetz-Mueller, Rodney D. Presley, Janice Cooper, and Craig L. Katz. "Mothers in Distress: Cases from the Maternal-Child Mental Health Consultation Service, Liberia, West Africa." *Childhood in Africa: An Interdisciplinary Journal* 3(1) 2013:70-76.
- Awodola, Bosede. "An examination of methods to reintegrate former child soldiers in Liberia." *Intervention* 10, no. 1 (2012): 30-42.
- Beleli, Oysel, Victoria Chang, Michael J. Feigelson, Jules A. Kopel-Bailey, Sheila A. Maak, Jacob P. Mnookin, Thu H. Nguyen, Mariana Salazar, Joy E. Sinderbrand, and Simon N. Tafoya. "Education in Emergencies and Early Reconstruction: UNICEF Interventions in Colombia, Liberia, and Southern Sudan." (2007).
- Behrendt, Alice. "Mental Health of Children Formerly Associated with The Fighting Forces in Liberia: A Cross Section Study in Lofa County." 2008.
- Betancourt, Theresa S., Stephanie Simmons, Ivelina Borisova, Stephanie E. Brewer, Uzo Iweala, and Marie de la Soudiere. "High hopes, grim reality: Reintegration and the education of former child soldiers in Sierra Leone." *Comparative Education Review* 52, no. 4 (2008): 565.
- Betancourt, Theresa Stichick, Ivelina Ivanova Borisova, Timothy Philip Williams, Robert T. Brennan, Theodore H. Whitfield, Marie De La Soudiere, John Williamson, and Stephen E. Gilman. "Sierra Leone's Former Child Soldiers: A Follow- Up Study of Psychosocial Adjustment and Community Reintegration." *Child Development* 81, no. 4 (2010): 1077-1095.

Culture and Mental Health in Liberia: A Primer

- Bledsoe, Caroline H., Douglas C. Ewbank, and Uche C. Isiugo-Abanihe. "The effect of child fostering on feeding practices and access to health services in rural Sierra Leone." *Social Science & Medicine* 27, no. 6 (1988): 627-636.
- Bogus, Joshua, Lincoln Gankpala, Kerstin Fischer, Alison Krentel, Gary J Weil, Peter U Fischer, Karsor Kollie, and Fatorma K Bolay. "Community Attitudes toward Mass Drug Administration for Control and Elimination of Neglected Tropical Diseases after the 2014 Outbreak of Ebola Virus Disease in Lofa County, Liberia." *The American Journal of Tropical Medicine and Hygiene* (2015): 15-0591.
- Borba, Christina PC, Lauren C Ng, Anne Stevenson, Oriana Vesga-Lopez, Benjamin L Harris, Lindsey Parnarouskis, Deborah A Gray, et al. "A Mental Health Needs Assessment of Children and Adolescents in Post-Conflict Liberia: Results from a Quantitative Key-Informant Survey." *International Journal of Culture and Mental Health* 9, no. 1 (2016): 56-70.
- Buseh, Aaron. *Empowering Resilience: Improving Health Care Delivery in War-Impacted African Countries: A Case Study of Liberia*. USA: University Press of America Inc. 2008.
- Callands, Tamora A., Heather L. Sipsma, Theresa S. Betancourt, and Nathan B. Hansen. "Experiences and acceptance of intimate partner violence: associations with sexually transmitted infection symptoms and ability to negotiate sexual safety among young Liberian women." *Culture, Health & Sexuality* 15, no. 6 (2013): 680-694.
- Carey, Benedict. "Experts Offer Steps for Avoiding Public Hysteria, a Different Contagious Threat." *New York Times*, October 15 2014.
- Cheng, Margaret Harris. "Reviving health care in Liberia." *The Lancet* 373, no. 9671 (2009): 1239-1240.
- Cheung, Eliza YL. "An outbreak of fear, rumours and stigma: psychosocial support for the Ebola Virus Disease outbreak in West Africa." *Intervention* 13, no. 1 (2015): 70-76.
- Childs, George Tucker. "The Changing World in Microcosm: The Dying Languages of Liberia, Sierra Leone, and Guinea." (2015).
- Conteh, Al-Hassan. (1990) "Reflections on Some Concepts of Religion and Medicine in Liberian Society." *Liberian Studies Journal*. 15(2).
- Cooper, Janice L. "Mental health and psychosocial support in the face of Ebola in Liberia: the personal and professional intersect. A personal account." *Intervention* 13, no. 1 (2015): 49-57.
- Cooper, Janice, and Renato Libanora. "Report on Comparative Study of Community Mental Health in Low and Middle Income Countries: Liberia Case Study." Monrovia, Liberia: AIFO and the Carter Center, 2016.
- Coulter, Chris. *Bush Wives and Girl Soldiers: Women's Lives Through War And Peace In Sierra Leone*. Ithaca, NY: Cornell University Press, 2009.
- Davtyan, Mariam, Brandon Brown, and Morenike Oluwatoyin Folayan. "Addressing Ebola-Related Stigma: Lessons Learned from HIV/AIDS." *Global Health Action* 7 (11/07)
- Derderian, Katharine. "Changing Tracks as Situations Change: Humanitarian and Health Response along the Liberia-Côte d'Ivoire Border." *Disasters* 38, no. 4 (2014): 673-89.
- Diggins, J., and E. Mills. "The Pathology of Inequality: Gender and Ebola in West Africa." (2015).
- Dixon, Anna, David McDaid, Martin Knapp, and Claire Curran. "Financing mental health services in low-and middle-income countries." *Health Policy and Planning* 21, no. 3 (2006): 171-182.
- Downie, Richard. "The Road to Recovery: Rebuilding Liberia's Health System." Center for Strategic and International Studies (CSIS). Washington, DC: 2012.

Culture and Mental Health in Liberia: A Primer

- Dunn-Marcos, Robin. *Liberians: An Introduction To Their History And Culture*. Edited by Donald Adam Ranard. Center for Applied Linguistics, Cultural Orientation Resource Center, 2005.
- Ellis, Stephen. *The Mask of Anarchy: The Destruction Of Liberia And The Religious Dimension Of An African Civil War*. NYU Press, 2001.
- Ellis, Stephen, and Gerrie Ter Haar. *Worlds of Power: Religious Thought And Political Practice In Africa*. Vol. 1. Oxford University Press, 2004.
- Flomoku, Pewee, and Lemuel Reeves. "Formal and informal justice in Liberia." London: *Conciliation Resources* (2012).
- Fuest, Veronika. "'This is the Time to get in Front': Changing Roles and Opportunities for Women in Liberia." *African Affairs* 107, no. 427 (2008): 201-224.
- Fuest, Veronika. "Contested Inclusions: Pitfalls of NGO Peace-Building Activities in Liberia." *Africa Spectrum* (2010): 3-33.
- Galea, Sandro, Peter C. Rockers, Geetor Saydee, Rose Macauley, S. Tornorlah Varpilah, and Margaret E. Kruk. "Persistent psychopathology in the wake of civil war: long-term posttraumatic stress disorder in Nimba County, Liberia." *American Journal of Public Health* 100, no. 9 (2010): 1745.
- GIZ. *Female Genital Mutilation in Liberia*, 2011.
- Goudsmit, J., F. W. Van der Waals, and D. Gajdusek. "Epilepsy in the Gbawein and Wroughbarh Clan of Grand Bassa County, Liberia: The Endemic Occurrence of 'See-ee' in the Native Population." *Neuroepidemiology* 2, no. 1-2 (1983): 24-34.
- Geschiere, Peter. *The Modernity of Witchcraft: Politics And The Occult In Postcolonial Africa*. University of Virginia Press, 1997.
- Grady, Denise. "Ebola Survivors Face Lingering Pain, Fatigue and Depression." *New York Times*, AUG. 7 2015.
- Gray, D. A., C. P. C. Borba, B. L. Harris, S. Domínguez, R. Boxill, E. K. S. Wang, and D. C. Henderson. "Understanding Cohort Differences in Appraisals Of Reconstruction Priorities Of Mental Health Systems In Post-Conflict Liberia." *African Journal of Psychiatry* 16, no. 6 (2013): 437-444.
- Greenberg, Neil, Simon Wessely, and Til Wykes. "Potential Mental Health Consequences for Workers in The Ebola Regions of West Africa—A Lesson for All Challenging Environments." *Journal of Mental Health* 24, no. 1 (2015): 1-3.
- Gurman, Tilly A, Regan M Trappler, Angela Acosta, Pamella A McCray, Chelsea M Cooper, and Lauren Goodsmith. "'By Seeing with Our Own Eyes, It Can Remain in Our Mind': Qualitative Evaluation Findings Suggest the Ability of Participatory Video to Reduce Gender-Based Violence in Conflict-Affected Settings." *Health Education Research* (2014): cyu018.
- Harris, Benjamin L., Elizabeth J. Levey, Christina PC Borba, Deborah A. Gray, Julia R. Carney, and David C. Henderson. "Substance use behaviors of secondary school students in post-conflict Liberia: a pilot study." *International Journal of Culture and Mental Health* 5, no. 3 (2012): 190-201.
- Heaner, Gwendolyn K. *Destroying the Destroyer of your Destiny: The Role of Pentecostalism in Post-War Liberia*. Dissertation, School of Oriental and African Studies, London. 2011.
- Helleringer, Stephane, and Andrew Noymer. "Assessing the Direct Effects of the Ebola Outbreak on Life Expectancy in Liberia, Sierra Leone and Guinea." *PLoS Currents* 7 (2015).
- House, F. (2014). *Freedom in the World 2014: The Annual Survey of Political Rights and Civil Liberties*. Rowman & Littlefield.

Culture and Mental Health in Liberia: A Primer

- IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (IASC). *Mental Health, Psychosocial Support and Ebola Virus Disease: A Guide for Public Health Programme Planners*. Geneva: IASC, 2015.
- IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (IASC). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC, 2007.
- Jansen, Stefan, Ross White, Jemma Hogwood, Angela Jansen, Darius Gishoma, Donatilla Mukamana, and Annemiek Richters. "The "Treatment Gap" in Global Mental Health Reconsidered: Sociotherapy for Collective Trauma in Rwanda." *European Journal of Psychotraumatology* 6 (2015).
- Janzen, John M., and William Arkinstall. *The quest for Therapy in Lower Zaire*. No. 1. University of California Press, 1978.
- Jilek-Aall, Louise, Martica Jilek, John Kaaya, Lilian Mkombachepa, and Kalister Hillary. "Psychosocial study of epilepsy in Africa." *Social Science & Medicine* 45, no. 5 (1997): 783-795.
- Jones, Emma L. "Folk and Modern Medicine in Africa: A Case Study of Mental Health Care in Liberia." *MILES* 110.4 0 29, no. 2 (2004): 1.
- Johnson, Kirsten, Jana Asher, Michael Kisielewski, and Lynn Lawry. "Former combatants in Liberia: the burden of possible traumatic brain injury among demobilized combatants." *Military Medicine* 177, no. 5 (2012): 531-540.
- Johnson, Kirsten, Jana Asher, Stephanie Rosborough, Amisha Raja, Rajesh Panjabi, Charles Beadling, and Lynn Lawry. "Association of combatant status and sexual violence with health and mental health outcomes in post-conflict Liberia." *JAMA* 300, no. 6 (2008): 676-690.
- Jones, Nicola, Janice Cooper, Elizabeth Presler-Marshall, and David Walker. "The fallout of rape as a weapon of war." (2014). Overseas Development Institute.
<http://www.africanafican.com/folder13/african%20and%20african%20american%20history2/Ellen%20Johnson%20Sirleaf/8990.pdf>
- Kane, Jeremy C., Peter Ventevogel, Paul Spiegel, Judith K. Bass, Mark van Ommeren, and Wietse A. Tol. "Mental, neurological, and substance use problems among refugees in primary health care: analysis of the Health Information System in 90 refugee camps." *BMC Medicine* 12, no. 1 (2014): 228.
- Kohrt, Brandon A., Elise Blasingame, Michael T. Compton, Samuel F. Dakana, Benedict Dossen, Frank Lang, Patricia Strode, and Janice Cooper. "Adapting the Crisis Intervention Team (CIT) Model of Police–Mental Health Collaboration in a Low-Income, Post-Conflict Country: Curriculum Development in Liberia, West Africa." *American Journal of Public Health* 0 (2015): e1-e8.
- Kruk, Margaret E., Peter C. Rockers, S. Tornorlah Varpilah, and Rose Macauley. "Population preferences for health care in Liberia: insights for rebuilding a health system." *Health services research* 46, no. 6pt2 (2011): 2057-2078.
- Kruk, Margaret E., Peter C. Rockers, Elizabeth H. Williams, S. Tornorlah Varpilah, Rose Macauley, Geetor Saydee, and Sandro Galea. "Availability of essential health services in post-conflict Liberia." *Bulletin of the World Health Organization* 88, no. 7 (2010): 527-534.
- Kruk, Margaret E., Peter C. Rockers, S. Tornorlah Varpilah, and Rose Macauley. "Which doctor? Determinants of utilization of formal and informal health care in post conflict Liberia." *Medical Care* 49, no. 6 (2011): 585-591.
- Kutalek, Ruth. "The Psycho-Social Situation of EVD Survivors in Liberia: Rapid Preliminary Analysis & Results." Monrovia, Liberia: World Health Organization (WHO), 2014.
- Kutalek, Ruth, Shiyong Wang, Mosoka Fallah, Chea Sanford Wesseh, and Jeffrey Gilbert.

Culture and Mental Health in Liberia: A Primer

- "Ebola Interventions: Listen to Communities." *Lancet Glob Health* 3, no. 3 (2015): e131.
- Landis, Debbie, and Lindsay Stark. "Examining Promising Practice: An Integrated Review of Services for Young Survivors of Sexual Violence in Liberia." *Intervention* 12, no. 3 (2014): 430-41.
- Lee, Patrick T., Gina R. Kruse, Brian T. Chan, Moses BF Massaquoi, Rajesh R. Panjabi, Bernice T. Dahn, and Walter T. Gwenigale. "An analysis of Liberia's 2007 national health policy: lessons for health systems strengthening and chronic disease care in poor, post-conflict countries." *Global Health* 7 (2011): 37.
- Lekskes, Jeannette, Susan van Hooren, and Jos de Beus. "Appraisal of psychosocial interventions in Liberia." *Intervention* 5, no. 1 (2007): 18-26.
- Leslie, Charles. "Medical pluralism in world perspective [1]." *Social Science & Medicine. Part B: Medical Anthropology* 14, no. 4 (1980): 191-195.
- Levey, E. J., C. P. C. Borba, B. L. Harris, J. R. Carney, S. Domínguez, E. K. S. Wang, R. Boxill, and D. C. Henderson. "Assessment of the needs of vulnerable youth populations in post-conflict Liberia." *African Journal of Psychiatry* 16, no. 5 (2013): 349-355.
- Liebling-Kalifani, Helen, Victoria Mwaka, Ruth Ojiambo-Ochieng, Juliet Were-Oguttu, Eugene Kinyanda, Deddeh Kwekwe, Lindora Howard, and Cecilia Danuweli. "Women war survivors of the 1989-2003 conflict in Liberia: The Impact of Sexual and Gender-based violence." *Journal of International Women's Studies* 12, no. 1 (2013): 1-21.
- Lori, Jody R., and Joyceen S. Boyle. "Cultural childbirth practices, beliefs, and traditions in post-conflict Liberia." *Health Care for Women International* 32, no. 6 (2011): 454-473.
- Maximore, Ernest S. "Liberia's Mental Health Care: A Crucial Need for Improvement." *FrontPage Africa* 25 June 2011. <http://www.frontpageafricaonline.com/old/op-ed-editorial/commentary/608-liberias-mental-health-care-a-crucial-need-for-improvement.html>. Accessed 25 March 2015.
- McDaid, David, Martin Knapp, and Shoba Raja. "Barriers in the mind: promoting an economic case for mental health in low- and middle- income countries." *World Psychiatry* 7, no. 2 (2008): 79-86.
- McGovern, Mike. "Rebuilding a failed state: Liberia." *Development in Practice* 15, no. 6 (2005): 760-766.
- Medeiros, Emilie. "Integrating Mental Health into Post-Conflict Rehabilitation: The Case of Sierra Leonean and Liberian Child Soldiers." *Journal of Health Psychology* 2007: 12(3): 498-504.
- Ministry of Health, Republic of Liberia. Mental Health Policy and Strategic Plan for Liberia (2016-2021). Monrovia, Liberia: 2016.
- Ministry of Health, Republic of Liberia. National Knowledge, Attitudes and Practices Study on Ebola Virus Disease. Monrovia, Liberia, 2015.
- Ministry of Health and Social Welfare (MOHSW), Republic of Liberia. "Basic Package of Health and Social Welfare Services for Liberia." June 2008. http://www.basics.org/documents/Basic-Package-of-Health-and-Social-Welfare-Services_Liberia.pdf Accessed 25 March 2015.
- Ministry of Health and Social Welfare (MOHSW), Republic of Liberia. "Essential Package of Health Services. Primary Care: The Community Health System, Phase 1." June 2011 (2011a). <http://apps.who.int/medicinedocs/documents/s19808en/s19808en.pdf>. Accessed 18 April 2015.
- Ministry of Health and Social Welfare (MOHSW), Republic of Liberia. "Essential Package of Health Services. Secondary & Tertiary Care: The District, County, & National Health Systems." November 2011 (2011b).
- Modarres, Najmeh, and Katrina Berg. "Qualitative Assessment on Health System Trust and Health Service Utilization in Liberia." Baltimore: Johns Hopkins School of Public Health,

Culture and Mental Health in Liberia: A Primer

- Center for Communication Programs, 2016.
- Moffic, Steven H. "Ebola, Courage, Fear, and the Ethic of Reverence for Life." *Psychiatric Times*, September 2014, 2.
- Mohammed, A., Sheikh, T. L., Poggensee, G., Nguku, P., Olayinka, A., Ohuabunwo, C., & Eaton, J. Mental health in emergency response: lessons from Ebola. *The Lancet Psychiatry*, 2(11), 955-957. Doi:10.1016/S2215-0366(15)00451
- Mohammed A, Sheikh TL, Gidado S, et al. Psychiatric treatment of a health care worker after infection with Ebola virus in Lagos, Nigeria. *Am J Psychiatry* 2015; **172**: 222 – 24.
- Mohammed A, Sheikh TL, Gidado S, et al. An evaluation of psychological distress and social support of survivors and contacts of Ebola virus disease infection and their relatives in Lagos, Nigeria: a cross sectional study—2014. *BMC Public Health* 2015; **15**: 824.
- Moran, Mary H. "Surviving Ebola: The Epidemic and Political Legitimacy in Liberia." *Current History* 114, no. 772 (2015): 177.
- Moran, Mary H. "Taking Up the Slack: Female Farming and the 'Kru Problem' in Southeastern Liberia." *Liberian Studies Journal* 11, no. 2 (1986): 117-124.
- Moran, Mary H. "Woman and "Civilization": The Intersection of Gender and Prestige in Southeastern Liberia." *Canadian Journal of African Studies/La Revue canadienne des études africaines* 22, no. 3 (1988): 491-501.
- Moran, Mary H. *Civilized women: gender and prestige in Southeastern Liberia*. Cornell University Press, 1990.
- Moran, Mary H. "Civilized servants: child fosterage and training for status among the Glebo of Liberia." In *African Encounters With Domesticity*. Karen Tranberg Hansen, (ed.) New Brunswick, NJ: Rutgers University Press, 1992: pp. 98-115.
- Mugele, Josh, and Chad Priest. "A Good Death—Ebola and Sacrifice." *New England Journal of Medicine* 371, no. 13 (2014): 1185-87.
- Murphy, William P. "Secret knowledge as property and power in Kpelle society: Elders versus youth." *Africa* 50, no. 02 (1980): 193-207.
- Nolan, Jay Hamilton. *Culture and Psychosis Among the Loma Tribe of Liberia, West Africa*. Department of Anthropology, Stanford University. 1972.
- Oliphant, John. "'Present': Ebola's Impact on PA's in Liberia ". *Clinical Reviews* 25, no. 9 (September 2015): 41-42.
- Olubunmi, Mokuolu B., Yarseah Alphonso D. "Assessment of Posttraumatic Stress and Its Pre-Traumatic Factors among Liberian Refugees in Nigeria." *IOSR Journal of Humanities and Social Science* 2013 9(4): 1-5.
- Olukoju, Ayodeji. *Culture and Customs of Liberia*. Vol. 1530, no. 8367. Greenwood Publishing Group, 2006.
- Omidian, Patricia, Kodjo Tehoungue, and Josephine Monger. *Medical Anthropology Study of the Ebola Virus Outbreak in Liberia/West Africa*. Monrovia, Liberia: World Health Organization, 2014.
- Passanisi, Cora. *Program Evaluation Report: Community Healing Dialogues (CHD)*. Monrovia, Liberia: World Health Organization. unpublished, 2016.
- Patel, Vikram, Gary S. Belkin, Arun Chockalingam, Janice Cooper, Shekhar Saxena, and Jürgen Unützer. "Grand challenges: integrating mental health services into priority health care platforms." *PLoS Medicine* 10, no. 5 (2013): e1001448.
- Palermo, Tia, and Amber Peterman. "Undercounting, over counting and the longevity of flawed estimates: statistics on sexual violence in conflict." *Bulletin of the World Health Organization* 89, no. 12 (2011): 924-925.
- Platform for Dialogue and Peace, *The Role of Traditional Healers in the Outbreak of Ebola*. Final Report (Draft). Monrovia, Liberia: 2015.

Culture and Mental Health in Liberia: A Primer

- Rasmussen, Andrew, Hawthorne Smith, and Allen S. Keller. "Factor structure of PTSD symptoms among west and central African refugees." *Journal of Traumatic Stress* 20, no. 3 (2007): 271-280.
- Reardon, Sara. "Ebola's Mental-Health Wounds Linger in Africa." *Nature* 519 (5 March 2015).
- Rebuilding Basic Health Services (RBHS). "Costing the Basic Package of Health Services at Clinics and Health Center in Liberia." Published 07 August 2009.
http://www.MoHSW.gov.lr/documents/Costing_Report_Liberia_BPHS_7Aug09.pdf. Last accessed 25 March 2015.
- Reno, William. "Anti-corruption efforts in Liberia: Are they aimed at the right targets?" *International Peacekeeping* 15, no. 3 (2008): 387-404.
- Republic of Liberia. Embassy of the Republic of Liberia to the United States. About Liberia.
<http://www.liberianembassyus.org/index.php?page=about-liberia>. Last accessed June 5, 2015.
- Republic of Liberia Ministry of Health (GOL/MOH). Annual Consolidated National Plan for FY 2015. Published August 2015.
- Republic of Liberia Ministry of Health and Social Welfare (MoHSW). In-Service Module on Mental Health for Health Workers in the Clinical Areas, Essential Package of Health Services. Published 2010, Revised 2013. RBHS.
- Richters, Annemiek, Théoneste Rutayisire, and Henny Slegh. "Sexual Transgression and Social Disconnection: Healing through Community-Based Socioterapy in Rwanda." *Culture, health & sexuality* 15, no. sup4 (2013): S581-S93.
- Sawyer, Amos. *Social capital, survival strategies, and their potential for post-conflict governance in Liberia*. No. 2005/15. Research Paper, UNU-WIDER, United Nations University (UNU), 2005.
- Schoepf, Brooke G. and Amanda Guannu. "Sociocultural Aspects of Primary Health Care Design: The Case of Liberia." 1981.
- Schröder, Günter, and Hans Dieter Seibel. *Ethnographic survey of southeastern Liberia: the Liberian Kran and the Sapo*. No. 3. Published for the Tubman Center of African Culture by Liberian Studies Association in America, 1974.
- Schubert, Bernd. "Social Protection Issues in Liberia." Study Commissioned by the United Nations, Monrovia, Liberia, 2008.
- Shepler, Susan. "Transnational fosterage of war-affected children in West Africa: Immediate coping capacities across borders." *UNICEF, West and Central Africa Regional Office, Dakar* (2005).
- Shriberg, Janet. "Fractured help: Social justice and teacher well-being in postwar Liberia." PhD Dissertation, Teachers College, Columbia University, 2008.
- Shriberg, Janet. "Perpetuated Suffering: Social Injustice in Liberian Teachers' Lives." *Critical Approaches to Comparative Education* (2009).
- Shultz JM, Baingana F, Neria Y. The 2014 Ebola outbreak and mental health: current status and recommended response. *JAMA* 2014; **313**: 567 – 68.
- Sifferlin, Alexandra. "The 5 Biggest Mistakes in the Ebola Outbreak." *Time* September 25 2014.
- Stepakoff, S., Hubbard, J., Katoh, M., Falk, E., Mikulu, J. -B., Nkhoma, P., & Omagwa, Y. Trauma healing in refugee camps in Guinea: A psychosocial program for Liberian and Sierra Leonean survivors of torture and war. *American Psychologist*, 61(8), 921-932. 2006.
- Summerfield, Derek. "The Impact of War and Atrocity on Civilian Populations: Basic Principles for NGO Interventions and a Critique of Psychosocial Trauma Projects." Overseas Development Institute, 1996.

Culture and Mental Health in Liberia: A Primer

- Sun, Xin-yang, Lin Zhao, Chun-xia Chen, Xue-lian Cui, Jian Guo, and Li-yi Zhang. "Mental Health of Chinese Peacekeepers in Liberia." *The European Journal of Psychiatry* 28, no. 2 (2014): 77-85.
- Svoronos, Theodore, Rose Jallah Macauley, and Margaret E Kruk. "Can the Health System Deliver? Determinants of Rural Liberians' Confidence in Health Care." *Health Policy and Planning* (2014): czu065.
- Swiss, Shana, Peggy J. Jennings, Gladys V. Aryee, Grace H. Brown, Ruth M. Jappah-Samukai, Mary S. Kamara, Rosana DH Schaack, and Rojatu S. Turay-Kanneh. "Violence against women during the Liberian civil conflict." *JAMA* 279, no. 8 (1998): 625-629.
- Thébaud, E. F. "Psychiatre, guérisseurs et prophètes au Liberia." *Confrontations Psychiatriques* (1982).
- Thomas, Sandra P. "Ebola and Mental Health." *Issues in Mental Health Nursing* 36, no. 4 (April 2015): 247-48.
- "Tolerance and Tension: Islam and Christianity in Sub-Saharan Africa". Pew Forum on Religious & Public Life. April 5, 2010.
- United Nations (UN) (2015). Least Developed Countries: Country resolutions and reports. Source: Development Policy and Analysis Division. http://www.un.org/en/development/desa/policy/cdp/ldc2/ldc_countries.shtml. Last accessed June 5, 2015.
- United Nations Development Program (UNDP). *Liberia Country Report*. 2004.
- UNICEF and Ministry of Education (MOE), Liberia (2003). *Teacher Guide for Emergency Education*. Monrovia: Ministry of Education.
- United States Department of State. International Religious Freedom Report for 2013. Bureau of Democracy, Human Rights, and Labor, State Department, Washington, DC. 2013. <http://www.state.gov/j/drl/rls/irf/2013/af/222065.htm>
- Utas, Mats. "Abject heroes: marginalized youth, modernity and violent pathways of the Liberian civil war." *Years of Conflict: Adolescence, Political Violence and Displacement* (2008): 111-138.
- Van Bortel, Tine, Anoma Basnayake, Fatou Wurie, Musu Jambai, Alimamy Sultan Koroma, Andrew T Muana, Katrina Hann, *et al.* "Psychosocial Effects of an Ebola Outbreak at Individual, Community and International Levels." *Bull World Health Organ* 94 (2016): 210-14.
- Vinck, Patrick, and Phuong N. Pham. "Association of exposure to intimate-partner physical violence and potentially traumatic war-related events with mental health in Liberia." *Social Science & Medicine* 77 (2013): 41-49.
- Vinson, Gregory A., and Zoua Chang. "PTSD symptom structure among West African War trauma survivors living in African refugee camps: A factor- analytic investigation." *Journal of Traumatic Stress* (2012) 25(2): 226-231.
- Weil, Ana A., Corey M. Cameron, Jacob Soumserai, Kerry L. Dierberg, Alphonso Geelue Mouwon, David R. Kraemer, Daniela Lewy, Patrick T. Lee, John D. Kraemer, and Mark J. Siedner. "Alcohol use and health care utilization in rural Liberia: Results of a community-based survey for basic public health indicators." *The International Journal of Alcohol and Drug Research* 3, no. 2 (2014): 169-181.
- Weine, Stevan Merrill, Norma Ware, Toni Tugenberg, Leonce Hakizimana, Gonwo Dahnweih, Madeleine Currie, Maureen Wagner, and Elise Levin. "Thriving, Managing, and Struggling: A Mixed Methods Study of Adolescent African Refugees' Psychosocial Adjustment." *Adolescent Psychiatry* 3, no. 1 (2013): 72.
- Williams, James H. "Education and reconstruction in post-conflict Liberia." *Journal of International Cooperation Studies* 18, no. 3 (2011).

Culture and Mental Health in Liberia: A Primer

- Winthrop, R., & Kirk, J. (2006). *Creating healing classrooms: Tools for teachers and teacher educators*. New York, NY: International Rescue Committee, Child and Youth Protection and Development Unit. <http://www.theirc.org/sites/default/files/migrated/resources/hci-tools.pdf>. Last accessed 26 March 2015.
- The World Bank Group (2014). *Update of the Economic Impact of the 2014 Ebola Epidemic on Liberia, Sierra Leone, and Guinea*. Published 2 December 2014. <http://www.worldbank.org/content/dam/Worldbank/document/Economic%20Impact%20Ebola%20Update%202%20Dec%202014.pdf>. Last accessed 9 June 2015.
- World Bank Group. (2015a). Liberia. <http://data.worldbank.org/country/liberia>. Last accessed June 5, 2015.
- World Bank Group (2015b). Heavily indebted poor countries (HIPC). <http://data.worldbank.org/income-level/HPC>. Last accessed June 5, 2015.
- World Bank Group (2015c). Liberia. <http://data.worldbank.org/country/liberia>. Last accessed June 5, 2015.
- World Bank Group. 'Invisible Wounds: A practitioner's Dialogue on Improving Development Outcomes Through Psychosocial Support'. May 6, 2014: Washington, DC. <http://www.worldbank.org/en/events/2014/04/07/invisible-wounds-a-practitioners-dialogue-on-improving-development-outcomes-through-psychosocial-support>. Accessed 25 March 2015.
- World Health Organization (WHO). (2013) *Building Back Better: Sustainable Mental Health Care After Emergencies*. Geneva: WHO.
- World Health Organization (WHO). The Adapted mhGAP Intervention Guide for Mental, Neurological, and Substance Abuse Disorders in non-specialized health settings in Liberia. Mental Health Gap Action Program (mhGAP). WHO: July 2012.
- World Health Organization (WHO). Ebola virus disease outbreak response plan in West Africa—a call for action, 2014. <http://www.who.int/csr/disease/ebola/evd-outbreak-response-plan-west-africa-2014.pdf?ua=1> (accessed May 1, 2015).
- World Health Organization (WHO). Liberia: WHO Statistical Profile. Source: Country statistics and global health estimates by WHO and UN partners. Last updated January 2015. <http://www.who.int/gho/countries/lbr.pdf?ua=1> Last accessed 25 March 2015.
- World Health Organization (WHO). Mental Health Services in Liberia: Building Back Better. Last updated March 2016. <http://www.who.int/features/2016/mental-health-liberia/en/>. Last accessed May 24 2016 (2016a).
- World Health Organization (WHO) & United Nations High Commissioner for Refugees (UNHCR). "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings." Geneva: WHO, 2012.
- Yadav, Sankalp, and Gautam Rawal. "The Current Mental Health Status of Ebola Survivors in Western Africa." *Journal of Clinical and Diagnostic Research: JCDR* 9, no. 10 (10/01
- Zegura, Ellen W, Elena Derkits, and Janice Cooper. "See My Work: Sustaining a Data Reporting Practice by Mental Health Clinicians in Liberia." Paper presented at the Proceedings of the Seventh International Conference on Information and Communication Technologies and Development, 2015.