



COUNTRY PROFILE:
FGM IN LIBERIA

DECEMBER 2014

 **28 TOOMANY**
FGM...
let's end it.



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E-mail: info@28toomany.org

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Efua Dorkenoo OBE

1949-2014

28 Too Many dedicates this report to Efua Dorkenoo. A courageous and inspirational campaigner, Efua worked tirelessly for women's and girls' rights and to create an African-led global movement to end Female Genital Mutilation (FGM).

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FOREWORD

Since first researching FGM in Liberia in 2012, the progress made towards ending this harmful traditional practice has been taken over by a new and urgent crisis – tackling Ebola. This has not only impacted the anti-FGM work of our partners, but has become embedded into the core of society. As well as the many lost lives (2,963 deaths in Liberia as of 18 November 2014), Ebola is affecting the social norms of women hugging and men handshaking as greetings, and funeral customs that have never before been challenged.

Ebola has also shattered the health sector where health workers have been amongst those most likely to be infected. In addition, women cannot access care during childbirth, and we know over 34 doctors have left a country with an already poor health infrastructure. Schools have closed and radio lessons are being broadcast instead. 75% of those contracting the virus are women who are primary care givers, which results in their loss leaving a deeper impact on the physical and mental wellbeing of their families and communities. 30% of Liberian households are headed by women (2009) and 90% are employed in the informal or agricultural sector compared to 75% of men, so Ebola has devastating consequences on the social and economic welfare of Liberia. However, many in Liberia and across West Africa are showing great courage and resilience. One positive role model is Fatu Kekula, a 22 year old nursing student, who survived Ebola and nursed most of her family to health, showing the use of up-to-date medical knowledge being put to positive use.

Since September, the Liberian Government has declared that the FGM Sande secret societies practising initiation activities should be suspended, but it is reported that some initiations were still continuing in October 2014. It is telling that arrests are threatened for breaking the anti-Ebola mandate, but not for committing FGM. The case of ‘Blessing’ at the end of this section highlights the horror of kidnapping for forced FGM.

Liberia fits into a wider context where globally one girl has FGM every ten seconds, leaving the staggering figure of 3 million a year. If we do not act now, 30 million girls just across Africa will have FGM by 2024 – to add to the already 140 million alive today who have experienced FGM. Whilst we at 28 Too Many are initially focussing on Africa, and the global diaspora in which they settle, we are also aware of the increase of FGM in the Middle East and Asia.

This Country Report on FGM in Liberia shows the fall in prevalence between older and younger cohorts from 72.4% among 45-49 year old women to 39.8% among 20-24 year olds reported in the 2013 DHS. This is a fall of 32.6 percentage points equating to more than a 40% decline. There is also a fall in reporting of membership of the Sande within the same cohort across time, suggestive of underreporting of membership possibly due to increased anti-FGM messaging in the media and by government around the time of the survey, identifying the need for more research.

There remains a strong taboo against speaking about FGM in Liberia. This is coupled with the fear of retribution, including forcible FGM, if seen to be working on anti-FGM projects, and this affects INGOs, NGOs, journalists and the general public. However, there appears to be a weakening of the taboo in that more women are speaking out loudly against all forms of FGM, notably Phyllis Kimba at NATPAH and journalist Mae Azango. They are supported by the growing international movement against FGM.

There is no law against FGM in Liberia, and there is not currently sufficient political will to address ending FGM or enforce policies to ensure that Sande schools are held outside of term times. This adds to the continuing disparity of boys’ and girls’ education opportunities.

It is striking to note that FGM in Liberia is an extreme form of gender based violence, mostly performed on young girls and occurring in a country where 90% of rapes are on young girls

aged 10-14 years. FGM is performed as part of the Sande initiation, and is still supported by many members, where attitudes are hardening in each younger cohorts.

There is a danger that while instituting culturally relevant and sensitive interventions around Sande, and supporting the call for the end to forcing children into the bush for FGM, NGOs may take a culturally relativist stance on no FGM for children only and miss out the wider point that FGM is a violation of women's as well as girls' human rights.

We also see little involvement of faith leaders in ending FGM in Liberia and hope that this can be addressed in the post-Ebola era, when orphans and widows stigmatised by being affected by Ebola will need to be integrated back in the community. Here there is a potential role for correcting false beliefs about causes of disease and mortality, and providing education on FGM at the same time as dispelling untrue myths around it.

One aspect of hope is that Sande initiations are officially banned at the time of this report. We hope that the ban on FGM as part of initiations continues as Liberia recovers from the Ebola outbreak, and that the successful interventions mentioned in our Executive Summary and Conclusions can be universally adopted as a strand of development work when agencies and overseas governments help Liberia rebuild its infrastructure.

I look forward to visiting Liberia next year and in the meantime we continue to support our partners in their fight against Ebola and in tacking FGM.

Ann-Marie Wilson

Founder/Executive Director, 28 Too Many

An FGM case reported in the Liberian press in June 2014 concerning a 10 year old girl, 'Blessing'* , illustrates that forced initiation into Sande society is a major issue in Liberia. Blessing was caught and forcefully initiated into the Sande society, without her mother's knowledge, because she strayed too close to the Sande bush. On an errand for her mother, Blessing was drawn to the sound of drumming, and she was then taken captive. Blessing described how she spent most of her month-long imprisonment doing washing up, but also that she was blindfolded, held down, and had FGM – her wound treated with a leaf.

As well as the suffering she endured from her capture and forced FGM, Blessing feared that she was to blame for this as she should have stayed away. Furthermore, her mother was forced to pay a fine to have her released from the bush after four weeks (Liberian Daily Observer, 2014). In a follow up comment on this story, radio journalist Claudia Smith wrote that Blessing's mother has since died of Ebola.

This story is one of many of forced initiation in Liberia and also now just one of many stories of the terrible impact of Ebola.

*Name changed for protection

BACKGROUND

28 Too Many is an anti-female genital mutilation (FGM) charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010, and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework, where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We hope to build an information base, including the provision of detailed Country Profiles for each country practising FGM in Africa and the diaspora. Our objective is support anti-FGM networks and organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

PURPOSE

The prime purpose of this Country Profile is to provide improved understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. Whilst there are numerous challenges to overcome before FGM is eradicated in Liberia, many programmes are making positive change.

USE OF THIS COUNTRY PROFILE

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content, suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

For referencing this report, please use: 28 Too Many (2014) Country Profile: FGM in Liberia. (www.28toomany.org/countries/liberia/)

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THE TEAM

Katherine Allen is Lead Editor and a Research Intern for 28 Too Many. She is also a DPhil (PhD) student in the history of medicine at the University of Oxford.

Molly Brown is a Research Volunteer for 28 Too Many.

Winnie Cheung is a Research Volunteer for 28 Too Many.

Amy Hurn is Research Project Manager for 28 Too Many. She has an MSc in Transport Planning and Management.

Daisy Marshall is Research Administrator for 28 Too Many and is currently studying for an MA in Sociological Research at the University of Sheffield.

Esther Njenga is a Research Volunteer for 28 Too Many. She has an MA in understanding and securing human rights and is a qualified solicitor.

Philippa Sivan is Research Coordinator for 28 Too Many. Prior to this she worked for seven years with Oxfam.

Ann-Marie Wilson founded 28 Too Many and is the Executive Director.

We are grateful to the rest of the **28 Too Many** Team who have helped in so many ways, including **Caroline Overton, Louise Robertson** and **Johanna Waritay**.

Mark Smith creates the custom maps used in 28 Too Many's country profiles. **Rooted Support Ltd** donated time through its Director Nich Bull in the design and layout of this Country Profile, www.rootedsupport.co.uk.

Photograph on front cover: ©EC/ECHO/Anouk Delafortrie.

Please note the use of the photograph of the woman on the front cover does not imply she has, nor has not, had FGM.

LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ARP	Alternative Rites of Passage
BPHS	Basic Package of Healthcare Services
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of Discrimination against Women
CHWs	Community Health Workers
CPJ	Committee to Protect Journalists
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisation
DHS	Demographic and Health Survey
ECOWAS	The Economic Community of West African States
FBO	Faith-Based Organisation
FC	Female Circumcision

FGC	Female Genital Cutting
FGM	Female Genital Mutilation
GBV	Gender Based Violence
GDI	Gender Development Index
GDP	Gross Domestic Product
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HTP	Harmful Traditional Practice
IAC	Inter-African Committee
ICCPR	International Covenant on Civil and Political Rights
ICESR	International Covenant on Economic, Social and Cultural Rights
ICRL	Inter-Religious Council of Liberia
INGO	International Non-Governmental Organisation
LFP	Liberia Fistula Program
LGBT	Lesbian, Gay, Bisexual, Transgender
LNP	Liberia National Police
LURD	Liberians United for Reconciliation and Democracy
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
NDPL	National Democratic Party of Liberia
NGO	Non-Governmental Organisation
NIB	National Integrity Barometer
NPFL	National Patriotic Front of Liberia
PFUL	Pentecostal Fellowship Union of Liberia
PRC	People's Redemption Council
SGBV	Sexual and Gender-Based Violence
SIGI	Social Institutions and Gender Index
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
US	United States of America
VAWG	Violence against Women and Girls
WAEC	West African Examination Council
WFP	World Food Programme
WHO	World Health Organisation
WWSF	Women's World Summit Foundation (UN)

INGO and NGO acronyms are found in Appendix I.

EXECUTIVE SUMMARY

This Country Profile provides comprehensive information on female genital mutilation (FGM) in Liberia. The report details the current research on FGM and provides information on the political, anthropological and sociological contexts of FGM. It also includes an analysis of the current situation in Liberia and reflects on how to improve anti-FGM programmes and accelerate the eradication of this harmful practice. The purpose of this report is to enable those committed to ending FGM to shape their own policies and practice to create positive, sustainable change.

This Country Profile is especially sensitive in addressing issues surrounding FGM within the context of the devastating outbreak of Ebola in 2014. 28 Too Many empathises with those who are suffering, those who have lost loved ones, and with the Liberian Government, health and education sectors, and other organisations, as they attempt to combat the virus and rebuild lives. It is our hope that when the epidemic comes to an end, positive efforts will be made once more in areas related to women's rights and health, and that programmes related to ending FGM will continue to see progress.

FGM is estimated at 49.8% in Liberia for girls and women aged 15—49 (DHS, 2013). The percentage of women who have been initiated into Sande (and therefore have had FGM) has fallen among younger age cohorts. In the cohort aged 20—24, the rate fell from 58.4% in 2007 to 39.8% in 2013. These remaining members, however, show stronger support for its continuation than had been shown earlier. More research is needed to understand fully these trends. The Demographic and Health Surveys (DHS) for Liberia do not provide in-depth statistics on FGM practices. Rather than asking directly about FGM, the surveys asked three questions relating to Sande society membership. The Liberian Government chose this simplified form of questioning because FGM is part of the initiation into the prevalent female secret society, and is therefore taboo and secret. 85% of Liberia's population is comprised of Sande practising ethnic groups. FGM is higher in northern regions of the country (including Lofa and Bong Counties), and is particularly prevalent among the Mende, Gola, Kissi and Bassa ethnic groups. FGM is lower in southern regions (lowest in Maryland), and is not practised by the Kru, Grebo, Krahn, or Americo-Liberians. In the case of Americo-Liberians, former male presidents have elected to undergo Poro (male secret society) initiation to garner support.

FGM is performed by Zoes, who are the leaders of the Sande bush schools, and are also often local birth attendants. Zoes hold significant authority in communities, and FGM is a central part of their livelihood. Types I and II are said to be most commonly

practised, though data is scarce (NATPAH report). There are more Sande members in rural regions than urban regions, and the DHS survey shows that 39.3% of current members want Sande society to be stopped, and this includes FGM initiation. Notably, in the capital Monrovia, only 30% of Sande members want the practice to stop. The desire to end Sande is stronger in rural areas with 47% of members against.

There is currently no law criminalising the practise of FGM in Liberia. It can be argued, however, that FGM falls under legislation related to children's rights, women's rights, bodily harm, and kidnapping. It is also illegal to forcibly take someone into the sande bush. Despite the current Government's efforts to support women's rights, health and education, forced initiation into Sande (including FGM) reportedly occurs regularly. Gender inequality remains a major issue in the country, as does rape and domestic violence. There is a lack of government enforcement of secret society policies primarily because government figures are afraid to speak out against the Sande and lose votes. Moreover, there can be a severe threat of physical harm, and intimidation towards activists and journalists speaking out against FGM. The case of the National Association on Traditional Practices Affecting the Health of Women and Children's (NATPAH) head, Phyllis Kimba, whose house was burnt down after addressing the United Nations (UN) about FGM in Liberia, exemplifies this threat. Hence, international and national non-governmental organisations (INGOs and NGOs) often express their interest in combating FGM indirectly, and structure their programmes around broader issues surrounding human rights and women's health.

In addition there is an extremely worrying discourse in Liberia among some NGOs and members of Government that FGM is a child's rights violation with no mention of the fact that it is a rights issue for women too, which is seen clearly in a statement made by the head of all Liberian Zoes and Executive Director for Culture and Female Affairs in the Government, Madam Tormah, that said, 'People should join the Sande of their own free will, but underage children – no one should carry them anywhere. Girls should be 18 or 20. That means you go there for yourself, of your own free will. Seven-year-olds – it is not right for them to go there'. This should not go unchallenged.

There are numerous INGOs, NGOs and CSOs working to eradicate FGM using a variety of strategies, centred around discussions on human rights, advocating for women's and girl's rights, community forums, lobbying and media campaigns. For instance, NATPAH, the national committee partner for the Inter-African Committee (IAC), works on raising awareness of the harmful effects of FGM. They have created a successful programme for facilitating alternative livelihoods for Zoes. The Association of Disabled Families International (ADFI) holds community forums and has hosted over 45 workshops on

issues related to FGM. In 2013, Women Solidarity Inc. (WOSI) conducted a survey in order to understand attitudes towards FGM. They have participated in radio talk shows, lobbying for an anti-FGM law, as part of the 2014 International Day of Zero Tolerance for FGM. A comprehensive overview of these organisations is included in this report.

We propose measures relating to:

- Adopting culturally relevant programmes. For Liberia this means structuring programmes that are sensitive to the cultural significance of the Sande society, and recognising that FGM is a central part of initiation into that society (and provides a livelihood for Zoes). It is also imperative to be aware that FGM remains a taboo subject, and often needs to be addressed in the larger context of women's health and human rights.
- Sustainable funding. This is an issue across the development (NGO) sector; for Liberia it is most urgent in the context of the ongoing Ebola crisis. Sustainable funding is needed for long-term planning and rebuilding of the country's healthcare and education sectors.
- Considering FGM within the Millennium Development Goals (MDGs) and post-MDG framework. Despite having made notable progress post-civil war in striving to meet the targets, the Ebola epidemic has halted and reversed many of these achievements and they will not be met.
- Facilitating education. In Liberia, this is a particular challenge since schools have closed in efforts to curb the spread of the Ebola virus. The Government with partners is looking at the use of radio lessons to bridge the gap.
- Improving access to health facilities and managing health complications of FGM. Again, this is a significant obstacle given Ebola, as discussed in this report.
- Increased advocacy and lobbying
- The criminalisation of FGM and increased law enforcement, which means greater enforcement of government policies in the conduct of sande bushes.
- Fostering the further development of effective media campaigns, such as the positive work done by WOSI and the Association of Female Lawyers of Liberia (AFELL), who use radio shows to raise awareness of the harmful effects of FGM and lobby for an anti-FGM law.

- Encouraging faith-based organisations (FBOs) to act as agents of change and be proactive in ending FGM.
- Increased collaborative projects and networking
- Further research into the support for Sande and the current age at which FGM occurs. Determine whether or not it is possible to separate FGM from Sande, or if they are synonymous.

INTRODUCTION

'It is now widely acknowledged that FGM functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families' (The General Assembly of the United Nations, 2009).

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the World Health Organisation (WHO) as referring to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. Over 125 million girls and women alive today have had FGM in the 28 African countries and Yemen where FGM is practised and 3 million girls are estimated to be at risk of undergoing FGM annually (UNICEF, 2013).

HISTORY OF FGM

FGM has been practised for over 2000 years (Slack, 1988). Although it has obscure origins, anthropological and historical research has been conducted on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to the 5th

century BC in Egypt, with infibulations (Type III FGM) being referred to as 'Pharaonic circumcision' (Slack, 1988). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom among stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein, 1983).

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently among different peoples (Lightfoot-Klein, 1983), aided by Egyptian slave raids from Sudan for concubines and maids, and traded through the Red Sea to the Persian Gulf (Mackie, 1996) (sources referred to by Wilson, 2012/2013).

GLOBAL FGM PREVALENCE AND

PRACTICES

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and to the Democratic Republic of Congo (DRC) in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North America, Australasia and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past, and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

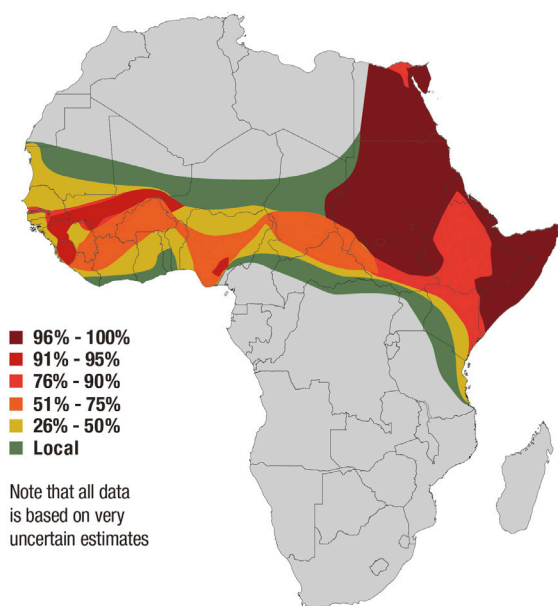


Fig. 1: Prevalence of FGM in Africa (Afrol News)

The WHO classifies FGM into four types (WHO, 2008):

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood, and necessary for a girl to go through in order to become a responsible adult member of society.

FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious scripts require the practice, practitioners often believe the practice has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic (UNICEF, 2005). Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth complications and new-born deaths; and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013).

The eradication of FGM is pertinent to the achievement of six Millennium Development Goals (MDGs): MDG 1 – eradicate extreme poverty and hunger, MDG 2 – achieve universal primary education, MDG 3 – promote gender equality and empower women; MDG 4 – reduce child mortality, MDG 5 – reduce maternal mortality and MDG 6 – combat HIV/AIDS, malaria and other diseases. The post-MDG agenda is currently under discussion and it is hoped that it will include renewed efforts to improve the lives of women, particularly as we near 2015.

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM. A key strategic objective is to provide detailed, comprehensive Country Profiles for each of the 28 countries in Africa where FGM is practised. The reports provide research into the situation regarding FGM in each country, as well as providing more general information relating to the political, anthropological and sociological environments in the country to offer a contextual background within which FGM occurs. This can

also be of use regarding diaspora communities that migrate and maintain their commitment to FGM.

The Profile also offers some analysis of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound knowledge base from which to determine the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we have met many anti-FGM campaigners, CBOs, policy makers and key influencers. We wish to help facilitate in-country networking to enable information sharing, education and increased awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM, locally and internationally.

NATIONAL STATISTICS

GENERAL STATISTICS

It should be noted that, due to the Ebola epidemic, some of these statistics are no longer an accurate reflection of health in Liberia. As of 18 November 2014 there were 2,963 confirmed deaths, and the epidemic has severely impacted the health and education sectors.

POPULATION

4, 504, 213 (8 November 2014) (Country Meters)

Median age: 17.9 years (2014 est.)

Growth rate: 2.52% (2014 est.)

HUMAN DEVELOPMENT INDEX

Rank: 175 out of 186 (UNDP, 2014)

HEALTH

Life expectancy at birth (years): 58.21 years (2014)

Infant mortality rate (per 1,000 live births): 69.19 deaths

Maternal mortality rate: 640 deaths/100,000 live births (World Bank, 2013); rank in country comparison to the world: 8 (World Factbook, 2014)

Fertility rate, total (births per woman): 4.81 (2014 est.)

HIV/AIDS – adult prevalence rate: 1.1% (UNAIDS, 2013 est.)

HIV/AIDS – people living with HIV/AIDS: 25,000 (UNAIDS, 2013 est.); country comparison to the world: 80

HIV/AIDS – total deaths: 2,700 (UNAIDS, 2013 est.)

LITERACY (AGE 15 AND OVER WHO CAN READ AND WRITE)

Total: 42.9% (UNICEF, 2012 est.)

Youth (15–24 years): 49% Female: 37.2% Male: 63.5% (UNICEF, 2012)

GDP (IN US DOLLARS)

GDP (official exchange rate): \$1.977 billion (2013 est.)

GDP per capita (PPP): \$700 (2013 est.)

GDP (real growth rate): 8.1% (2013 est.)

URBANISATION

Urban population: 48.2% of total population (2011)

Rate of urbanisation: 3.43% annual rate of change (2010-15 est.)

ETHNIC GROUPS

Kpelle 20.3%, Bassa 13.4%, Grebo 10%, Dan (Gio) 8%, Mano 7.9%, Kru 6%, Lorma 5.1%, Kissi 4.8%, Gola 4.4%, other 20.1% (Census, 2008)

RELIGIONS

Christian 85.6%, Muslim 12.2%, Traditional 0.6%, other 0.2%, none 1.4% (Census, 2008)

LANGUAGES

English 20% (official language) and some 20 ethnic group languages, few of which can be written or used in correspondence

Unless otherwise stated, all citations are from World Factbook.

MILLENNIUM DEVELOPMENT GOALS

The eradication of FGM is pertinent to six of the UN's eight Millennium Development Goals (MDGs). Throughout this report, the relevant MDGs are discussed within the scope of FGM.



Fig. 2: Millennium Development Goals

POST-MDG FRAMEWORK

As the MDGs are approaching their 2015 deadline, the UN is evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace. Currently, the UN is working with its partners on an ambitious post-2015 development agenda, and striving for open and inclusive collaboration on this

project (UN website). The UN is also conducting the MY World survey in which citizens across the globe can vote offline and online (including using mobile technologies) on which six development issues most impact their lives. These results will be collected up until 2015 and will influence the post-2015 agenda (Myworld2015.org).

Coinciding with this survey is 'The World We Want' platform, an online space where people can participate in discussions on the UN's 16 areas of focus for development. On the issue of gender violence, there has been a growing call for the post-MDG agenda to include a distinct focus on ending violence against women (Harper, 2013).

Though FGM will not be eliminated in Liberia by 2015, it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM. Progress with MDGs in Liberia has halted because of the Ebola crisis, but it is hoped efforts will resume in the near future. The post-2015 agenda will undoubtedly provide renewed, if not stronger, efforts to improve women's lives. Additionally, the African Union's declaration of the years from 2010 to 2020 to be the decade for African women will certainly assist in promoting gender equality and the eradication of gender violence in Liberia.

POLITICAL BACKGROUND

HISTORICAL

It is believed that the first indigenous peoples of Liberia migrated to what is now modern Liberia between the 12th and 16th centuries, from the north and east. Through Portuguese exploration in the 15th century, the area was named *Costa da Pimenta* (Pepper Coast), and later, in 1602, it was briefly the locale of a Dutch trading post at Grand Cape Mount. Apart from British trading posts in the 1660s, no further settlements by non-African colonists existed until 1821. Between 1821 and 1838 the first settlement of freed slaves was established by the American Colonization Society on land bought from the Grebo.

In 1847, Americo-Liberians established a republic and this continued until the Republican Party was dissolved in 1876. Subsequently, the Americo-Liberian True Whig Party dominated politics until the coup in 1980. Hence, Liberia was governed by an elite ethnic minority until 1980. Liberia has had a complex political and economic history with the United States. For instance, rubber was a long-standing commodity produced in Liberia. During the Second World War, Liberia sourced rubber for the US and its allies, in addition to providing land to build American military bases. As a result, the American military presence enhanced the Liberian economy, causing an influx of migrating labourers and enabling Liberia to focus on another important commodity, iron ore. During the Cold War, Liberia was influenced by the US to resist Soviet power. Agreeing to this anti-communist agenda, President William Tubman, who served from 1944-71, worked closely with the US and gained substantial foreign investment. Moreover, from 1962 to 1980, the US gave \$280 million in aid to Liberia.

Liberia's political history is founded on a number of military and transitional governments and violent conflicts. Liberia's twentieth president, William R. Tolbert Jr., encountered resistance after his government tried to increase the price

of rice. Demonstrations in Monrovia and the resulting riots escalated into a military *coup d'état* in April 1980, led by Samuel Kanyon Doe. Tolbert and many of his supporters were murdered, and this marked the end of Americo-Liberian control. Doe's military regime under the party of the People's Redemption Council (PRC) was generally welcomed by Liberians, who had little political agency. During the Reagan administration, Doe re-established good relations with the US, which again resulted in foreign aid. This aid, however, declined at the end of the Cold War. When Doe became President in 1986, he called for increased suppression of certain northern ethnic groups (Dan (Gio) and Mano), who were associated with a failed coup in 1985. The human rights abuses carried out during this period created divisions and violence among several ethnic groups in Liberia. Doe's National Democratic Party of Liberia (NDPL) was also charged with fraud and rigging during the elections, and later with government corruption.

Ethnic conflicts erupted into the first Liberian civil war when the Krahn tribe (of President Doe) attacked tribes in Nimba County. Charles Taylor, with his National Patriotic Front of Liberia (NPFL) – a group of rebels from Dan (Gio) and Mano people groups invaded Nimba County in 1989, causing inter-tribal war. The Economic Community of West African States (ECOWAS) was forced to intervene with a group of 4,000 troops. Doe was captured and killed in 1990. An interim government was created in the Gambia under ECOWAS, but Taylor refused to cooperate and continued the war. By 1995, after several peace accords, Taylor agreed to the creation of a transitional government. Following disarmament and demobilisation of the warring factions, elections were held in 1997 and Taylor and his National Patriotic Party won a majority. At the close of the first civil war there were between 200,000 and 250,000 casualties and over a million people were displaced into refugee camps.

During Taylor's administration violence continued and several West African countries

accused Taylor of assisting rebel forces in the Sierra Leonean civil war. This led to the start of the second civil war. In 1999, the Liberians United for Reconciliation and Democracy (LURD) group emerged with the support of Guinea in northern Liberia and began fighting in Lofa County. By spring of 2001 the LURD was a major threat and this led to a conflict between Liberia, Sierra Leone and Guinea. Also, the United Nations Security Council declared that Taylor had played a role in the Sierra Leonean civil war and barred all arms to – and diamond sales from – Liberia, and banned Liberian Government members from travelling to UN-states. A peace agreement was signed in 2003, ending the civil war. Taylor was forced to resign, while facing charges for war crimes in Sierra Leone. Another transitional government was established under Gyude Bryant until the 2005 elections.

CURRENT POLITICAL CONDITIONS

President Ellen Johnson Sirleaf came into power in 2005 and subsequently won re-election in 2011. The 2011 election was boycotted by the opposition, declaring that Sirleaf had promised in her 2005 campaign to serve only one term. Despite allegations of the voting being fraudulent, international observers reported the elections to be free and fair, although with low voter turnout. Sirleaf was awarded the Nobel Peace Prize in 2011 for efforts to secure peace, promote economic and social development and strengthen the position of women. Under Sirleaf’s administration, corruption remains a serious problem (US Dept. of State, 2013).

The UN has previously maintained around 15,000 soldiers in Liberia. However, in 2012 a resolution was passed to reduce the number of UN troops by half by 2015, which will bring the new total to fewer than 4,000. Furthermore, in 2012, the United Nations High Commissioner for Refugees (UNHCR) and the Liberia Repatriation and Resettlement Commission completed the voluntary repatriation of 29,380 Liberian refugees from other West African countries (US Dept. of State, 2013).

In March 2014, Liberia suffered its first casualties of the largest Ebola epidemic in history, becoming the epicentre of it in the summer. As of November 2014, it was cautiously reported that new cases in Liberia were apparently declining, though they are still increasing in Sierra Leone and Guinea. The outbreak has resulted in civil unrest and violence against aid workers. Liberia’s health infrastructure has been severally tested and strained during the outbreak.

Unless otherwise states, all information from World Factbook.

SANDE SECRET SOCIETY

Sande is a name for the secret society of women in Liberia, which uses initiation rituals for membership that involve FGM within the bush schools they operate. It is also the name given by members to the spirit mediator between the living and the dead. This institution has been seen as central to women’s lives, affording them a measure of political autonomy, respect within the community, freedom of movement and association when the sande bush school is in session and also power within their communities to mediate social relations and the conditions women live in. At present the cost of this social good is FGM – or disenfranchisement if it is refused. Women who are uninitiated in Lofa County are called Kpolo wa, meaning ‘sinner’ according to the Zorzor District Women Care Inc. (ZODWOCA), a women’s human rights organisation. They also stated that unless you are a member of Sande, you cannot hold any position of power within your community (ZODWOCA, 28 Too Many research, 2014).

During the social and economic devastation of the civil wars, the power of the Poro (men’s society) and Sande, and the old gerontocratic (rule by age) power structure in communities, broke down. Though women and children suffered severely during this time of war, they also found a measure of independence from men and society’s imposed gender roles and a powerful voice, especially in peace agreements made in the aftermath of the war. Yet, the power of the secret societies has been unwittingly bolstered by NGO interventions in the peace building processes after the civil war, when they were empowered to help re-establish authority in communities (Fuest, 2010). See Intervention section for further explanation on page 59.

In Liberia, 49.8% of women are members of Sande and it includes over half of all ethnic groups, including: Kissi, Loma, Gbandi, Gola, Vai, Belle, Kpelle, Mano, Sapo, Mende, Bass and Dan (Gio) (DHS, 2013). Sande was traditionally viewed as giving women agency and a sense of community.

For example, in rural northern Liberia women are required to gain their husband’s permission to do tasks outside the home. Yet, the Sande society is a place where a woman can go without her husband’s permission. Sande initiation is tied to conceptions of sexual/gender identity and fertility. The sande bush represents fertility and the essence of ancestral and supernatural spirits (Koso-Thomas, 1987).



Fig. 3: Initiated girls in the Sande society, Liberia 1910 (www.biantouo.com)

During the initiation ceremony, the Sande often perform a masquerade, with both the masks and dances having ritualistic powers. These masquerades for the Sande, and their Sierra Leonean counterpart Bondo, are the only known instances of women in Africa wearing masks. There are no Sande masks used in the ritual of the Kpelle, Loma or Mano. In some ethnic groups, such as the Bassa and Kissi, the complementary men’s society, the Poro, may not exist. Among the Dei and Loma, the Sande society regularly admits male-blacksmiths as ritual specialists (possibly to carry out FGM) and, in Gola society, the spirit represented by the mask is considered to be male rather than female.

The Sande have laws of secrecy prohibiting members from discussing their practices, with supernatural and physical sanctions on those who break the laws. This is highlighted in a news article where an informant explains, ‘I can’t use

my real name because they will throw some kind of sickness on me to kill me when I visit our home because I burst out the secret' (New Narratives, 2014). All males and uninitiated girls and women are non-members, and are not permitted to discuss Sande issues (including FGM). There are stories of forced initiation as a punishment for breaking Sande law, or even for straying too close to the sande bush, carried out on non-members.



Fig. 4: A Sande society mask for initiation rituals (<http://www.tribal-art-auktion.de>)

FGM is not illegal in Liberia, though kidnapping and forced initiation into the Sande and Poro societies is illegal. Most girls and women are unaware of their rights to decline initiation. The most widely reported case of this behaviour was the kidnapping in 2010 of Ruth Berry Peal and two of her children into the sande bush and her forced FGM, though she herself is from a non-Sande ethnic group. This followed an argument in the

market with women from the Gola ethnic group (who have Sande societies) among whom she was living after being displaced from her traditional homeland during the civil war. With the help of international and national support, her case was taken to court and two women were sentenced to three years' imprisonment.

'I blame the government because they know about it [sande bush]. You can't go near the Sande when drums are beating or they will catch you; and it's bad.'

-Madam Gray, principal of AGOM, an elementary school

Another case reported in 2014 is that of a 10 year old girl (anonymised) called 'Blessing'. Her case is discussed in the foreword.

Meima Sirleaf Karneh, Assistant Minister for Research and Technical Services at the Ministry of Gender and Development, spoke in an interview after the incident concerning Blessing (*Liberian Daily Observer*, 2014), and clarified the policies that have been laid down in conjunction with the Ministry of Internal Affairs to regulate the operating of the bush schools, both Sande and Poro where the secret society initiation and teaching sessions are held. These are:

- Forced initiation should not happen (but she did not state that it is a crime).
- Sande bushes should not be set up in residential areas; they should be at least 25 miles away; they should not operate in cities and certainly not close to official schools.
- Sande schools should not run during government school term times.
- Communities should report violations to the ministries of Gender, Internal Affairs or Education.

- Sande schools should be set up in consultation with local leaders and the community.



Fig. 5: Ruth Berry Peal pictured in Monrovia, Liberia, February 27, 2013. Photo by Ruth Njeng'ere of Equality Now (<http://www.trust.org/item/?map=kidnapers-jailed-for-forcing-liberian-woman-to-undergo-fgm/>)

It is reported that these controls are not enforced. In the town where Blessing was taken and forcibly initiated into the Sande, two bush schools were operating. One of these was next to the elementary school, where the head mistress complained that there was drumming every day and children found straying too close were taken captive and initiated.

'We are all from traditional and cultural backgrounds, so we're not saying at Gender [Ministry of Gender and Development] that we should stop the other culture, what we are saying is these are modern days, lets modernize things to conform to present day reality.'

-Meima Sirleaf Karneh, Assistant Minister for Research and Technical Services at the Ministry of Gender and Development

Quotes in text boxes are from the *Liberian Daily Observer*, 2014.

THE ECONOMICS OF FGM

There are two ways to address the economics of FGM: the cost to the family and the cost to the state. There are no figures published for the latter, but they may be expanded from available data and knowledge. For the former, in addition to the cost of the rites, families face further economic costs if healthcare is needed to help with FGM complications either immediately, or in the long term.

Most of the correspondence that 28 Too Many had with NGOs working in Liberia stated that, for Zoes, the practice of FGM is their livelihood and that they could not be expected to give it up without compensation. Internal Affairs Minister Dukuly is reported to have said that initiation is done for the Zoes' commercial gain, but reiterates that people should willingly join the society instead of being forced (allafrica.com, 2013). In a news report published in March 2012 an anonymous informant (for fear of her life) claimed that initiation used to be 'a no money business', but now she said Zoes do not even train the children in the bush to save time, and allow the Zoes to make more money from more initiations. Furthermore, if someone wants to initiate their child to help her social advancement, the parents are told that they must be initiated as well and the cost is 'two bags of rice, two five-gallon cans of palm oil, and 5,000 Liberian dollars (\$54 US) for beginners to join the bush' (pulitzercenter.org, 2012). This is a considerable sum for the 84% of families in Liberia that live on less than \$1.25 US a day. According to WOSI's baseline survey, 90% of initiations are paid for by the family, 6% by husbands and 2% by future husbands (WOSI, 2013). Communications between 28 Too Many and local NGOs have also confirmed that the extended family will contribute to a girl's initiation when required.

The sparse literature that is available about the operations of the sande bush speak of two payments that are now made for initiation, one at the start and one at the end of the sande bush seclusion to release the child back into the

community. This payment is sometimes spoken of as being equivalent to a ransom payment. The case of Blessing highlighted in the foreword of this report is a case in point, where the 10 year old was taken by force into the bush and the mother had to ask for financial assistance from neighbours and a journalist covering the story in order to free her child. It was also reported that Blessing's mother needed to pay for Blessing's medical treatment because of FGM complications (*Liberian Daily Observer*, 2012).

It has been reported that the Ministry of Internal Affairs charges for the licences they provide for bush schools to operate.

The other side of the economics is the additional costs to the state in healthcare and loss of human potential. Additional healthcare provision needed by women with all types of FGM is shown by the WHO to be about 0.1% to 1% of all healthcare spending on women aged 15-45 (Bishai *et al.*, 2010). Deaths caused by complications during or after initiation, and the school drop-out rate fuelled by early marriage, also incur losses of human potential to the state and its development. The high number of teenage pregnancies, which is often correlated with FGM, causes more loss of human potential by launching girls into a cycle of poverty and ill health.

ANTHROPOLOGICAL BACKGROUND

Liberia's sixteen ethnic groups are subdivided primarily by language. The Kru (Kwa) linguistic group is comprised of the Kru, Grebo, Krahn, Bassa, Dei and Kuwaa, and inhabits the southern, coastal regions of Liberia. The Mel group is located in the north of the country, and consists of the Gola and the Kissi, among the earliest settlers in Liberia. The Mande are by far the largest linguistic grouping, and are subdivided into the Mande Ta and the Mande Fu. The Mande Ta (Vai and Mandingo) live along the northern coast, while the Mande Fu (Kpelle, Dan (Gio), Mano, Loma, Gbandi and Mende) inhabit the northwest of the country. The Mel and the Mande both practise FGM and as a

result, bear various similarities – their societies are patrilineal, and hierarchies are determined by association with the founding ancestor, as ingrained in secret societies. Kru speakers, in general, do not follow Poro/Sande structures and therefore do not practise FGM. Generally, groups that traditionally live in the south-east part of Liberia are socio-politically distinct from other groups. They have less centralised secret societies that do not involve FGM, and can have female chiefs and female members of the council of elders. Their settlements are historically smaller, and societies are structured by age, although they remain patrilineal.

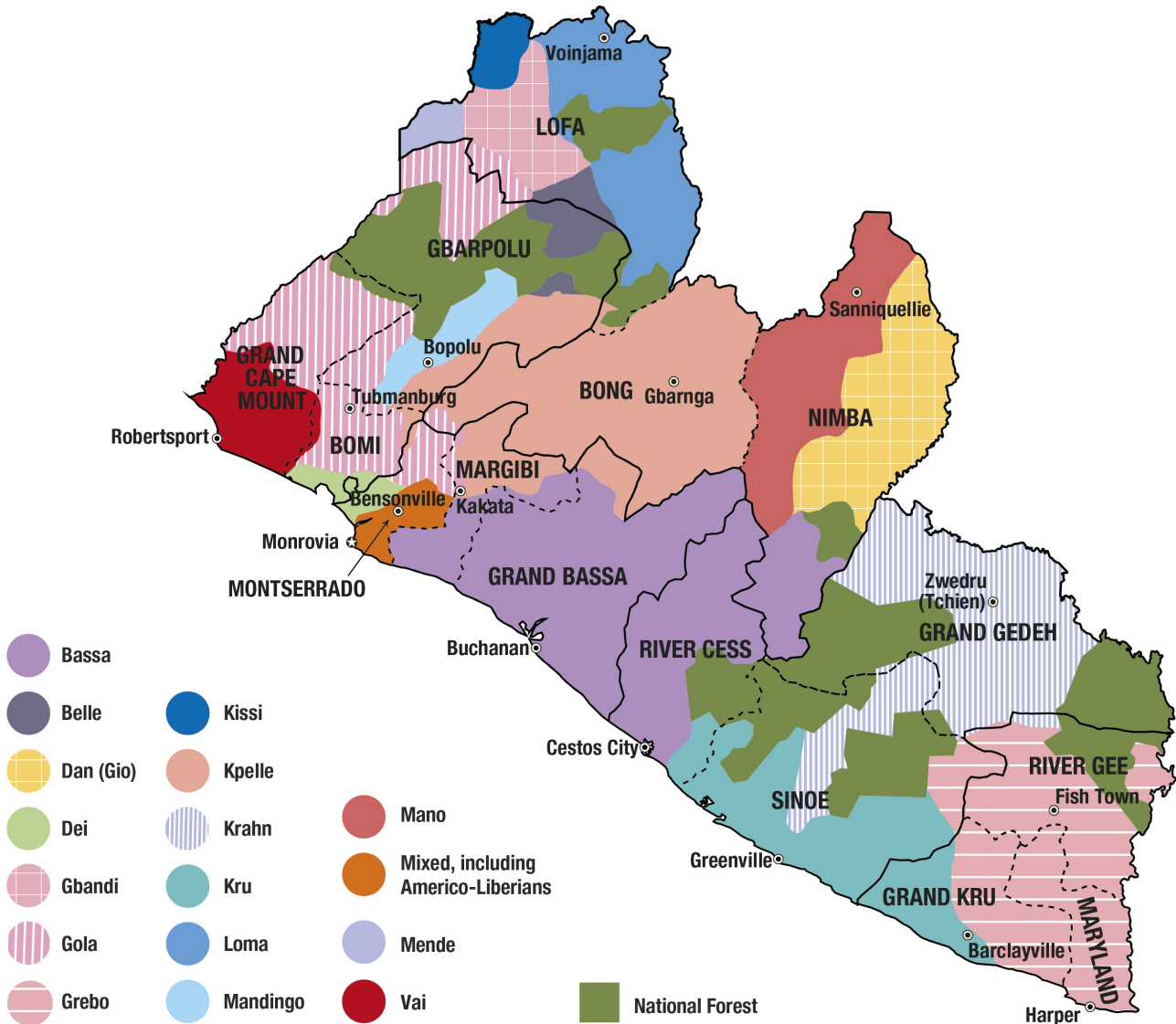


Fig. 6: Geographical distribution of ethnic groups within Liberia

ETHNIC TENSIONS

Successive waves of ethnic groups migrating into what is now Liberia fought territorial battles on arrival until their homelands were established. The arrival of freed slaves, and the establishment of the republic of Liberia in 1847, caused more conflict. Indigenous ethnic groups felt separated from and were made to feel inferior to the Americo-Liberian colonists. These tensions continued between indigenous ethnic groups and descendants of Americo-Liberians and were one factor that led to civil war.

Current ethnic tensions now are focused between various ethnic groups, predominately the Loma, Mano and Dan (Gio), mainly in the north of Liberia, with the Mandingos. Though present in the country for over four centuries, the Mandingos are still referred to as 'strangers', and men are denied entry to Poro Society. This then excludes them from local positions of authority. Women, however, are allowed initiation into Sande societies. Being Muslim, Mandingos accept wives from local populations, but refuse to allow Mandingo women to marry outside the group, as their children adopt the father's religion. Mandingos arrived in Liberia as traders and dominated the trade routes from the coast to neighbouring countries until they were forced to flee during the civil war. During the war, 'a cycle of violence was created by mutual desecrations or destruction of religious sites, i.e. mosques and secret *Poro* groves' (Fuest, 2010). Violence continues to this day, suggesting religious tensions, but in fact the violence is based on contentions over land rights and usage (Fuest, 2010).

ETHNIC GROUPS

AMERICO-LIBERIAN

Americo-Liberians are the descendants of freed slaves; they comprise 5% of the population and live primarily in Monrovia (Census, 2008). Following the abolition of the slave trade the American Colonisation Society (ACS) was founded in 1817. The repatriation group facilitated the settling of

Americo-Liberians in Monrovia, which they named after US President James Monroe. The maturing colony gained independence from the US in 1847 (see Political Background section). They tended to remain distanced from indigenous peoples and even excluded tribal people from high-powered jobs. The Americo-Liberians are a mixture of those descended from slave origins in the US and Caribbean and were referred to as 'Congos' by the indigenous population. The Americo-Liberians are predominantly Christian and do not practise initiation rituals.

BASSA (BASA, BASSO, GBASA)

According to the 2008 census, the Bassa people are the second largest ethnic group in Liberia, comprising 13.4% of the population. The Bassa language is part of the south-eastern Kru linguistic group, but 'Bassa' or 'Vah' has its own writing system, an indigenous script developed around 1900. The Bassa practise Christianity alongside ethnic religions, and in 2005 the Bible



Fig. 7: Women celebrate in Grand Bassa county after a victory over a land grab by a palm oil company that threatened their forest and livelihood (newint.org/features/web-exclusive/2014/05/09/land-grabs-liberia/)

was translated into Bassa. They live in south-central Liberia, and a small population also resides across the border in Sierra Leone. The Bassa are structured in chiefdoms, each subdivided into ethnically distinct clans. Originally subsistence farmers of rice, cassava and yams, the Bassa settled into Monrovia as artisans, clerks and domestic

servants, assimilating, like the Dei, into the culture of the Americo-Liberians. Unlike other peoples of the Kru linguistic group, the Bassa are known to practise FGM as part of initiation into secret Sande societies, although the equivalent Poro society for men is not part of their culture.

DAN (GIO)

The Dan (Gio) live in the east of Liberia, in Nimba County, and across the border in the mountainous west of Ivory Coast. Some scholars believe that their homeland was north-west Ivory Coast, and that in the 17th and 18th centuries they were driven to their current territories. In Liberia, they are often referred to as the Gio, a label derived from the Bassa phrase for slave people, but the people themselves prefer Dan. They comprise 8% of the population (Census, 2008), and are part of the wider southern Mande group (Fu). The Dan are farmers of rice, cassava and sweet potato, alongside cash crops of cocoa, coffee and rubber. They also extract palm oil from trees for fuel and cooking. The Dan have a fierce, warlike reputation; peace with neighbouring tribes was achieved only in the early 1900s. The Dan resisted the Islam of their northern neighbours, retaining their religious tradition which acknowledges a supreme god, Xra. The Dan believe that the Xra may only be accessed via the spirit, or Du, which inhabits all people and animals. When a person dies their Du will be reborn in another, joining a myriad forest spirits. Villages are divided into quarters, each housing an extended family and headed by a quarter chief. The Dan maintain age-structured hierarchies, as well as those determined by secret societies. For the men, this means the leopard society, or Go (*Gor*), which spans villages and unites the Dan. The Dan practise FGM as part of female initiation rituals.

DEI

The Dei live in Montserrado County and Bomi County just north of Monrovia, and comprise just 0.3% of the population (Census, 2008). They were one of the first to come into contact with the settling Americo-Liberians in the 19th century, and

together with the Bassa became assimilated in Monrovia as artisans, clerks and domestic servants. Although the Gola are said to be the earliest tribe to settle in Liberia, the Gola themselves claim the Dei were already there (Sherman, 2010). The Dei speak a Kruan language called Dewoin.

GBANDI (BANDI/BANDE/GBANDE)

The Gbandi make up 3.1% of the Liberian population (Census, 2008). They speak Bandi, a subgroup of the southern Mande-Fu language family. Originally the Gbandi and the Mende migrated south from Guinea to avoid 16th century Mandingo expansion. Now they live in upper Lofa County (Minority Rights website), as well as in Guinea where many fled during the civil war. Like other peoples of the Mande-Fu group, the Gbandi practise FGM as part of Sande initiations.

GOLA

The Gola live in west Liberia and southern Sierra Leone, having fled across the border prior to 1918 to escape a ruthless government campaign. Gola people now comprise 4.4% of the Liberian population (Census, 2008). Their language is an isolate within the Niger-Congo language family (Mel), although they have borrowed considerably from the neighbouring Mande branch. When the Gola moved further south in Liberia, to benefit from coastal trade, they successfully assimilated native Dei and Vai people into their society. Although they are predominantly Islamic, they retain animist beliefs, including that of reincarnation. Many anthropologists trace the origin of Sande societies to the Gola people, and they continue to practise initiation rites, including FGM.

GREBO

The Grebo live on the eastern coast of Liberia, as well as across the Cavalla River in the Ivory Coast. The Grebo language is part of the Kru group, and is comprised of several dialects, or sub-languages. Together the Grebo people make up 10% of the Liberian population (Census, 2008). Like the Kru, they migrated to West Africa in the 16th century,

following the collapse of the Songhai Empire. Of great importance to the tribe's long-lasting memory is their flight across the Cavalla River and into the forest to escape persecution (Meneghini, 1974). Until the construction of a road bridge in the 1960s, the Grebo were relatively isolated, owing to their geographical position among rivers, deltas and swamps. Travel to Monrovia was possible only by boat, or by walking north through the Dei and Krahn territories, a factor which Meneghini cites as evidence for their cultural similarity. They live in small villages, structured by age-hierarchies and ruled by a council of elders, headed by the Bodio (high priest). Grebo men can traditionally marry more than one woman; Meneghini describes how Grebo girls are granted relative freedom and allowed to 'love-play' with select people before settling into marriage after a trial period. The Grebo are subsistence farmers known for 'cane juice' – rum made from distilled sugar cane – as well as for joining the Kru as crewmen 'Krumen' on European vessels. They are primarily Christian, practised alongside ethnic religions. Like the Kru, they do not practise FGM, a fact that can be seen in traditional wooden carvings of female figures (Meneghini, 1974). Though they have no FGM rituals themselves the sande bush is sometimes referred to as the Grebo bush by other ethnic groups.

KISSI

Along with the Gola people, the Kissi are known to be the oldest inhabitants of Liberia, having migrated as early as the 12th century from north-central Africa. They are part of the Mel linguistic group. The Kissi now comprise 4.8% of the Liberian population, and speak Kissi, a Niger-Congo language (Census, 2008). The Kissi live in the hilly Lofa County in the extreme north-west of Liberia, where Liberia, Sierra Leone and Guinea meet. While the Liberian Kissi share a dialect with their Sierra Leone counterparts, the language of the Kissi of Guinea varies slightly. The Kissi are famous for their basket making, weaving, and, historically, for their skills as blacksmiths – the iron-made Kissi penny was once used widely in West Africa.

Farmers grow rice, yams, bananas and melons, as well as coffee and kola nuts for trade. Kissi villages are small and self-governing, dominated by age-defined structures as well as by secret societies. The Kissi practise FGM.

KPELLE

The Kpelle people comprise 20.3% of the population (Census, 2008), making them Liberia's largest ethnic group. Their language, Kpelle, is part of the Mende-Fu language family, and is also spoken by the Kpelle population in the south of bordering Guinea, there known as the Guerze. The Kpelle originated from Sudan and migrated to Liberia via Mali in the 16th century, following the collapse of the Songhai Empire. Most live in Bong County, in north central Liberia, although, since the 1960s, many have relocated to Monrovia. The Kpelle developed their own syllabic script in the early 20th century, which was used for record-keeping, but was predominantly restricted to the elite (Sherman, 2010).

The Kpelle grow and harvest the majority of the food supplied to the capital. They traditionally farm rice, cassava, and peanuts, using an annual slash and burn cycle. While their society is traditionally polygamous, patrilineal and patriarchal, Erchak emphasises the economic role of women, as well as fishing and working in the fields, Kpelle women often own rice farms and chickens, as well as being responsible for selling produce at markets. They keep the profits, and, in some cases, this income is the only source of currency (Erchak, 1974).

The Kpelle recognise a high God, but the majority of their beliefs centre on the spirits that dominate secret societies. The Poro and Sande are widespread among the Kpelle and all girls are initiated at puberty. FGM is rationalised as a means of controlling female sexuality (Bledsoe, 1980; Lancy, 1996). While it is often argued that bush schools are an essential feature of the dissemination of cultural knowledge, Bledsoe (1980) argues that girls learn little that they do not already know, or that they would not otherwise

learn through imitating older women. Erchak notes that girls begin helping with domestic tasks from around 5 years old; boys, however, do not assume responsibilities until the age of around 10 (Erchak, 1980).

KRAHN (WEE, GUÉRÉ)

Part of the Kru language family, the Krahn, known as the Wee (or Guéré) in the Ivory Coast, live along the border between Liberia and the Ivory Coast. They comprise 4% of the population (Census, 2008), and their structure and lifestyle is similar to that of the Kru. In 1980 Samuel Doe, a member of the Krahn, took power in Liberia, raising the profile of the ethnic group, historically demeaned as 'uncivilised' by Americo-Liberian elites as well as indigenous peoples. During the civil war in 1990, Krahns were attacked by the National Patriotic Front of Liberia (NPFL) and many fled to the Ivory Coast.



Fig. 8 Young girl dancing (http://www.state.gov/cms_images/liberia_child_2007_01_16.jpg)

Kpelle Initiation Case Study

When girls enter the bush, they are ritually devoured by the 'forest spirit' or 'devil' known as zèyele. Erchak reports that, in some communities, girls leave the village through a thatched tunnel from the Zoe's house (Erchak, 1992). Upon arriving in the sande bush, girls are seized by masked figures and are subjected to scarification (to represent the devil's teeth) and to FGM (Lancy, 1996). The removal of the clitoris symbolises the excision of the 'male' (the male part of the female body), and therefore a girl's initiation into womanhood (Erchak, 1992). A girl's behaviour during the procedure is said to indicate her future character; showing pain is not allowed.

Bush schools traditionally lasted three years, as part of a seven year complete cycle with the Poro, but initiation periods are increasingly diminishing. In the bush school, girls are instructed in marriage, domestic skills, farming and medicine. Teaching is differentiated according to social standing— young girls who will become Zoes are given a higher degree of instruction, including medical training (Bledsoe, 1980). Girls are taught music and dance at the bush school, and their return is an opportunity to demonstrate these new skills in festivities lasting three days (Olukoju, 2006). The girls are dressed in grass skirts, with elaborate coiffure, and adorn themselves in white clay (Erchak, 1974).

Traditionally, every girl will be initiated between the ages of 6 and 16. Fees for exiting the bush used to be paid by a girl's future husband. However, increasing restraints with schooling, and girls being cut younger, means that parents now commonly pay both the entry and exit fee (Bledsoe, 1980).

On leaving the sande bush, girls are ritually invested with fertility, signalling their marriageability. They exit, accompanied by a midwife, and this symbolises a new birth. A kendue (brier) is carried in the procession to represent the excised clitoris (Jedrei, 1976). Girls are given new names (Lancy, 1996; Erchack, 1992), and must claim no connection to their former self who was 'eaten by the devil' (Bledsoe, 1980). Although they are reunited with their family, the girls must pretend not to recognise each other, as a sign of the transition into womanhood. Should a girl die while in the bush, her death is symbolised by placing a broken pot by the parents' door on the day the girls come out of the bush. Families are unable to grieve as their child is supposedly already dead (Bledsoe, 1980). Thus, the Zoes retain power over the bestowing of children both as birth attendants and also heads of the society.

KRU (KLAO, KRAO, KROO, KRUMEN)

The Kru, or Klao, live along the southern part of the Liberian coast, and comprise 6% of the population (Census, 2008). They speak Kru (Kwa), which is part of the Niger-Congo language family, and are also found in the Ivory Coast and Sierra Leone. In their oral tradition, the Kru migrated from the north-east to the West African coast in the 16th century, settling as fishermen and sailors, as well as trading minerals and spices with European merchants. By the 19th century, the Kru were indispensable as crew on European ships, and as migrant labourers, deployed as far away as the Panama Canal (Martin, 1985). Martin argues that 'going down the coast' as a labourer became somewhat of a rite of passage for young men. In reality, the 'Krumen', as they were dubbed by the Europeans, comprised a variety of ethnic groups, including the Grebo. Kru ethnicity, it has been argued, was to a certain extent imposed, and emerged as part of migration (Bretiborde, 1991; McEvoy, 1977).

The tribe is famous for resisting capture as slaves, although an alternative account reports that the Kru made a bargain with the Europeans that slaves could be transported across their territory, providing the Kru themselves were allowed to remain free. They subsequently wore tattoos on their foreheads to identify themselves. In 1856 the Kru combined with the Grebo to rebel against Americo-Liberian restrictions on trade, commencing a series of struggles against taxation. Following a 1930 tax imposition, many Kru migrated to Monrovia. Rural Kru communities farm rice and cassava alongside traditional fishing. The political structure of the Kru is traditionally decentralised: they were organised in small social units called *pate*, related to larger groups called *dake* through the father's line of descent (Breitborde, 1991). The Kru are predominantly Christian, and many follow the teaching of William Harris, an early 20th century missionary. The practice of FGM and secret initiations is practically unheard of among the Kru.

KUWAA/BELLE/BELLEH

The Kuwaa, or Belle, comprise only 0.4% of the population (Census, 2008). They speak Kuwaa, part of the Kru linguistic group, and live in Lofa County. Minority Groups report that their alternative name, Belle, has disparaging connotations.

LOMA (LORMA/BOUZE/BUSY/BUZI)

The Loma people make up 5.1% of the Liberian population (Census, 2008), residing in the mountainous upper Lofa County on the border with Guinea, where they are known as the Toma. They are part of the wider southern Mande family of languages. The pejorative *Bouze*, *Busy*, *Buzi* is often applied to both the people and the language. The Loma are animists, but believe in the singularity of a god who is one with all aspects of the universe. On death, an individual becomes one with this universe as well.

The area in which they live is rich in iron ore, and the Loma traditionally use iron as a currency. They use slash and burn agricultural techniques to farm rice. Loma society is traditionally polygamous and patrilineal. Marriage ceremonies last many days and bride wealth is paid over a period of several years. Poro and Sande societies are pervasive, and the Loma practise FGM.

MANDINGO (MANDIKA, MANDIGO, MALINKE)

Originally from Mali, the Mandingo spread across West Africa from the 13th century, and now have an estimated global population of eleven million. In Liberia they make up only 1.4% of the population and live in Lofa County. In Liberia their trade routes linked locals with the savannah, and they settled among the Mano and Vai peoples. Mandingos are part of the wider Mande ethnic group (Mande Ta), but are distinguished by their belief in Islam and have Koranic schools teaching Arabic. Like other Mande groups, the Mandingo are patrilineal, and live in villages led by a chief and a council of elders. Besides agriculture, the Mandingos trade in leather and gold-work as well as being blacksmiths. Traditionally, women

did the majority of the agricultural labour, while men were tasked with long-distance trade and hunting. During the slave trade around a third of the population was transported to the Americas, and we arguably derive the word 'jazz' from the Mandingo language (*jahaasi* means 'to mix up'). In addition, the Mandingo language is the source of the derogatory corruption 'mumbo-jumbo' – from *maamajomboo*, one of the most feared of their *kankurango*, or spirits (Schaffer, 2005). Mandingo men are kept out of the Poro, but some women are members of Sande and therefore undergo FGM.

MANO (MAA, MAH, MAWE)

The Mano people speak Mano, which is part of the southern Mande language group. Mano literally means 'Ma-people' in the Bassa language, and they comprise 7.9% of the population (Census, 2008). Like the Dan (Gio), Loma, Mende, Kpelle and Gbandi groups, they migrated to the region around the 16th century. They live in Nimba County and have close links both with the Dan (Gio) people, who are considered their 'small brothers', and with Mano groups living across the border in Guinea. The Mano are farmers, using slash and burn agriculture to grow rice, as well as peppers, beans, okra, bananas, coffee and peanuts. The Mano believe in witchcraft, and use FGM as part of their Sande initiation rituals.

MENDE

The Mende live predominantly in Sierra Leone, and comprise only 0.6% of the Liberian population (Census, 2008). Similar to their neighbours the Gbandi, the Mende live in upper Lofa County, having migrated there in the mid-16th century. They speak Mende, which has become the *lingua franca* of south eastern Sierra Leone. Sande societies dominate women's lives and FGM is regularly practised.

VAI

The Vai live predominantly in Liberia, although there is a small Vai population in south-eastern Sierra Leone. In the 1820s Duala Bukele and tribal elders developed a unique syllabic writing system for the Vai language, part of the Mande family (Mande Ta). Although the writing system was popular in the 19th century, it has subsequently declined – modern computer technology could prompt its reinstatement. The Vai are Muslims, converted by Dioula traders, although Taylor notes that this religion runs in parallel with beliefs in the power of evil spirits (Taylor, 2014). Traditionally traders, Vai leaders formed links with Americo-Liberians, but somehow resisted taxation until 1917. Vai society is structured around Poro and Sande societies, and girls are initiated around puberty.



Fig. 9: Sande society members dancing in the streets of Monrovia. Photo Democrat Newspaper, 2012 (safeworld.caringworld.net (cc))

OVERVIEW OF FGM IN LIBERIA

This section gives a broad picture of the state of FGM in Liberia. The following sections of the report give a more detailed analysis of FGM prevalence set within their sociological and anthropological framework, as well as efforts at eradication.

NATIONAL STATISTICS RELATING TO FGM

The estimated prevalence of FGM in girls and women (15-49 years) is 49.8% (DHS, 2013). It should be noted that the percentage of 66% in figure ten is from UNICEF's 2012 statistical overview, which uses data from the DHS 2007 for Liberia (now outdated). Liberia is classified as a Group 2 country, according to the United Nations Children's Fund (UNICEF) classification; Group 2 countries have an FGM prevalence rate of 25%-79%.

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Cluster Indicator Survey (MICS). For Liberia they are DHS 2007 and 2013. Unlike many DHS and MICS reports on

countries in Africa with FGM modules, the Liberia DHS asks only three questions related to FGM, each contingent on the question before:

1. Have you heard about Sande society?
2. If yes, are you a member?
3. If a member, do you think the society should stop?

The DHS uses the positive answers to question 2 as a proxy for FGM prevalence, as it is a compulsory part of initiation into the society.

FGM remains a taboo subject in Liberia and there are few studies of the practice within Sande society that are current, which tell of age at FGM, reasons it is practised and attitudes about FGM.

AFELL report that 85% of the population of Liberia is made up of Sande practising ethnic groups (tribunals decisions website). Therefore figures in 2007 that showed 85% of women aged 45-49 were cut illustrate that the practice was almost universal within practising communities pre-civil war (Fig. 11).

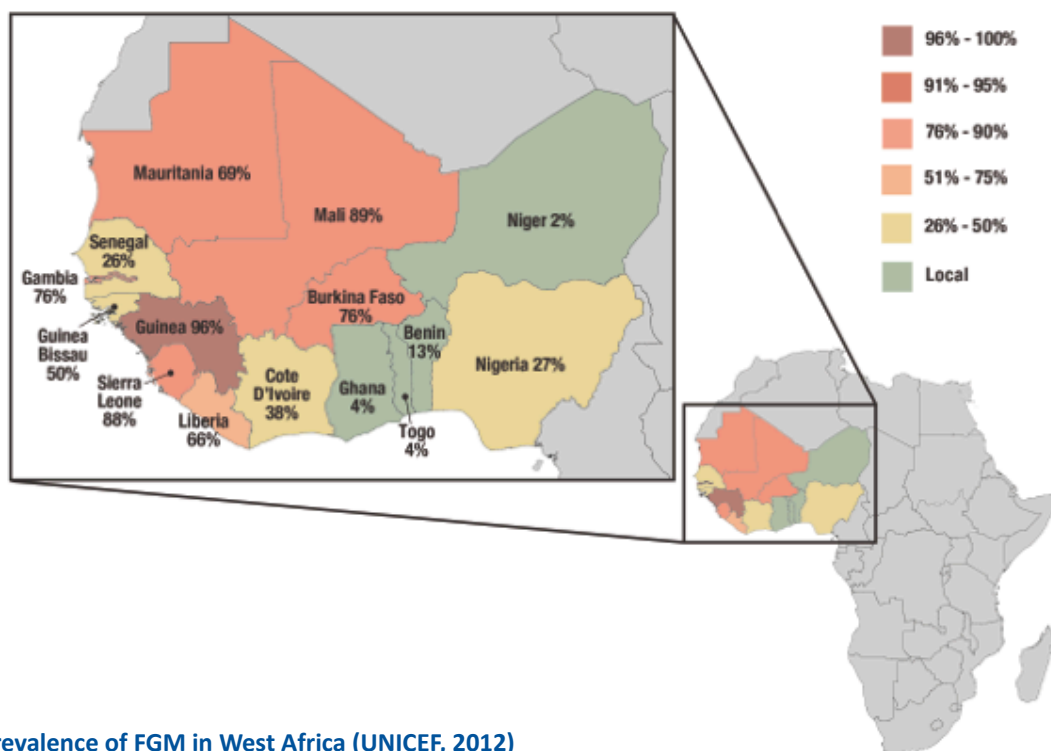


Fig. 10: Prevalence of FGM in West Africa (UNICEF, 2012)

Percent distribution of women aged 15-49 who are members of Sande and therefore have FGM

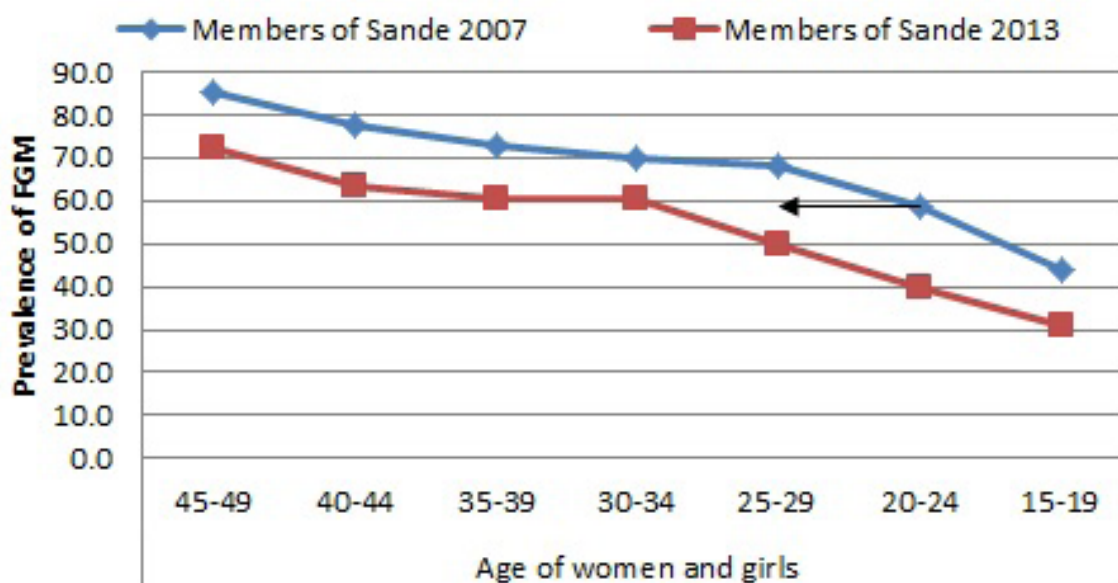


Fig. 11: Percent distribution of women aged 15-49 who are members of Sande and therefore have FGM (DHS, 2013). The arrow highlights where figure should be without under-reporting (see below for details).

PREVALENCE OF FGM IN LIBERIA BY AGE

FGM in Liberia is still viewed in some areas as part of the rites of passage into womanhood, adult responsibility and marriage. There are no statistics for the age at which FGM is performed given either in the 2007 or the 2013 DHS reports. Traditionally, girls between ages 8 and 20 years old were initiated. Though there are reports now of much younger girls being initiated (reported by the NGO NATPAH), overall it still appears to be older girls who are cut, and this means that girls in the age 15-19 cohort are still at risk of being cut. The comparisons between the oldest cohort of women and a younger cohort therefore use figures for those aged 20-24 who will no longer be exposed to the risk in the normal course of events, unlike those aged 15-19.

Figure 11 shows two clear trends. The first is good news that the percentage of women who are initiated members of Sande (and therefore have had FGM) falls markedly with the younger age sets, and this occurs across both data sets.

The oldest cohort in 2007 contained 85.4% of all women as members of Sande, and 72.4% in 2013; these prevalence rates had fallen such that the youngest cohort aged 20-24 contained 58.4% in 2007, and only 39.8% in 2013.

The second trend is a systematic significant decrease in the reported prevalence of FGM in the same age cohort when it is five years older. This suggests under-reporting of FGM by the cohort as it ages (CR33 DHS, 2013). For example, those aged 20-24 in 2007 had a reported prevalence of 58.4%, but the same cohort of women aged 5-6 years older in 2013 reported prevalence as 50.1%, a fall of 8.3 percentage points (shown by the arrow on the graph, whose head points to where the figure would be without under-reporting).

In fact, all the cohorts' figures fell between 4.2 and 9.7 percentage points, not because fewer women were cut (as that is not possible), but possibly because they no longer feel comfortable admitting their FGM status or membership of Sande. Further research is needed to understand

this decline in reported prevalence; it may be in response to increased media exposure to anti-FGM proponents, and views in particular around the time of the data collection (CR33 DHS, 2013).

In Liberia's case, the data collection took place from 10 March to 19 July 2013. Also in March 2013, Ruth Berry Peal's mutilators were sent to prison for her abduction and forced initiation back in 2010. The previous year in March, Mae Azango published a piece in a Liberian newspaper about the negative effects of FGM, and suffered a national storm of abuse and had her life continually threatened by Sande members for breaking the taboo. This was followed by the government asking for all Sande schools to close. However, the reach of the taboo appears to have been broken and FGM is now talked about in the government, the press, on radios and in the community (see Interventions section).

Members of the Sande society who believe the society should stop, data from 2007 and 2013

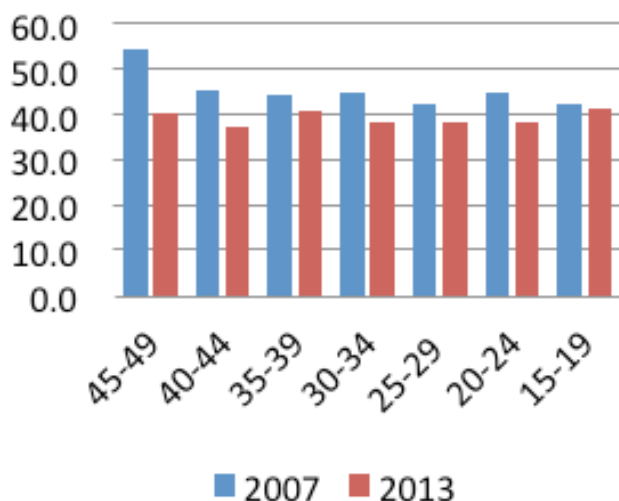


Fig. 12: Members of the Sande society who believe the society should stop, data from DHS 2007 and 2013

In addition, it could also be that the noted fall in the respondents claiming to be Sande members is correlated to a worrying fall in those who say

the society should stop, in which the percentage is higher for all ages in 2007 than 2013 (Fig. 12). This difference could also be because women who still admitted to being members of Sande in 2013 were more convinced of the value of membership and less likely to want it to stop. This fall in Sande membership, but increasing support, needs further research to identify audiences for intervention and type of anti-FGM message.

PREVALENCE OF FGM IN LIBERIA BY PLACE OF RESIDENCE

Figure 13 shows the distribution of prevalence of FGM among women and girls aged 15-49 years according to whether they live in urban or rural locations. In the 2008 census, Greater Monrovia held 29% of the total population of the country, from which 31.9% of the women had had FGM by 2013. This compares to 53.9% in other urban locations and 64.8% in the countryside. 48% of Liberia's population live in urban areas, but the urban percentage of a population is highly variable at the county level. All counties in the country with the exception of Monteserrado, Grand Kru and Maryland have less than 20% urban populations, while Monteserrado has 79% urban population (Audiencescapes, 2008). These variations, and the distribution of the numbers of people within each county, will impact on how many women and girls are actually cut in the different locations. Figure 13 also shows support for the practice of Sande stopping by location. Of note is that even though Monrovia reported the least number of Sande members, 70% of those members were in favour of it continuing while in rural locations there are more members but only 57.3% believe it should continue.

Figure 15 shows prevalence rates recorded in DHS 2007 for the different counties, which reflect the ethnic distribution of practising and non-practising groups. Figure 14 shows FGM prevalence rates by region and figure 6 shows the distribution of the ethnic groups within the different counties of the country.

Percent distribution of women and girls aged 15-49 with FGM shown by urban or rural residence and the percentage of those members who believe Sande should stop.

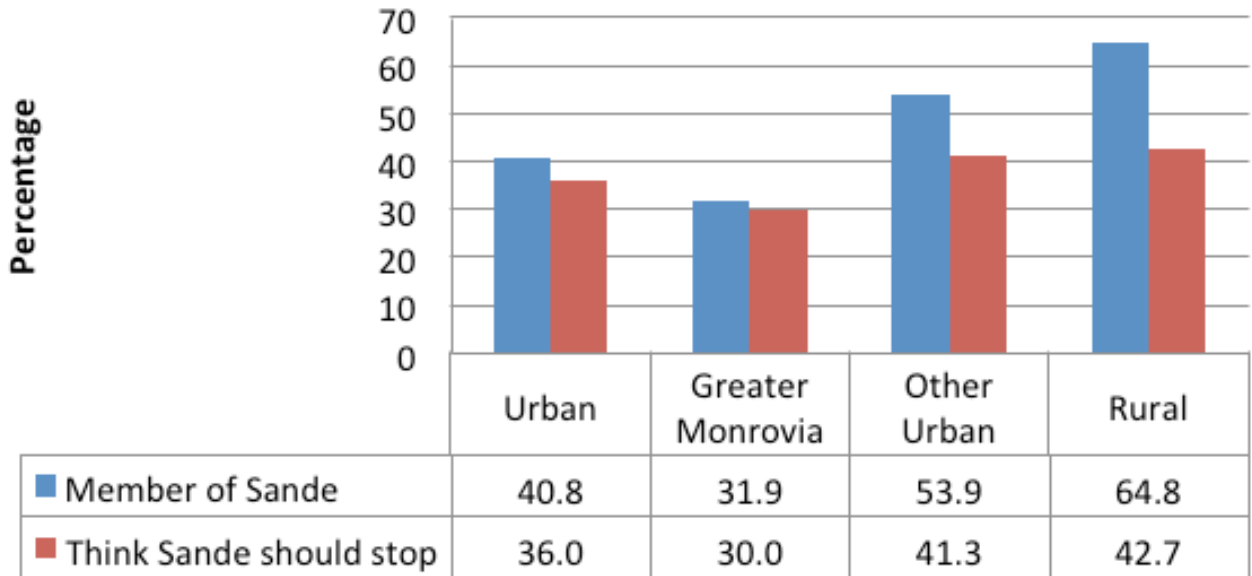


Fig. 13: Percent distribution of women and girls aged 15-49 with FGM shown by urban or rural residence, and the percentage of those members who believe Sande should stop (DHS, 2013)

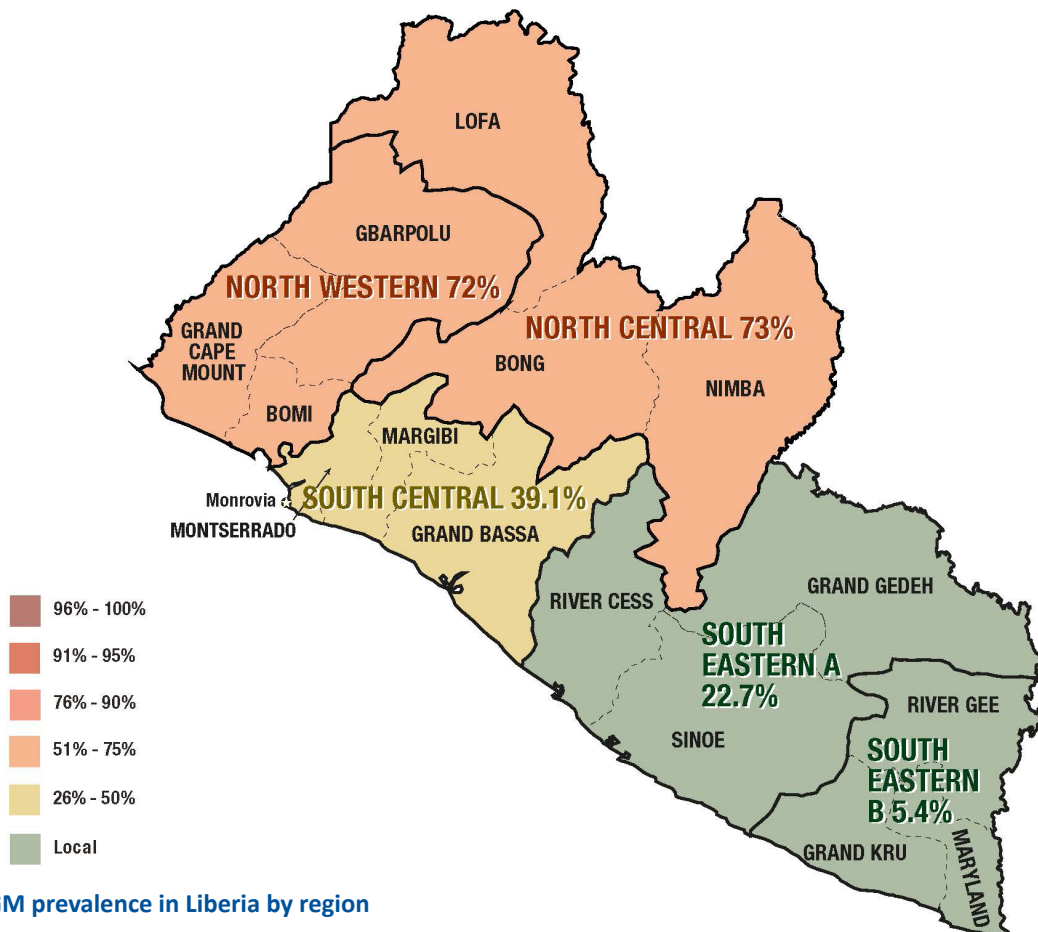


Fig. 14: FGM prevalence in Liberia by region

Percent distribution of women and girls aged 15-49 with FGM shown by county in 2007

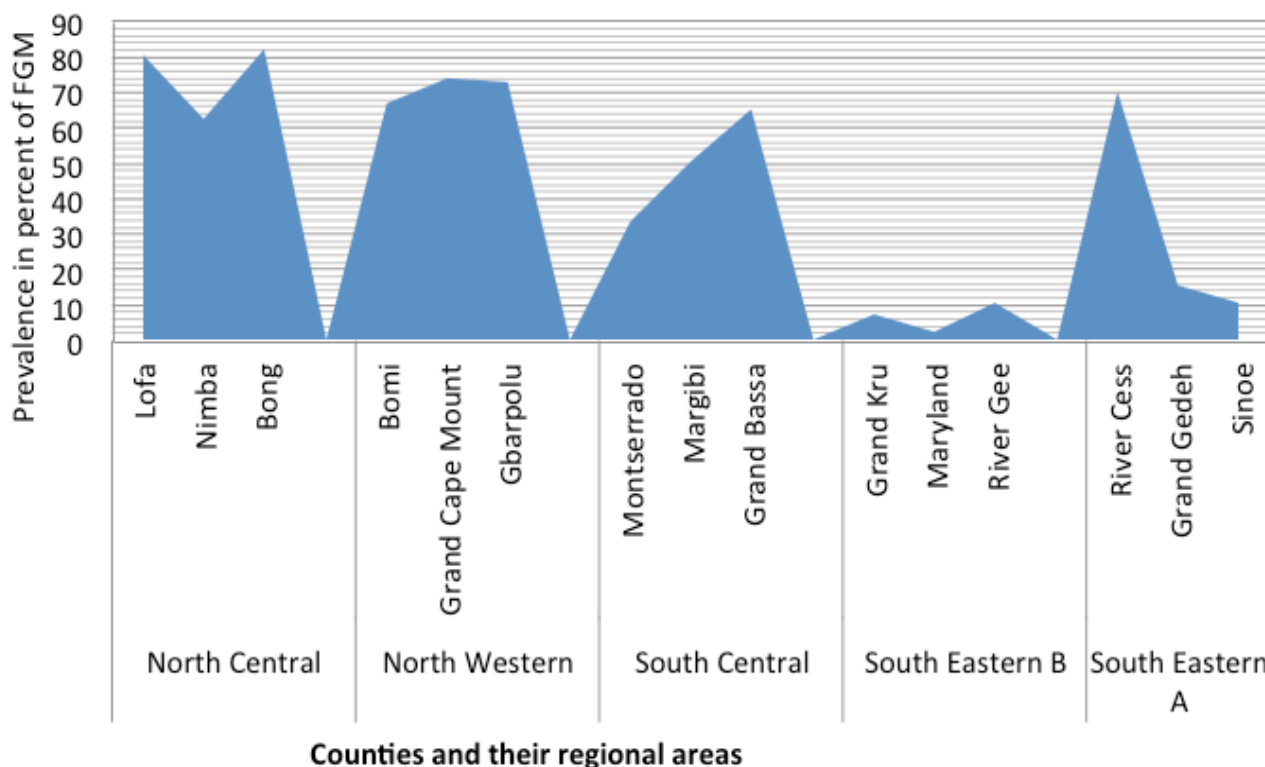


Fig. 15: Percent distribution of women and girls aged 15-49 with FGM shown by county in 2007 (DHS, 2007)

The DHS does not show prevalence of FGM by ethnic group and in 2013 not even by county. The Gesellschaft für Internationale Zusammenarbeit (GIZ) reported in 2011 that the Mende, Gola, Kissi and Bassa practise FGM with particular frequency, whereas the practice is virtually unknown among the Kru, Grebo, Krahn, the Muslim Mandingos and the Americo-Liberian population (GIZ, 2011).

PRACTITIONERS OF FGM

All studies of FGM that were found for this Country Profile place the practice of FGM within the sande bush, and performed by Zoes, the head of the bush, who is also often the local traditional birth attendant. Details of the Zoes' role within the society are outlined in the Sande section above on page 20. The Sande and Poro bushes were suspended due to the Ebola outbreak, and figure 16 is from a news article on the issues of sande bush suspension and licensing (*The New Dawn Liberia*, 2014).

TYPE OF FGM AND PRACTITIONERS

Types I and II of the WHO typology of FGM are most commonly inferred in the literature to be practised in Liberia, but current survey data on type of FGM was not available. A report used by NATPAH, using data collected in 1990, showed that 84% of FGM was WHO Type II excision, 5% had the clitoris intact but the inner labia removed, and 2% had undergone Type III infibulations.

No recent reports were found of medicalisation of FGM. However, data collected for a report in the late 1980s said that in response to the high death rate of girls undergoing traditional Sande initiation: 'the staff of one Christian hospital decided to intervene. After negotiating with the tribal leaders, permission was granted for Kpelle doctors and nurses secretly to perform the rituals

in the forest. This was a successful example of “culture care accommodation” between the community and the hospital. The hospital team performed the Type I procedure in a mobile van’ (Morris, 1996).

This strategy was successful in reducing the mortality rates of initiates in the bush. It was viewed as a transitional measure until the practice could be re-examined by tribal leaders and accepted as a practice harmful to women. Until then, the Western practitioners felt it would save more lives to do the surgical procedures. Since this time WHO has published a statement prohibiting all medical personnel from performing FGM.



Fig. 16: Girls dressed for a Sande celebration (www.thenewdawnliberia.com)

COUNTRYWIDE TABOOS AND MORES

Taboos are cultural or religious practices that are based on a precautionary principle, forcing individuals to comply or face punishment or stigma. Taboos can be forbidden actions, nourishment, words and themes, ideas, books and pictures, and signs. In African traditional religion, taboos are considered crimes; in African society, customs that are sacred and secular are often inseparable. To break a taboo means that an individual faces societal punishment or suffers from guilt. A person who breaks a taboo is then tabooed, as he or she is a threat of luring others to follow suit.

All references cited within Ogunyemi, 2008.

In a country shrouded in beliefs in witch craft and secrecy, it is difficult to find documented evidence of taboos in their original meaning as stated above. The clearest case, and one highly relevant to this report, is the taboo on talking about secret societies and their practices with non-initiated people. The punishment was traditionally death for society violations and the threat of it now hangs over activists and journalists bent on breaking the taboo and addressing the harm of FGM. At the Sande initiation ceremony, revealing/acknowledging that dancers in masks are anything other than the spirit that they represent is forbidden. Equally, the dancers themselves must not reveal themselves (Harley, 1950).

There are taboos on speaking about pregnancy so as not to invite jealousy and witchcraft. Lori has stated that this secrecy is internalised by women so they do not even share information about pregnancy or childbirth with each other (Lori, 2009). Other traditional beliefs around pregnancy and childbirth are that difficult labour is caused by having broken a taboo, or is due to infidelity. Journalist Mae Azango wrote of her own labour complications, when help was denied until she falsely admitted to extra marital sex (pulitzercenter.org, 2012b). Dietary taboos can leave mothers anaemic and malnourished when, in some cases, they are denied meat and eggs.

Discriminatory practices against those living with physical and mental disabilities are being actively fought by NGOs, such as ADFI. Much of the discrimination surrounding disability has to do with the lack of provision of government services and the inaccessibility of buildings and facilities, and access to education (US Dept. of State, 2013). There is also discrimination concerning citizenship and land ownership for those of non-‘Negro descent’ (US Dept. of State, 2013).

The Liberian law prohibits same-sex activity, and their culture is strongly opposed to homosexuality. The social stigma against LGBT persons means that most are cautious about revealing their identities, and victims of abuse and discrimination are reluctant to press charges. In the 2014 Ebola epidemic, LGBT persons have become the scapegoats for causing the virus, and have been demonised for calling down a plague from God, in response to their homosexuality. As a result there has been significant threat and violence against LGBT persons in recent months (*Reuters*, 2014).

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN

Liberia is ranked at 142 out of 146 countries on the Gender Inequality Index of the UNDP with a score of 0.655 (1 being gender parity), and 175 out of 187 on the human development index (HDI). The UNDP report warns that ‘the HDI is an average measure of basic human development achievements in a country’. Like all averages, the HDI masks inequality in the distribution of human development across the population at the country level. This translates as the rural population having a much lower level of development than the better educated and wealthy populations in some parts of the urban communities. In 2014 the UNDP introduced a new measure of human development called the gender development index (GDI). This compares men and women on three basic indices: life expectancy at birth, expected years of schooling and command over economic resources (measured by the estimated earned income per capita for females and males). The 2013 female HDI value for Liberia is 0.379, in contrast to 0.482 for males, resulting in a GDI value



Fig. 17: Woman selling chilies in a Liberian market (dreamstime)

of 0.786. With the election of President Sirleaf, the first female president of Liberia, the Government of Liberia has made significant strides in advancing gender equality and women’s empowerment. This achievement was recognised with Liberia winning the prestigious MDG Three Award (award for Goal three) in 2010. However, the gains are observed

mainly in the policy arena, and sharp gender inequality is still evident in all basic indicators of human development. Women and girls have limited access to education and healthcare services. Maternal mortality rate is high, at 640 per 100,000 live births. Sexual and gender-based violence remains a major threat to the peace and security of women and girls. The inadequate capacity of institutions is a major barrier to institutionalising gender mainstreaming, slowing down the implementation of policy instruments (UNDP Liberia annual report, 2014).

WOMEN AND EDUCATION

Statistics from the DHS 2013 report show a low level of education in Liberia among both female and male respondents. Nevertheless, men have a huge advantage in average educational attainment, having completed a median of 6.5 years of schooling, compared to 3.4 years among women. 15.7% of women and 39.2% of men have some secondary education.

Literacy is an important personal asset allowing individuals increased opportunities in life and these are being denied to women.

WOMEN AND MARRIAGE

The Domestic Relations Act sets the minimum age of marriage at 21 for men and 18 for women. However, the same act allows for both men and women to marry at a minimum age of 16 with the consent of their parents or in the absence of parents or guardians, with an order of a judge. The Equal Rights of Customary Marriage Law of 1998, Section 2.9, permits the customary marriage of a girl at a minimum age of 16.

DHS (2013) shows that 58% of women age 15-49 and 54 % of men age 15-49 are in a union; that is, they are currently married or living with a partner as if married. The proportion of women married by age 15 declined from 17% among those aged 45-49 to 4% among women aged 15-19. Overall, four in ten women aged 25-49 married by the time they were 18, and six in ten married by age 20.

Only 1 in 6 men aged 20-49 marries by that age (DHS, 2013).

Various characteristics such as area of residence, education and wealth have a bearing on the age at which women get married. Among women aged 25-49, the median age at marriage is nearly two years older among urban women (19.6) than among rural women (17.8). The median age at first marriage among women aged 25-49 with no formal education is 17.8 years, and it rises to 21.6 years among those with at least some secondary education. There is a positive correlation between wealth and age at marriage. The median age at marriage among women aged 25-49 in the lowest quintile is four years younger than women in the highest wealth quintile (17.6 and 21.7 years of age, respectively).

Though customary law in Liberia allows for polygamy, only 13% of currently married women are married to men who are in a polygamous union and only 6 % of currently married men are in a polygamous union. The proportion of women with co-wives increases with age, ranging from 6% among women aged 15-19 to 19% among women aged 45-49.

Civil and customary law are both recognised in Liberia. Under customary law women were considered the property of the man. They were not allowed to inherit property or to have custody of their children in the event of the father's death, and widows were expected to marry their dead husband's relative. However, in recent years the Government has introduced several laws to ensure equality between men and women.

The 1998 Equal Rights of the Customary Law (which was adopted in 2003) offers the same rights afforded to civil marriages to customary marriages. This means that women now have custody of their children in the event of their husband's death. They are entitled by law to a third of their husband's property upon his death. Under the act it is a criminal offence to force a widow to either marry her dead husband's relative, or to remain

within his family. However in practise, there is little awareness of this law and hence the continuance of many practices that are discriminatory towards women (Equal Rights Act, 1998).

PHYSICAL INTEGRITY

The law prohibits domestic violence; however, it has remained a widespread problem. According to the WHO, 33% of married women reported experiencing domestic violence (US Dept. of State, 2013).

When presented with a list of five different 'reasons' for a man to beat his wife, for example she burns the food or goes out without permission, in the 2013 DHS questionnaire, 43% of women (in comparison to 24% of men) responded that a husband is justified in hitting or beating his wife for at least one of the five reasons. This data shows a decline in this perception in comparison to the 2007 DHS data, which showed that 59.3% of women and 30.2% of men felt that it was justified for a man to beat his wife with respect to those five reasons (Census, 2008).



Fig. 18: Women marching against violence (action aid.org)

In 2006, the Government promoted a new law that recognises rape as a crime (although does not recognise spousal rape). The maximum sentence is life imprisonment for first-degree rape (causing bodily injury) and ten years for second-degree rape. According to the WHO, 77% of women and girls had been the victim of sexual violence. The Government does not always enforce the law effectively (US Dept. of State, 2013). Human rights groups claimed that the real prevalence rates are even higher, as many cases are not reported, and the survivors do not seek help because of the stigma surrounding sexual violence (CEDAW, 2008).

The Sexual Pathways Referral Program, a combined effort of the government and NGOs, has improved access to medical, psychosocial, legal, and counselling assistance for victims. As mandated by the 2008 Gender and Sexually Based Violence Bill, the special court for rape (Court E) and other sexual violence, located in Montserrado County, has exclusive original jurisdiction over cases of sexual assault, including abuse of minors. The sexual and gender-based violence prosecution unit within the Ministry of Justice continues to coordinate with the special court and collaborate with NGOs and international donors to increase awareness of sexual and gender-based violence issues (US Dept. of State, 2013). A large number of NGOs are part of the national SGBV Task Force working on these issues as well, chaired by the Ministry of Gender.

RESOURCES AND ENTITLEMENTS

Women and men enjoy the same legal status regarding access to land, and access to property other than land. Under the law women can inherit land and property, receive equal pay for equal work, and own and manage businesses. Women experience discrimination in such areas as employment, credit, pay, education, and housing. In rural areas a woman's right to inherit land has often not been recognised by traditional practice or traditional leaders. While progress was made through programmes to educate traditional

leaders about women's rights, authorities often do not enforce those rights (US Dept. of State, 2013).

Under Liberian law, women have the right of access to bank loans. In practise, it is often difficult for women to access credit because they are illiterate, or because they cannot meet the requirements needed to take out a loan (CEDAW, 2009). Micro credit programmes are provided by NGOs and the government, and women are the main beneficiaries (CEDAW, 2009).

Women experience some economic discrimination based on cultural traditions. The Government has promoted women in the economic sector through programmes and NGO partnerships to conduct workshops on networking, entrepreneurial skills, and micro credit lending programmes. A number of businesses are owned or operated by women.

No specific office exists to enforce the legal rights of women, but the Ministry of Gender and Development and the Women, Peace, and Security Secretariat generally are responsible for promoting women's rights.

CIVIL LIBERTIES

Liberian women's civil liberties, like those of all other citizens, are guaranteed by the constitution. Women's day-to-day movement may be restricted by partners and husbands: in 2007, 26.2% of women aged 15-49 questioned reported that their partner would not let them visit female friends, and 12.6% that their partner limited their contact with their family (Census, 2008).

In recent years, the participation of women in leadership has been pushed for by the Government, which led to gradual improvement, but not without fierce opposition. The proposed Gender Equality Bill, which called for a minimum of 30% representation of women at all levels of governance, was intended to address the entrenched inequalities that exist in Liberian politics. To the disappointment of most women's rights advocates, the Gender Equality Bill was

thrown out of the national legislature (Holmgren, 2013).

Nevertheless, women's participation in politics has gradually improved over the years; in 2013 there were six female ministers in the 21-member Cabinet. There were five women in the 30-seat Senate and eight in the 73-seat House of Representatives. Two female associate justices sat on the five-seat Supreme Court. Women constituted 33% of local government officials and 31% of senior and junior ministers (US Dept. of State, 2013).

THE EFFECT OF EBOLA ON WOMEN AND GIRLS

Young women and girls in Liberia have been coping with many challenges, ranging from social marginalisation to sexual and gender-based violence. The outbreak of Ebola has worsened these challenges, placing women and young girls into an increasingly disadvantageous position in Liberia.

In 2014 the Ebola virus has now become Liberia's number one challenge, putting young women and girls at high risk of early death, loss of income, loss of family ties, loss of social mobility, and delay in formal education and professional development. In Liberia, women and girls carry the responsibility of catering for the family by providing basic home services, such as preparing meals, collecting water and attending to sick relatives. These responsibilities make women more exposed to the virus. While in the process of rendering services to sick relatives, women are likely to contract Ebola because they do not have the necessary personal protective equipment to safeguard themselves. Economically, Liberian women, who mostly rely on informal business as a means of sustaining their families, are unable to continue their daily activities because of the outbreak. In the market-places, women are experiencing drastic reduction in sales and hence a decrease in their already meagre incomes. This situation is bringing

economic hardship to women, especially young single mothers, as they are currently finding it extremely difficult to meet their daily survival needs.

As Liberia tries to recover from years of civil unrest, which left young women and girls as the worst affected, it has been trying to recover from educational paralysis by enabling girls to compete with their male counterparts. Unfortunately, the outbreak of the Ebola virus has set back the education for all in the country. (See education and Ebola section below)

The closure of major health centres in Liberia since the outbreak of Ebola has also greatly affected women and girls. Amongst the most vulnerable women, pregnant women have been badly affected. Many pregnant women who are suffering pregnancy complications or are in labour have been turned away from health facilities because there are either not enough resources or health workers. Indeed it has been reported that some health workers are rejecting sick people in order to keep themselves safe from the virus, something which has caused the death of many young women in the country. The struggling healthcare infrastructure will continue to complicate matters (Sendolo, 2014).

HEALTHCARE SYSTEM

The healthcare system in Liberia has three tiers: Central, County and Peripheral. The Ministry of Health and Social Welfare is responsible for policy at the Central level and County Health Teams provide primary and secondary healthcare (Liberia's National Health Policy, 2007). Healthcare services under the basic package of healthcare services (BPHS) are delivered at two levels:

1. The community level, where community health workers (CHWs) aim to promote healthier lifestyles and environmental control, promote appropriate use of health services, provide accessible preventative and curative services in the community, and advocate for the community, providing a link between them and formal health services.
2. The formal level, where primary care is provided at all health facilities for citizens in the catchment area and secondary care is provided at health centres and county hospitals.

In 2008, the Ministry of Health and Social Welfare aimed to improve and decentralise its healthcare system by implementing the BPHS, which covered the following areas: Maternal and new-born health; Child health; Reproductive and adolescent health; Communicable disease control; Mental health; and Emergency care. Before the implementation of this programme, 90% of health services were provided by agencies and NGOs after the civil war (WHO, 2006). In 2012, in a report about Liberia's health service recovery from the American Center for Strategic & International Studies, author Downie gave a positive perspective on the progress of Liberia's attempts to rebuild, suggesting that despite challenges, health outcomes were improving. However, he warned that Liberia was entering a crucial, potentially destabilising phase of the rebuilding process, as it ambitiously attempted to decentralise the healthcare system in order to address shortages in healthcare in rural areas (Downie, 2012).

Even prior to the Ebola epidemic being identified in March 2014, there was no running water in hospitals, even in Monrovia. There was also no electricity in many facilities. Moreover, for a population of 4.5 million in 2012 (of which one million were women of reproductive age), the following health personnel were available: one doctor for 100,000 patients, 806 midwives, 57 nurse midwives, 65 auxiliary nurse midwives, 800 clinical officers and medical assistants, 289 physicians and 9 obstetricians and gynaecologists in total (UNFPA, State of the World's Midwifery, 2014). However, these figures are likely to be far more alarming since the Ebola outbreak; many doctors have died of the disease and Forrester *et al.* (2014) state that doctors are leaving the country due to Ebola (50% in the four counties studied had already left).

HEALTH AND THE MDGS

GOAL 4: REDUCE CHILD MORTALITY

- Target: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate (64 per 1,000 live births) (UNDP, 2010)

Prior to the Ebola outbreak, Liberia had not been on track to meet the 2015 target, but had managed to halve the mortality rate of children under five to 94 (DHS, 2013).

GOAL 5: IMPROVE MATERNAL HEALTH

- Target: Reduce the maternal mortality ratio by three quarters, between 1990 and 2015
- Target: Achieve universal access to reproductive health by 2015 (UNDP, 2010)

Prior to the Ebola outbreak, targets were unlikely to be achieved by 2015. Current figures on maternal health are given below.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

- Target: Have halted and begun to reverse the spread of HIV/AIDS by 2015

- Target: Have halted and begun to reverse the incidence of malaria and other major diseases by 2015 (UNDP, 2010)

Prior to the Ebola outbreak, it was likely that Liberia would meet their 2015 targets for Goal 6. HIV prevalence in Liberia is low, only 1.1% of the population are infected; pregnant women are more likely to have the virus (4.6%) (DHS, 2013).



Fig. 19: Mother and baby (Ken Harper (cc) flickr)

HEALTH AND THE EBOLA EPIDEMIC 2014

The Ebola crisis has had a devastating effect on the healthcare system in Liberia, and many of the advances the country has made towards meeting its MDGs have been wiped out. According to UNFPA (2014), Ebola is a double threat for pregnant women and women in labour. Not only are women in danger of contracting Ebola in addition to the usual risks and complications associated with pregnancy and childbirth, but the crisis has also diminished Liberia's progress towards meeting MDG 5. IRIN (2014) report that, since the outbreak of Ebola, the number of births attended by a trained healthcare professional has dropped dramatically, and this is set to increase the incidence of infant and maternal deaths. This drop is due to a number of Ebola-related factors: first, women are scared of contracting the virus if they attend healthcare facilities; second, many healthcare workers have died of Ebola and the ones remaining are reluctant to deliver babies.

WOMEN'S HEALTH AND INFANT

MORTALITY

WOMEN'S HEALTH

The current maternal mortality rate in Liberia is 640 deaths per 100,000 live births (World Bank, 2013); this has decreased from 770 in 2010. The neonatal mortality rate is 26 per 1,000 live births. Rape remains a serious problem in Liberia, with 77% of women reportedly having been victims of sexual violence.

REPRODUCTIVE HEALTHCARE

The DHS (2013) provides the following statistics on antenatal healthcare in Liberia:

- Proportion of births attended by skilled health personnel: 61%
- Antenatal care coverage: Percentage of women who had during the last pregnancy at least one antenatal clinic visit 1.6%; at least four visits 78.1%
- 88% of women had been administered a neonatal tetanus vaccination during their last pregnancy; this number had risen from 78% in 2007
- Median age at first birth: 18.7 years
- Unmet need for family planning: 31.1%
- Contraceptive prevalence rate (modern methods): 19.1%

Lori and Starke (2010) conducted a study into the issues surrounding maternal morbidity and mortality in Liberia. The study focused on one county in north-central Liberia with high levels of FGM and with particularly high levels of disruption to services due to the civil war. Mothers and families were interviewed to help the researchers understand the social factors in delays in seeking treatment. The findings showed that 16% of referral hospital deliveries were near-miss events (in which a pregnant or recently delivered woman

experienced complications, which immediately threatened her life but did not end it), and that these near-miss events were six times as common as maternal deaths.

Lori and Starke found that 85% of near-miss events occurred before women reached the hospital, and all were identified upon or after arrival. Reasons for all delays in treatment were analysed under Thaddeus and Maine's Three Delays Model.

Percent distribution of near miss maternal mortality events

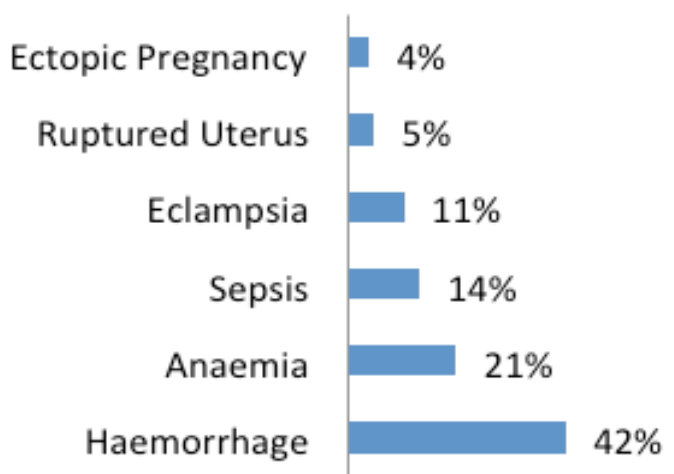


Fig. 20: Percent distribution of near miss maternal mortality events (Lori and Stark, 2010)

In addition to second-delay practical issues such as distance to clinic and transportation difficulties, first-delay complex socio-cultural factors (including gender inequalities in decision making) also prevented women from receiving timely attention. Third-stage delays (delays in treatment at the hospital) were not found to be a significant issue.

The paper discusses taboos surrounding childbearing and maternal deaths. Pregnancy and childbirth in Liberia are shrouded in secrecy. While this culture of secrecy is learned at an early age in bush schools/Sande societies, and is intended to protect both mother and unborn child from harm, it can be seen to result in a lack of knowledge

of reproductive health preventing women from identifying, understanding, or acknowledging problems related to their pregnancy or delivery. Patriarchal power structures were also found to have a detrimental effect on maternal health, as women are often required to gain male permission to seek treatment at a healthcare facility and healthcare professionals also reported being obliged to seek permission from a male family member before treating or assisting a woman. Use of birth control was similarly found to be dependent on the husband's permission. Additional issues surrounding the treatment of obstetric complications included a culture of blaming the victim, with women suffering from complications being accused of infidelity. Lori (2009) also found a general distrust of the medical profession, with participants preferring traditional practices to modern methods, and often choosing not to seek formal medical care even after the development of complications.

Looking to the future, a 5-year plan launched in 2011 set aside \$117.2 million for health service provision and aimed to increase the number of skilled attendants by 50% to provide both emergency and basic obstetric and new-born care (UNFPA, 2011). In 2006, WHO stated that it was a priority to reduce maternal mortality rates to 550 in 100,000. By 2015, national policy aims to double the number of midwives from 2006 by opening two additional schools to train midwives and by improving the retention of midwives (UNFPA). It is unlikely these goals will be met given the Ebola epidemic.



Fig. 21: Pregnant women waiting outside a clinic (pre-Ebola epidemic) (<http://forcechange.com.c.presscdn.com/wp-content/uploads/2012/06/liberia.jpg> (cc))

REPRODUCTIVE HEALTH COMPLICATIONS

Haemorrhage is a known birth complication for women who have had FGM of all types due to the inelasticity of the scar tissue, which leads to tearing during delivery and potentially excessive loss of blood. 26% of maternal deaths in sub-Saharan Africa are due to haemorrhage.

It is estimated that around two million women and girls across Asia and sub-Saharan Africa are affected by fistula, a condition caused by long and obstructed labour which causes a permanent abnormal passageway between two organs in the body. Prolonged pressure from the baby getting stuck in the birth canal damages the tissues between the vagina and the urethra and/or the rectum, resulting in incontinence. Prolonged and obstructed labour is more common in young mothers due to underdevelopment, and 80% of those affected by fistula are under 15. As well as being physically devastating, fistula is a socially disabling illness; sufferers are mocked and ostracised due to the smell and leakage.

Fistula can often be successfully treated by surgery. In 2013, 48 health clinics were trained to treat the condition, and the Liberia Fistula Program (LFP) was launched in 2007, with the help of Zonta International and UNFPA. Treatment is free and as

of July 2013, doctors had treated 1,026 cases. In total, the programme had 300 trainees enrolled, and 65 nurses had been trained, though only six doctors could perform the fistula corrective surgery. UNFPA reported that the majority of cases were impoverished girls and women aged 11-20 (IRIN, 2013).

PLACE OF DELIVERY

Liberia suffers from an inadequate number of certified midwives, with midwifery programmes only being offered at four out of the eight medical training institutions. This particularly affects rural regions, as midwives move away for better living conditions and salaries in cities (Liberia MOHSW). Disparity between both location of births and birth attendants can be seen from figure 22 (and table 1), which shows a greater proportion of home births and births without a midwife or doctor in rural areas. On average across the country, 46% of births have a skilled attendant present (UNICEF, 2013).

Percent distribution of live births and where they took place according to residence

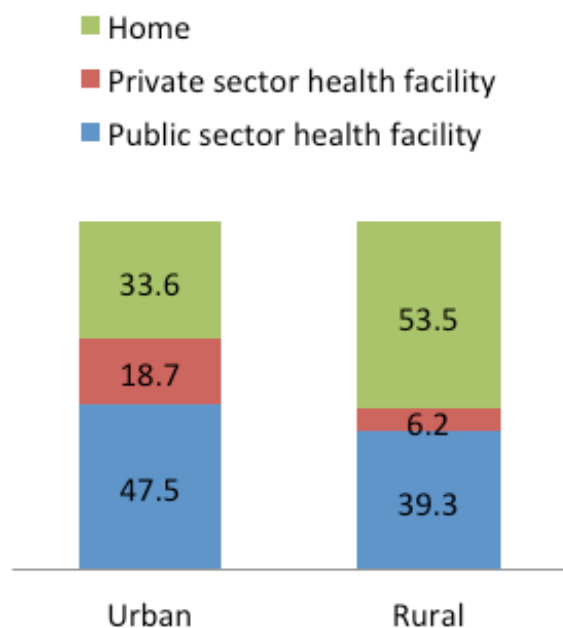


Fig. 22: Percent distribution of live births and where they took place according to urban/rural residence (DHS, 2013)

	Residence	
	Urban	Rural
Doctor	9.0	7.4
Nurse/ Midwife	63.4	41.4
Physician's Assistant	0.3	0.8
Traditional Midwife	24.3	44.8
Relative/ Friend/Other	2.7	5.1
No one	0.2	0.4
Don't know/ missing	0.1	0.2

Table 1: Percentage of births according to the person attending mother at birth by urban or rural residence (DHS, 2013)

INFANT MORTALITY

Liberia's infant mortality rate (per 1,000 live births) is 69.19 deaths (World Bank, 2014). According to the DHS (2013) the under-5 mortality rate is 94 deaths (per 1,000 live births).

In a multi-country survey, the WHO (2006) demonstrated that death rates among new-born babies are higher in mothers who have had FGM. There was an increased need to resuscitate babies whose mothers had had FGM (66% higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15% higher in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries.

EDUCATION

Both primary and secondary education in Liberia is free and compulsory from the ages of 6 to 16, with a special effort having been made by the government of President Sirleaf towards the education of girls (UNICEF, 2012). Figure 23 shows that enrolment is not enforced at school age, and in addition UNICEF claims 500,000 school-age children are not in education.

The outbreak of Ebola has dealt a further blow to Liberia's education system – described as a 'mess' by Sirleaf in 2013 – which had already been struggling to recover from the consequences of years of civil war and conflict (allafrica.com, 2013b). President Sirleaf's declaration of Liberia's state of emergency in August 2014, in an attempt to help curtail the effects of Ebola, has halted the progress the country had been making in education. With Liberia's 4,413 schools closed indefinitely, it is unlikely the country will achieve its educational

MDGs (mashable.com, 2014). An initiative by the Government to broadcast lessons by radio for out of school children started in September and has reportedly reached over 1 million listeners. The lessons are broadcast at least twice a day for half an hour each to try to keep children engaged with education so they do not fail to return to school when they re-open (IRIN, 2014b).



Fig. 24: Children at school before Ebola

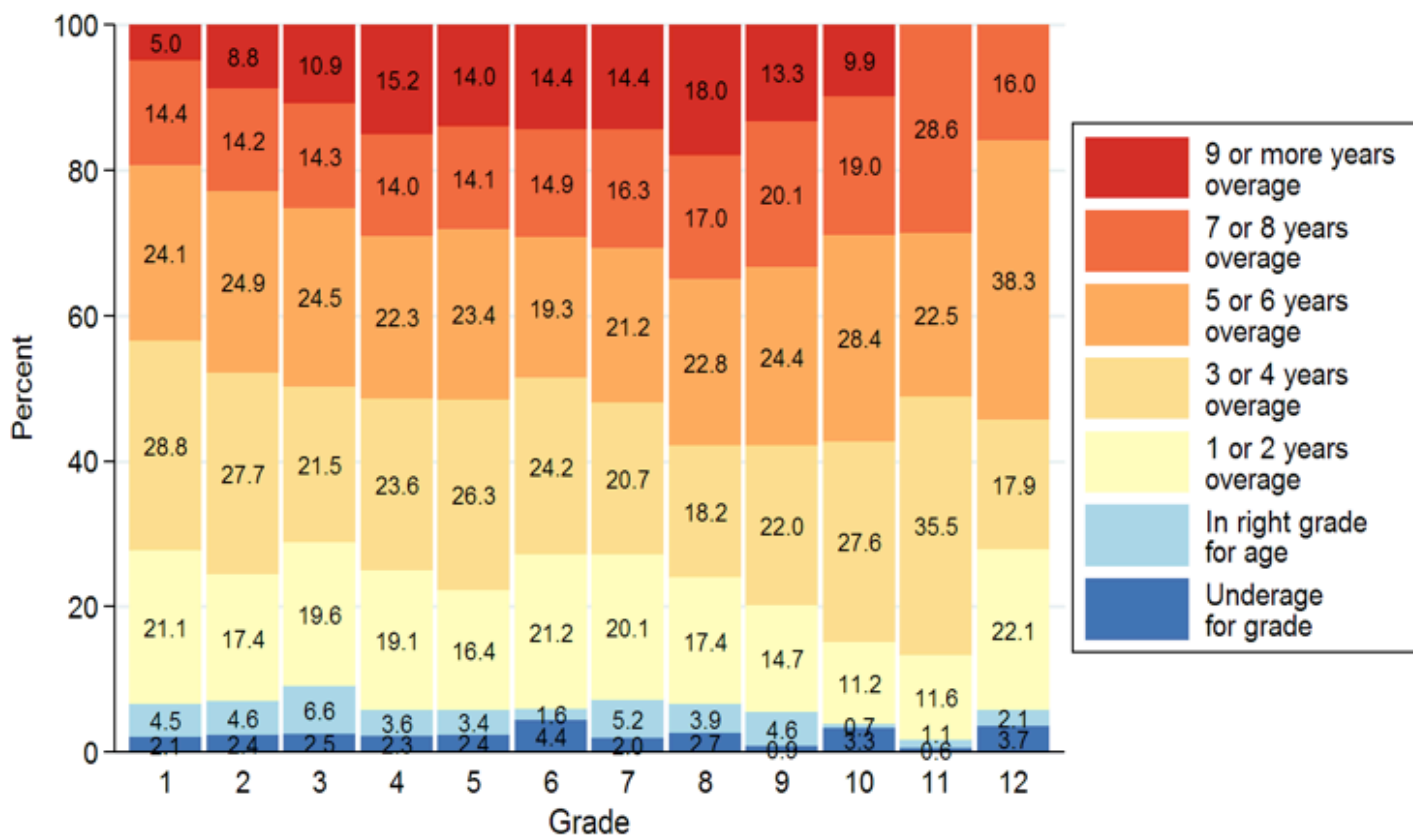


Fig. 23: The age distribution in the 12 grades of primary and secondary education in Liberia. (Educational Statistics' Fredrich Huebler using data from DHS, 2007) (heubler.blogspot.co.uk, 2012)

Table 2 shows the literacy rates for the Liberian population of those aged 15 and over, broken down by age groups and gender. The population over age 15 had literacy rates of 60.8% for males, while only 27% for females. Youth literacy is not much better, with female youths reaching a literacy rate of 37.2%. These figures illustrate that girls and women are being denied an education.

Literacy rate % (2007)	Total	Female	Male
15-24 years	49.1	37.2	63.5
15 +	42.9	27	60.8
65 +	32.8	9	55.2

Table 2: Levels of literacy by age and gender (UNICEF, 2013)

Upon successful completion of secondary education in Liberia, which lasts from grades 7 to 12, students are awarded a certificate or diploma issued by the West African Examination Council (WAEC). In 2011, the gross enrolment ratio for secondary education was 40.6% and 49.5% for girls and boys respectively. Following secondary education, students may choose to go on to vocational training, a primary teacher-training course which lasts three years, or a bachelor's degree at university, which lasts four years. Table 3 shows that the number of those who go on to tertiary education remains small, with the gross enrolment ratio in 2012 being just 9% for women, and 14.2% for men.

	Total	Female	Male
Secondary education	45.2	40.6	49.5
Tertiary education	11.6	9.0	14.2

Table 3: Gross enrolment ratio (percentage) (uis.unesco.org)

One result of the upheavals of the civil wars, which left children without stable schooling, is the common occurrence of over-age school attendance in Liberia. This is mainly attributed to late entry into education and the high level of grade repetition. While primary education in

Liberia is theoretically for children aged 6 to 11, according to the DHS (2007), nearly three quarters of students in the first grade were 'at least 3 years older than the official entrance age into primary education'. As can be seen in figure 23 of those students, 19.5% were over the age of 13 rather than 6. Furthermore, there are a significant number of children aged between 5 and 14 in pre-primary education. The lack of access to primary education has been cited as a possible explanation for about half of 5 to 8 year olds being kept in pre-primary education. Figure 23 shows that the rate of primary attendance reached its peak amongst 12 to 15 year olds. In secondary school grade 8 (proper age 13), one in five pupils were 22 years or older. Furthermore, attendance rates in tertiary education remain low overall, and 'do not exceed 2% until the age of 24' (huebler.blogspot.co.uk, 2012).

Progress in the education sector is held back by several factors. Lack of infrastructure, trained teachers and basic supplies affect the quality of the education provided. What in theory should be free primary and secondary education instead becomes a costly burden on households, with associated fees such as school uniforms, textbooks and other materials imposed on the students (UNDP MDG Report, 2010). Furthermore, the majority of secondary schools and universities are concentrated in Monrovia. This suggests that access to higher levels of education is largely unavailable to the nation's rural population.

Lack of clean and available water is also considered to be a major hindrance to children's education. It is usually a girl's job to collect water for her household and this can take many hours, not allowing time for school. A survey conducted in November 2012 found that just one in ten schools had clean drinking water. Clean water can be available to buy from street vendors in sachets, but this comes at a cost of up to 30 cents a day, a huge cost considering that 84% of the population survive on \$1.25 US per day (pulitzercenter.org, 2013). Furthermore, the lack of clean latrines

in schools is also a deterrent for menstruating pubescent girls. In 2013, the government spent 3% of their national budget on the education sector (*The Guardian*, 2013). A report by WaterAid and the UNDP criticised the Liberian government for meeting just 30% of commitments made in a 'Compact', which promised wide-ranging improvements in the water systems of the country (pulitzercenter.org, 2013).

In August 2013, the state-run University of Liberia (in its first year of externally marked entrance exams) failed all 25,000 applicants in their entrance and placement examinations, while in another entrance exam only 15 out of 13,000 students passed (allafrica.com, 2014). Though the university is an anomaly, failing all but a few applicants, many Liberian students also fail the West African Examination Council exams. Some critics of the education system have highlighted an epidemic of 'sex for grades' amongst female students in Liberia, which would appear to suggest that a large proportion of students who had failed were girls who had sex with teachers in exchange for good grades prior to the exams. A 2013 survey by the National Integrity Barometer (NIB) revealed that sex for grades in schools were higher than 24% (*Liberian Daily Observer*, 2013). Despite these findings, there is no concrete evidence to show that students are failing university entrance examinations because their high grades have been bought in exchange for sexual favours. Neither is there evidence to show that more female students are failing these entrance examinations than male students. Instances of sex for grades can also be found in tertiary education. A 2011 report by ActionAid found that in the three largest universities in Liberia (University of Liberia, African Methodist University, and Cuttington University) 'transactional sex' and 'sexual intimidation from teachers and faculty was a major theme across all [three] universities' (ActionAid, 2011).

Female students who fall pregnant during the academic year can be discriminated against by the school authorities. One case is of Patricia

Kollie, who was told to sit out of the academic year at St. Mark Lutheran High School in Banga for the duration of her pregnancy and to return when she had given birth, with the headmaster claiming that falling pregnant violated school rules (ipsnews.net, 2012). Patricia Kollie's situation, like that of many other Liberian girls, is ironic because she claims that the father of her child paid for her tuition fees; without him she would not have been able to attend school. For a country with one of the highest rates of teenage pregnancy, the possible exclusion of pregnant students poses one of the biggest obstacles to the education of girls and women. Save the Children reports that one in three Liberian girls will give birth before their twentieth birthday (ipsnews.net, 2012), while a February 2011 report by Defence for Children International found that rape was one of the most commonly reported crimes in Liberia, with girls aged 10 –14 as the most vulnerable to attack (ohchr.org, 2011).



Fig. 25: Patience was also expelled from school along with Patricia Kollie, because they had both fallen pregnant. Credit: Winston Daryoue (ipsnews.net, 2012)

EDUCATION AND EBOLA

With schools in Liberia shut down indefinitely since July 2014 following the outbreak of the Ebola epidemic, a major concern is that the education of Liberian students will fall behind. While some community initiatives have begun to compensate

for school closures, presently no government-driven schemes have been implemented. The Ministry of Education is working together with UNICEF to develop an education plan post-Ebola. UNICEF's Rukshan Ratnam has stated that 'long-term options' are being worked on, and that they are working in partnership with the Ministry to 'develop educational radio programs for children, so they can continue studies in their own homes' (mashable.com, 2014).

EDUCATION AND FGM

FGM can have many impacts on a girl's ability to access an education; the most obvious is removing girls from education to attend bush schools where they are cut. Although there are rules laid down by the government that sande bush schools should not be run during the other schools' term times, specifically not to interrupt a girl's schooling. These rules are not enforced and Sande seems to run with impunity all year round. Only one county out of fifteen has agreed to keep the schools at separate times, which is Grand Cape Mount region where a UN human right's programme is running to convince parents to allow girls to complete formal education. A UN human rights report in 2013 stated that girls, often under the age of 10, are removed from school by 'traditionalists' to attend bush schools. A film made by the UN accompanying the report uses the figure of 20% of girls dying from initiation due to excessive bleeding (ohchr.org, 2013). The effects of FGM also include long term disability, physical as well as psychological, stopping girls from getting to schools often far from home. Again, many girls are expected to marry after the initiation and will drop out of school.

EDUCATION AND THE MDGS

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

The two goals which were stipulated, to 'halve between 1990 and 2015, the proportion of people living on less than \$1 US a day and the proportion of people who suffer from hunger', are, according

to the 2010 UNDP MDG summary report, unlikely to be met. Approximately 84% of Liberians live below the poverty line, while 48% live in 'extreme poverty' (UNDP, 2010). One trend which has been highlighted among Liberia's poor is that households headed by women make up 73.4% of the poor. This has been attributed to the lack of educational attainment and limited access to wage employment.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

The aim of this MDG is to provide universal primary education with the target to ensure that by 2015 all boys and girls complete a full course of primary schooling. While Liberia has enforced free and compulsory education, and has received grants towards this goal, net enrolment still needs to increase by a significant 49.3%, and primary completion rates still lag behind. Associated fees, such as the cost of school uniforms, remain the biggest challenge to achieving universal primary education, and also contribute to the high dropout rates. 62 out of 100 students complete the six years of primary education (UNESCO, 2012).

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

The aim of this MDG is to eliminate all gender disparity in primary and secondary education no later than 2015. This is highly relevant given that FGM is a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women. According to the 2010 UNDP report, gender parity at primary levels will be achieved, though it is unclear whether gender parity will also be achieved at the secondary level (UNDP, 2010). However, following the outbreak of Ebola and subsequent school closures, it appears that gender parity will be achieved neither at primary nor secondary level.

RELIGION

The figures most commonly cited for the religious composition of modern Liberia were from the US Department of State (2008) and were: 40% Christian, 40% Animist and 20% Muslim. These figures were contested at the time with Muslim leaders claiming that 50% of the population were Muslims. Other sources also claimed that there were 5% Muslims and 15% Christians. The census from 2008 showed that 85.5% of the population were Christian and 12.2% Muslims, with only 0.5% having traditional religions and 1.8% no religion.

These discrepancies in figures for religious composition are large, and may have arisen for a number of reasons; for one, it might be difficult for Liberians to fit neatly into the aforementioned religious categories. This is compounded by the ready adoption of monotheistic religions alongside traditional beliefs and practices, this fusion of beliefs from differing religious practices forms new syncretic religions; and by the number and make-up of immigrants and refugees in Liberia at one time, as they flee conflict in neighbouring countries which are majority Muslim (Heaner, 2008).

Liberia is a secular state in name, if not function. All government schools teach Christianity and the Bible in their curriculum, and there are no exemptions from class for those of other faiths. There is no legal mandate to force schools and places of work to allow Muslims to conduct their daily prayers, though tolerance is the general practice. Christian holidays are celebrated as national holidays, but Muslim holidays are not. Petitions by Muslim groups to allow Sunday working and Friday afternoon off have been denied by the Government.

There is an Inter-Religious Council of Liberia (IRCL) aiming to facilitate the peace process, rather than inter-religious dialogue per se. Many instances of church or mosque burnings are down to ethnic-based conflicts between ethnicities with different religions, such as the Mandingo and the

Loma, rather than religious tensions.

Catholic Portuguese travellers first visited Liberia in the 15th century, but Catholicism was only established in the country in 1906. It was the advent of Baptist settlers in 1822 that truly brought Christianity to Liberia. These settlers were followed by denominations such as Methodists, Lutherans, Presbyterians and Episcopalians. The Pentecostal Church, along with other charismatic churches, has grown rapidly in all parts of the country since the 1980s. Many of these churches were Liberian-initiated, as well as arriving from Europe and the US.

The majority of Muslims in the country belong to the Sunni Maliki School. However, among the Mandingo ethnic group there are Wahhabi sects, and several thousand Vai belong to the Ahmadiyya sect. Islam arrived in Liberia in successive waves with groups migrating into the country from the 15th century onwards.

Traditional religious beliefs, such as the power of ancestors, are held by many Liberians, but it is mainly in rural communities that ancestral spirits are worshipped and sacrificed to. It is the strength of urban residents' connections with rural communities that often dictate whether urban girls and boys are taken to join the secret societies of Sande and Poro respectively. These beliefs, though, do not stop believers from also being active members of the church and mosque, which until recently had been tolerant of this duality. Pentecostal churches, however, are not tolerant and preach against all forms of traditional religions and Islam.

The churches in Liberia are intolerant of homosexuality. In 2012, the president of the Pentecostal Fellowship Union of Liberia (PFUL), who is also pastor of the Monrovia Free Pentecostal Church in Sinkor, said in connection with same-sex marriage that 'gay or lesbian right is not a human right' (care2.com, 2012). More recently, many members of churches in Liberia, including the Liberian Council of Churches and the

Catholic Archbishop of Liberia, have blamed Ebola on homosexuals, saying that God is angry with Liberians over immoral acts such as homosexuality and in punishing them with Ebola (*Reuters*, 2014).

All references are from Heaner, 2008, unless otherwise stated.

RELIGION AND FGM

FGM predates the Christianity and Islam and is not exclusive to one religious group. FGM has been justified under Islam, yet many Muslims do not practise FGM and many agree it is not in the Koran. Within Christianity, the Bible does not mention FGM, meaning that Christians in Liberia who practise FGM do so because of a cultural custom.

There were almost no current reports that we found for religious leaders being involved in the fight against FGM specifically, although there are reports that Pentecostal churches demonise all aspects of African traditional religions and the secret societies of Poro and Sande.

NATPAH has also used a religious-based approach in its programmes to end FGM by selecting ten churches each Sunday at which to preach about the harmful effects of FGM.

MEDIA

PRESS FREEDOM

The Constitution guarantees the freedom of speech; however, the Committee to Protect Journalists' (CPJ) report from 2013 shows that media freedom is sometimes threatened by onerous libel laws. In 2013, Rodney Sieh, the editor of *Front Page Africa*, was jailed for failing to pay \$1.5 million US, following a libel trial, and the paper was banned. Although the ban was lifted and the editor released later that year, the case shocked the international rights groups, who put pressure on the Liberian Government for legal reforms. According to CPJ, in the context of the recent Ebola epidemic journalists are being harassed and forced to cease printing by the Liberian Government, which does not tolerate being criticised for the way it is handling the crisis (CPJ, 2014). In August 2014, Liberia National Police (LNP) officers broke into the offices of *The National Chronicle*, arbitrarily closing the paper and arresting two members of staff.

MAIN NEWSPAPERS IN LIBERIA

The media sector includes both state-owned and private newspapers. Although they publish regularly, they are distributed mostly in the capital. There are 24 newspapers in Liberia and below is a selection of the main ones:

The Inquirer; The New Dawn; Front Page Africa; The Daily Observer; In Profile Daily; The Liberian Forum; The Liberian Journal; Liberian Online; The 1847 Post

The Daily Talk is an English-language news medium published daily on a black board attached to a hut on Tubman Boulevard in the centre of Monrovia. According to *The New York Times* (2006), it is 'the most widely read report' in Monrovia, as many Monrovia lack the money or the electricity necessary to access conventional mass media.



Fig. 26: Retired schoolteacher in Fish Town, Liberia, spends his early mornings reading announcements to people in his town (Bonnie Allen, Flickr)

ACCESS TO MEDIA

Due to low literacy rates and the high prices of newspapers, radio is the primary source of information, reaching 94% of Liberians. There are over 15 radio stations in Monrovia, at least two of which broadcast nationwide. Community radio has over 50 stations across the country (BBC World Service, ELBC FM, Radio Liberia FM, and Radio Veritas) and six TV stations. According to Freedom House (2014), most media outlets are not self-sustaining and rely heavily on financial support from politicians or international donors.

The DHS (2013) reports that 58.9% of Liberians own a radio, 14.1% a TV, 64.6% a mobile phone, 5.1% a computer and, only 3.8% of Liberians have access to the internet (ITU, 2013). The percentages of respondents who are not exposed to any media on at least a weekly basis are highest among women aged 45-49 and among men aged 15-19 (64% and 41%, respectively). Urban residents are more likely to be exposed to all forms of mass media than rural residents. Overall, 68% of rural women and 47% of rural men reported having no exposure to any form of mass media at least once a week, compared with 48% of urban women and 24% of urban men.

Media exposure at least once a week	Female	Male
Reads a newspaper	9%	30%
Watches television	19%	24%
Listens to radio	39%	60%
All three media	6%	13%
No media	56%	33%

Table 4: Media exposure for men and women (DHS, 2013)

MEDIA AND ANTI-FGM CAMPAIGNS

The Sande and Poro societies in Liberia forbid anyone from revealing their secrets. When in 2012 Liberian reporter, Mae Azango, published an exposé on female cutting, she received threats and had to hide, causing an outcry from international journalists and organisations. Urged by Azango’s report, the Government announced it had suspended the issuing of licences for Sande leaders, but campaigners said that despite this the bush schools and FGM continued (Reuters, 2014b).



Fig. 27: Mae Anzango’s first news story on FGM in Sande (photos by Mae Azango, Sumaya Agha and Joanne Devane) (www.frontpageafricaonline.com)

With the publicising of the case of Ruth Berry Peal, who was kidnapped and forcibly subjected to FGM in Bomi County in 2010, the campaigns against FGM gained momentum, putting pressure on the Liberian Government to outlaw the practice. There were a series of interviews with Ruth Berry Peal and her lawyer in the local newspapers and

on radio and the Vox Africa TV channel, which resulted in the sentencing of two members of the Sande society.

There was also considerable media coverage for the Zero Tolerance day in 2014, with President Sirleaf making a speech to mark the day, followed by radio talk shows and newspaper articles on the issue. Despite a positive step in anti-FGM media campaigns, Equality Now states that campaigners and journalists are still afraid to publically condemn the practice. 'Liberia is very tricky', said Grace Uwizeye, FGM programme officer at rights group Equality Now in an interview for *Front Page Africa*. Uwizeye further stated that 'the secret society makes it very difficult to penetrate or even to start talking about FGM because people are just scared. You have to make sure people understand it's OK to talk about FGM' (*Front Page Africa*, 2014).

ATTITUDES AND KNOWLEDGE RELATING TO FGM

The DHS (2013) reported that 89% of women in Liberia had heard of the Sande bush school; of those 50% were members and 39% of members thought the practice should stop. Around 60% of women in the two regions of the country where FGM is least practised had heard of Sande.

In the DHS 2013 report a survey on Sande membership was used to estimate the number of women with FGM. However, data on FGM cannot be extrapolated accurately because it is unclear if the respondents, when asked if the Sande should continue, based their answers on attitudes to FGM, rather than other aspects of Sande society. Those who wished the society to continue may in fact hold negative views about FGM but positive views about the society as a whole.

Figure 28 shows the geographic distribution of members of Sande, and the level of support for the society is shown by how many believe the society should stop. South Eastern B has the lowest

Percent distribution of women aged 15-49 years who had heard of Sande, were members of it, and the percent of members who wanted the Sande to stop

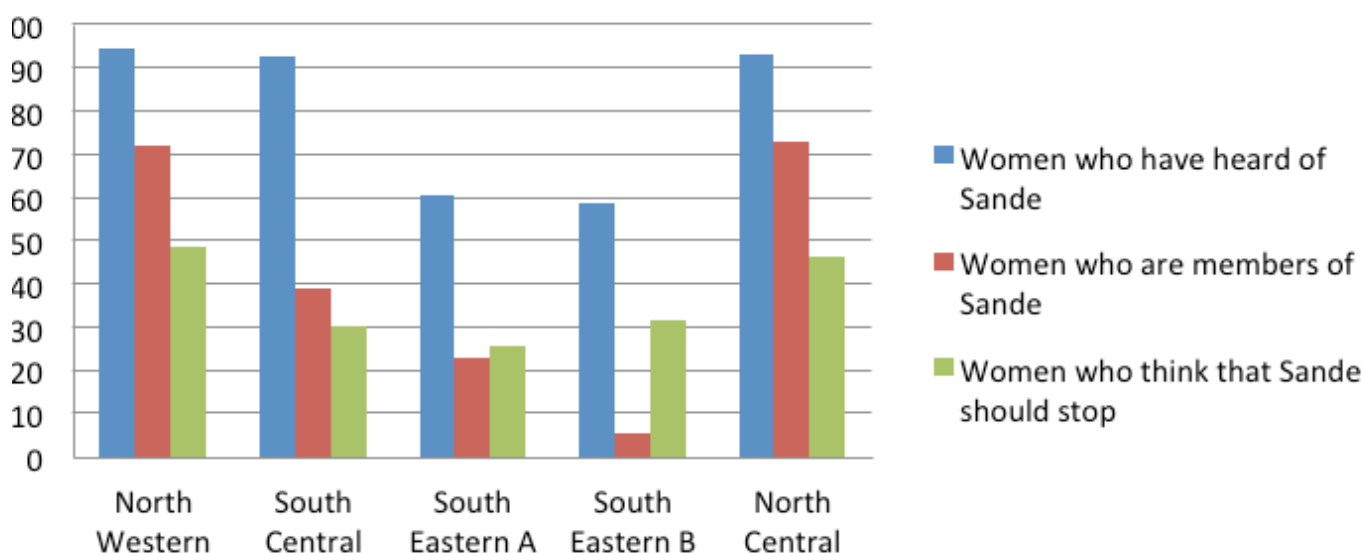


Fig. 28: Percent distribution of women aged 15-49 years who had heard of Sande, were members of it, and the percent of members who wanted the Sande to stop

Distribution by wealth of members of the Sande and their belief that it should stop (DHS, 2013)



Fig. 29: Distribution by wealth of members of the Sande and their belief that it should stop (DHS, 2013)

number of members at 5.4% of the population, but 31% of those wished Sande was stopped, whereas North Central has 73% membership, with not far off half the members believing the society should be stopped.

There are differences noted in both the prevalence of membership of Sande and the belief it should stop in relation to various background characteristics of the women respondents in the DHS survey.

Figure 29 shows that there is a 40 percentage point difference between the poorest and richest in membership of Sande, 69% to 29% respectively. Of the 29% of the richest group, only 24% wished it to stop, whereas 43% of the poorest respondents did want the society to stop.

A recent baseline study conducted by Women Solidarity Inc. (WOSI) in 2013 could shed light on the reasons why respondents did not wish the society to continue. The study showed that in the six counties surveyed, more than half of the

	Both sexes	Male	Female
Not necessary	77.5	72.6	82.3
Causes women not to bear children	4.9	2.6	7.7
Affects sexual enjoyment	7.1	6.2	8.3
Causes Scars	5.1	4.0	6.6
Causes Infections	9.1	10.6	7.2
It is harmful	15.2	17.2	12.7
Painful	9.8	11.0	8.3
Not healthy	15.2	16.7	13.3
Not our Culture	5.6	8.8	1.7

Table 5: Percent Distribution of respondents [Both sexes (n=408), Male(n=227) Female(n=181)] by sex and the reasons why they will not permit a relative to become member of Sande society/ initiated with female genital mutilation (WOSI, 2013)

respondents (61.3% of men and 59.2% of women) indicated that Sande society/the practice of FGM is not good for the community, compared to 31.8% who said that it is good. When asked if they would allow a relative of theirs to join Sande society, 63% of men and 51% of women said they would not. Table 5 below shows the reasons why the respondents would stop someone from joining.

REASONS FOR PRACTISING FGM AND ITS PERCEIVED BENEFITS

FGM is a social tradition, often enforced by community pressure and the threat of stigma. Despite differences relating to the practice between communities in which FGM is found in Liberia, within each practising community it manifests deeply entrenched gender inequality. One Mende member of the Sande society from Tubmanburg, Western Liberia, who asked not to be named, told IRIN that removing a girl’s clitoris helps her become a ‘prolific child bearer’ (IRIN, 2008). Due to the highly dangerous position of women if they talk about Sande, it is hard to find information on why girls need to be initiated. It is believed to control women’s sexuality, making

them less promiscuous and therefore faithful wives.

Reasons for becoming a member of Sande/FGM	Total (n=210)	Bong (n=10)	Margbi (n=69)	Nimba (n=34)
'It is our Culture'	87.6	82.2	97.1	85.3
'It is good for me'	16.7	15.9	15.9	20.6
'Made me attractive'	4.8	3.7	1.4	14.7
'Made me to get married'	1.0	0.9	1.4	-
'Made me more decent/proper'	3.8	2.8	1.4	11.8

Table 6: Reasons for becoming a member of Sande society / female genital mutation (WOSI, 2013)

The DHS does not contain any information on the reasons for practising FGM, but the small-scale base line study conducted by WOSI, found the following reasons for women being initiated into Sande society with FGM (Table 6). The predominant reason in all counties was that it is 'our culture', the same reason as given in many West African countries. Other women believed it was 'good for them' or made them more attractive, and in Nimba County 11.8% of women believed it made them decent/proper.

LAWS RELATING TO FGM

INTERNATIONAL & REGIONAL TREATIES

Liberia has signed (though not always ratified) several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights. The ratification of these conventions places a legal obligation on Liberia to work towards fully adhering to the provisions of these conventions with the aim of eradicating FGM:

- Convention on the Elimination of Discrimination Against Women (CEDAW) (accessioned, 1984)
- Convention on the Rights of the Child (CRC) (ratified, 1993)
- Universal Declaration on Human Rights 1948 (UDHR)
- International Covenant on Civil and Political Rights (ICCPR) (ratified, 2004)
- International Covenant on Economic, Social and Cultural Rights (ICESR) (signed, 2004)
- African Charter on the Rights and Welfare of the Child (ratified, 2007)
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the 'Maputo Protocol') (ratified, 2007)
- African Charter on Human and People's Rights (the 'Banjul Charter') (ratified, 1982)

The African Union declared the years from 2010 to 2020 to be the 'African Women's Decade' and as a signatory Liberia is expected to consolidate its efforts to promote and protect the rights of women.

In December 2012, the UN passed an historic unanimous resolution, calling on countries to eliminate FGM, and in 2013 the 57th UN Convention

on the Status of Women agreed on conclusions including a reference to the need for states to develop policies and programmes to eliminate FGM as well as other forms of violence against women (UN, 2012). In proving its commitment and fulfilling its legal obligation to eradicate FGM, Liberia will need to adopt and implement laws, policies and programmes that work towards the elimination of FGM and all other forms of violence against women.

FGM has long been considered discriminatory as a practice exclusively directed towards women and girls, with the effect of interfering with their enjoyment of their fundamental rights. Discrimination on the basis of gender is prohibited under Article 2 of the UDHR and has since been included in all international and regional human rights treaties and conventions.

The CEDAW and the CRC explicitly prohibit traditional practices that discriminate against women and harm children. Article 2 of CEDAW directs 'State Parties...(f) To take all appropriate measures, customs and practices which constitute discrimination against women.' Additionally, Article 5 states, 'State Parties shall take all appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes'.

Article 24(3) of the CRC states that, 'State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children'. In addition, Article 19(1) provides that 'State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse'.

Under the ICCPR, FGM is a violation of a person's physical integrity, liberty and security of person. The ICCPR protects individuals from 'torture or

cruel, inhuman or degrading treatment' and arbitrary or unlawful interference with his or her privacy (Articles 7 and 17). The ICCPR states that everyone has the 'right to liberty and security of person' and that '[e]very child shall have... the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State' (Articles 9 and 24). FGM thus violates the convention because it threatens a person's safety due to its negative life-threatening physical consequences (Centre for Reproductive Rights, 2006).

Under the ICESCR, FGM is a violation of the right to health. Article 12(2) provides that '[t]he steps to be taken by State Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for: (a) The provision for...healthy development of the child'. 'Health' is defined so as to include 'maturity, reproductive and sexual health'. FGM thus violates the convention due to its numerous health consequences, as discussed in the section Women's Health and Infant Mortality above.

Article 4(1) of The African Charter on the Rights and Welfare of the Child requires that the 'best interests' of the child are paramount in any decision concerning a child. Article 5(1&2) stress the inherent right to life of every child and requires that state parties... 'ensure to the maximum extent possible, the survival, protection and development of the child. Under Article 14(1), 'Every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health.' States are further required to pay particular attention to the reduction of infant and child mortality, which increase in cases of women who have undergone FGM. Article 21 requires member states of the African Union to abolish customs and practices harmful to the 'welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status'.

Under Article 4(2) of The Maputo Protocol, member states are required to adopt legislative,

administrative, social and economic measures to ensure the prevention, punishment and eradication of all forms of violence against women. The Protocol also explicitly refers to FGM under Article 5 whereby, ‘state parties shall prohibit and condemn...through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and para-medicalisation of female genital mutilation and all other practices in order to eradicate them’.

The Banjul Charter under Article 16 includes ‘the right to the best attainable state of physical and mental health.’ The right to physical integrity is provided for under Articles 4 and 5.

Unless otherwise stated, all references in this sub-section are to Mgbako *et al.*, 2010.

NATIONAL LAWS

AGE OF SUFFRAGE, CONSENT AND MARRIAGE

The age of suffrage in Liberia is 18 years.

Under the Liberian Children’s Act 2011, Article IV, Section 4, the age of consent for marriage is 18 for both men and women, while the Domestic Relations Act at section 2.2.2 sets the minimum age at 21 for men and 18 for women. However, the same section allows for both men and women to marry at a minimum age of 16 with the consent of their parents or in the absence of parent or guardians, with a judge’s order. The Equal Rights of Customary Marriage Law of 1998 at Section 2.9 permits the customary marriage of a girl at a minimum age of 16.

CONSTITUTION

The constitution of Liberia does not specifically discuss FGM. It is however arguable that a successful prosecution could occur under the Liberian Constitution which provides at Article 11(a) that ‘All persons are born equally free and independent and have certain natural, inherent and inalienable rights, among which are the right of enjoying and defending life and liberty, of pursuing and maintaining the security of the

person’. The Article also preserves ‘fundamental rights and freedoms to the individual’ under which freedom from FGM could be included. Article 20 further retaliates that ‘No person shall be deprived of life, liberty, security of person’ (Constitution of Liberia, 1984).

ANTI-FGM LAW

FGM is not specifically illegal in Liberia as it has not been addressed in the constitution or any specific law enacted to criminalise the practice. This is despite the requirement under Article 4(2) of the Maputo Protocol that state parties (Liberia being a signatory) enact specific legislative measures to eliminate FGM.

While there is no specific legislation on FGM, theoretically it is possible to use some sections of the penal law to bring about a case against FGM. Section 14.23 prohibits recklessly endangering another person where conduct ‘creates a substantial risk of death or serious bodily injury to another. There is risk within the meaning of this section if the potential for harm exists, whether or not a particular person’s safety is actually jeopardized’.

Similarly, given the reported frequent kidnapping of girls and women by the secret Sande society for the sole purpose of undergoing FGM, victims of such circumstances can bring cases under section 14.50 (e) which prohibits kidnapping where the purpose is ‘to inflict bodily injury’ and section 14.51(a) which prohibits felonious restraint, whereby the act done knowingly ‘restrains another unlawfully in circumstances exposing him to risk of serious bodily injury’.

A possible case could be brought under Section 20 of the 2011 Children’s Act which provides that a child is ‘protected from work or other practices that may threaten her health, education, spiritual and physical and moral development.’ While the meaning of other practices is not explained, it is arguable that the negative consequence of FGM would be covered by the section.

ENFORCEMENT

In addition to the lack of legislation, there has been a considerable lack of governmental action on the topic of FGM. As a women's rights activist, much was expected of President and Nobel Peace Prize winner President Ellen Johnson Sirleaf, though she, along with many government officials, has been reluctant to address the subject robustly to date.

There has, however, been progress in the Government's stand on the practice despite fierce opposition. The Minister of Gender and Development, Julia Duncan-Cassell, encouraged leaders to 'resist FGM' during a radio broadcast on the 26 March 2012. She reiterated this message the next day, saying her office was working to bring about an end to the practice and that 'Government is saying, "this needs to stop"'. This, so far, has been the clearest position of the Government on the practice to date (Lupick, 2012).

Another government official, Grace Kpaan, in even stronger condemnation of the ritual said, 'I believe it is evil, because there are times that little children even die in the bushes; seven, eight and nine year olds' (York, 2012).

Efforts to end FGM were seen in 2012 when the Ministry of Internal Affairs issued a notice directing that all Sande activities should be stopped with permits no longer being issued, and that failure to comply would result in fines (Lupick, 2012; Allen, 2012). Despite the issuing of this notice, 750 girls still underwent FGM in Nimba County (Mohamed, 2013). Opposition to ending FGM continues to exist within government-backed institutions, such as the National Traditional Council. Setta Saah, a senior official of the council, stated 'it's been here for a thousand years...The government won't say "No" without the approval of the people.' Another official in the council, Ella Coleman, stated that the bush schools are voluntary: 'you see children as young as seven walking into the bush. Nobody is holding their hand. Nobody is forcing them. This is our tradition, and this is how we live' (York, 2012).

CASE STUDIES

In 2010, Ruth Berry Peal was kidnapped by the Gola tribe after arguing with two of its members. FGM was performed on her resulting in her being hospitalised for three months. She brought an action against her kidnappers who were found guilty in July 2011 of kidnapping, felonious restraint and theft. They were sentenced to three-year prison sentences in February 2013.

Despite claims that this was the first ever prosecution for FGM in Liberia, there is evidence that suggests that in 1994 a Grebo girl who was forced by the Sande Society to undergo FGM brought an action against the practitioner. She received 500 Liberian dollars in damages, which at the time was equivalent to US\$11.75 (Rahman & Toubia 2000, cited in ADIOS, 2003).

INTERVENTIONS AND ATTEMPTS TO

ERADICATE FGM

BACKGROUND

The WOSI baseline survey (2013) was an important piece of work in a country where there is so little data on FGM. Examining attitudes towards Sande and FGM, this study highlighted the way communities feel about FGM interventions, how they should be approached and who they should address. Table 7 shows that, among the 639 participants, the preferred choice of interventions were 37.6% wanting a law banning it, and 41.8% believing more education and awareness raising is required.

What to do to stop Female Genital Mutilation	Both sexes (n=639)	Female (n=328)	Male (n=311)
Engage Government to make law against sande bush	37.6	38.7	36.3
Work with traditional people	15.2	13.7	16.7
Provide alternative income generation for practitioners	7.2	7.9	6.4
Improve the way Sande initiation is done	6.1	6.2	5.5
Education and awareness	41.8	40.9	42.8

Table 7: Baseline survey data on anti-FGM programme strategies (WOSI, 2013)

When asked about to whom interventions should be addressed, 26% believed both men and women should be addressed, 31% the local chiefs, and 39% of women and 29% of men felt that Zoes should be targeted for interventions. 14% of respondents felt that interventions addressed at health workers would be useful, but only 4% thought students should be included.

These choices were reflected in the main during our research into interventions, with little evidence

of work being conducted with faith leaders and few direct FGM activities with girls.

A number of organisations working in Liberia have braved the threats and censor of the secret societies to advocate change and the end to FGM. Several couch their work in terms of consensual initiation over the age of 18, or stopping forced initiation. Those who do mention FGM in their work are highlighted below. There are many more NGOs who work for the rights, health and education of women and girls that do not state outright that their programmes address FGM; these are profiled below and/or included in Appendix I.

Fuest's paper explored the unwitting outcome of some NGO interventions, specifically those into human rights and peace building in the early years after the conflict ended; it shows that the post-conflict interventions actually reinstated the failing power of Sande and Poro in post-war Liberia. The Zoes of both societies lost authority and status during the war as they were seen as unable to protect their communities, and many fled over borders during the conflict. The reinstatement process started with peace building workshops, and has extended to all workshop forums where criteria for inclusiveness have been laid down by the donor NGOs. This has reinvigorated the old power structures of pre-war rural society by requiring a mix of participants to be present, whose attendance is often within the gift of traditional leaders (elders). These forums have been instrumental in raising the awareness of many issues, although they may not be the place that NGOs would hope for in terms of free discussion because many voices are restricted by the presence of other social groups, such as elders by youth, or youth by elders, or women against Sande in front of Zoes.

However, with over 400 NGOs registered in the country by 2010, and in the absence of better models, holding workshops, as will be seen below, is the preferred method of social transformative teaching (Fuest, 2010).

GOVERNMENT POLICY AND SUPPORT

The Government and her ministries are working with UNFPA to develop policies to stop HTPs and GBV including FGM (UNDP, 2013). In January 2013, the Vice President Mr. Bookai in an interview said about FGM 'I think this is an issue that needs a referendum but with proper education to show our people the causes and effects (*Liberian Daily Observer, 2013b*). This was followed on 6 February 2013 by Proclamation by Order of President Sirleaf, which condemned the practice of FGM and HTPs, and declared and proclaimed 6 February as a working holiday to support activities to promote zero tolerance to FGM. Leading up to this proclamation the Government had made various statements about Sande schools needing to close, working with traditional leaders to stop FGM, a moratorium during the Ebola crisis on bush school operations, but none of them have apparently been followed up or enforced. While NGOs are free to work in the country, the Government offers no specific support or funding or legislation to strengthen their case against FGM.

ANTI-FGM INITIATIVES NETWORKS

There are several networks of NGOs working to eradicate FGM in Liberia. As well as the many organisations working on the national SGBV Task Force, networks such as the Women of Liberia Peace Network (WOLPNET) focuses on tackling violence against women. It works with partners such as ADFI, who actively lobby the Government for legislation against FGM and calls for a framework to regulate HTPs. West Africa Network for Peacebuilding (WANEP) works through local partners on ending gender-based violence in Liberia. Also NATPAH aims to create a 'Social Network' of women's groups, health workers, and NGOs in order to coordinate activities and raise awareness about the harmful effects of FGM.

OVERVIEW OF INTERVENTIONS

A broad range of interventions and strategies has been used by different types of organisations to eradicate FGM in Liberia. Often a combination

of the interventions and strategies below are used:

- Health risk/harmful traditional practice approach
- Addressing the health complications of FGM
- Educating traditional excisors and offering alternative income
- Alternative rites of passage. Not used in Liberia.
- Religious-oriented approach
- Legal approach
- Rights approach/'Community Conversations'/ Intergenerational Dialogue
- Promotion of girls' education to oppose FGM
- Supporting girls escaping from FGM/child marriage
- Media influence
- Working with men and boys

ALTERNATIVE RITES OF PASSAGE

Within a ceremony as symbolically rich as the initiation into the Sande society is, there is room to remove the harmful aspect of FGM while leaving the teaching aspects intact. Over the border in Sierra Leone some organisations have been able to support the Sande secret societies to retain tradition without cutting their girls. This leaves the Zoes' livelihoods intact and removes the potentially fatal aspect of FGM and future harm to girls during childbirth (Please refer to Country Profile: FGM in Sierra Leone, 28 Too Many).

HEALTH RISK/HARMFUL TRADITIONAL

PRACTICE APPROACH

Strategies that include education about the negative consequences of FGM have been the most frequently used globally for the eradication

of FGM. However, convincing people in areas of high FGM prevalence of the health problems can be challenging. Difficult childbirth and long post-partum recovery periods, which are exacerbated by FGM, are often seen as the norm. Communities may not therefore attribute the complications of FGM to the procedure itself (Winterbottom, 2009).

NATPAH report that some communities may never have examined the effect on their members of what is a valued custom, passed down from their ancestors. The head of NATPAH, Phyllis Kimba, has worked for many years to stop FGM and runs workshops with a model of a woman's anatomy, showing natural genitalia and the effects of FGM to audiences around the country.



Fig. 30: Phyllis Kimba's instructional workshops on female anatomy and the harmful effects of FGM (NATPAH)

AFELL works with many audiences in communities, towns and villages, raising awareness and promoting sensitisation about the harm of FGM. It also specifically highlights the clear distinction between 'male circumcision' and FGM. ADFI also engages the key actors in FGM, such as traditional leaders, the Zoes and women to explain the consequences of FGM and its long-term impact on the growth and development of healthy communities. WOSI insists that in raising awareness about the harm done to girls through

FGM, target audiences are addressed separately to reduce the sensitivities surrounding discussion on the practice.

ADDRESSING THE HEALTH COMPLICATIONS OF FGM

AFELL aims to provide quality healthcare and support for women and girls who have had FGM. It also provides support for other victims of gender-based violence, both physical and psychological. In 2009, NATPAH ran training workshops to teach recognition of the consequences of psychosocial effects and their management. Foundation for Women's Health, Research and Development (FORWARD) works with local partners on FGM, child marriage, sexual abuse and obstetric fistula. WOLPNET also works within the area of reproductive health.

EDUCATING TRADITIONAL EXCISORS AND OFFERING ALTERNATIVE INCOME

Although initiatives with FGM practitioners may be successful in supporting excisors in ending their involvement in FGM, they do not change the social convention that creates the demand for their services. Such initiatives may complement approaches that address demand for FGM, but alone they do not have the elements necessary to end FGM (UNICEF, 2005).

Many of the NGOs contacted by 28 Too Many during this research, as well as the Government, see this as a crucial intervention for Liberia. ZODWOCA felt that many do not understand that FGM is a business for Zoes and that their economic conditions must be cared for. ZODWOCA, along with ADFI, provides training for Zoes and other women in small enterprise businesses. However, they stress that funds are short and this intervention will not succeed without sustainable funding. NATPAH too has provided training in tie-dyeing, soap making, sewing and baking as alternative livelihoods with reported success. Equality Now notes that it hopes to explore further dialogue opportunities in Liberia in the areas of alternative rites of passage and alternative sources of

income for FGM practitioners. The United Nations Mission in Liberia (UNMIL) did set up a project on alternative livelihoods in 2011; however, this project lasted only a few months.



Fig. 31: 'Mobilized, sensitized and trained ex-excisors working with NATPAH' (NATPAH)

RELIGIOUS –ORIENTED APPROACH

A religious-oriented approach refers to an approach which demonstrates that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour.

NATPAH, the Liberian committee member for the IAC, speaks in schools, mosques and churches about women's health, rights, and FGM. On Sundays they visit ten churches and preach about the harmful effects of FGM and HTPs using Bible quotations.

In a 2009 Dutch government report on FGM in Liberia a pilot project run by the Inter-Religious Council in five districts in Cape Mount was mentioned, though not referenced. In addition to awareness training for local communities, the project temporarily removed groups of girls at the age of risk from FGM from the village during the time of Sande initiation. The girls were returned to

their homes after the risk of FGM had passed for another year. During the year of the project some parents decided not to allow their daughters to be initiated and some Zoes, on learning of the harmful consequences of FGM, stopped working (Dutch Government Movement of Persons, Migration and Immigration, 2009).

LEGAL APPROACH

This approach consists of lobbying the Government to enact legislation against the practice of FGM and advocating for effective enforcement of such legislation. AFELL works with various Liberian Ministries to write up legislation against FGM. They are currently lobbying the Liberian Government to uphold the provisions of the UN Convention on the Rights of the Child in order to protect girls against FGM. Women Against Female Genital Mutilation (WAFGEM) was reported to have petitioned to enact an anti-FGM law, and organisations such as WOLPNET, Child Rights Foundation (CRF), Save the Children, and Equality Now have been active in lobbying for the criminalisation of FGM.

RIGHTS APPROACH/'COMMUNITY CONVERSATIONS'/ INTERGENERATIONAL DIALOGUE

A rights-based approach acknowledges that FGM is a violation of women's and girls' rights. This approach is sometimes used alongside other strategies to eradicate FGM, based on the social abandonment theory of FGM (derived from the social change theory behind foot-binding in China). The components of this theory include (i) a non-judgemental human rights approach; (ii) community awareness-raising of the harmfulness of the practice; (iii) a decision to abandon FGM that is a collective decision by the entire community; (iv) the requirement of the community's public affirmation of abandonment; (v) intercommunity diffusion of the decision; and (vi) a supportive change-enabling environment, including the commitment of the Government (Wilson, 2012/13).

This approach was pioneered by Tostan in Senegal (UNICEF, 2005). The approach is based on the principle of different generations listening and questioning each other, aided by a facilitator. It enables participants to reflect on their values, customs, traditions and expectations and to consider whether, when, how and under what conditions change should take place (GIZ, 2011).

‘Our work does not include ending FGM, rather aspects of FGM that causes human rights violation is our concern’ said the head of ZODWOCA in a communication with 28 Too Many. They run workshops in Zorzor County that address women leaders, Zoes, and others on the rights of the child and underage 18 initiation being an abuse of this.

AFELL say that ‘to stop FGM in Liberia is a gradual process’, and that their workshops aim to raise awareness of the harm of it and ensure that nobody is initiated without consent. In addition, they are working to ensure Western education is compulsorily enforced.

PROMOTION OF GIRLS’ EDUCATION TO OPPOSE FGM

NATPAH (extensively profiled below) works with children to know their rights and the harms of FGM at the same time as encouraging them to stay in school. Similarly DCI-L, with funding from the Dutch Government, runs a Girl Power project encouraging them to stay in school and know their rights. WOLPNET works in 10 out of the 15 counties and has established Girls’ Clubs to campaign against FGM in the various schools in the communities. They hope to have created a platform for girls in communities where FGM is practised for them to express their views on this practice, especially in the cultural context of the Sande school initiation. WOLPNET hopes to utilise this information to aid in developing activities tailored to address challenges hindering the eradication of FGM in affected communities. One of these challenges is getting girls into formal schooling.

‘The Ministry of Gender and Development is not dealing with the issue of FGM as you call it, we’re looking at the protection of the girl child, and we’re using education as an entry point. We’re looking at refining and reforming the Sande school system’ (Liberian Daily Observer, 2014).

MEDIA AND COMMUNICATION

One particularly successful strategy is that of global campaigns opening up a platform for local advocates. This was exemplified by *New Narratives*, an media NGO backed by Goldman Sachs Gives, which (financially) supported Mae Azango, the Liberian journalist and anti-FGM advocate mentioned above. This support allowed Azango to contribute to international media such as *Global Post* and *Christian Science Monitor*. Chime for Change also opened up a platform for Mae Azango by publishing her work on the backlash she experienced after publishing a cover story on the health effects of FGM in Liberia’s major newspaper, *Front Page Africa*.

WOLPNET regularly publishes an FGM newsletter/brochure, which highlights its activities in communities but also covers personal stories of survivors and those who have lost their children to FGM. Its work endeavours to break the silence that keeps most victims suffering for fear of retribution.

WAFGEM Executive Director B. Clarence Farley said that ‘media institutions bow to the threat of retribution and do not support advocacy for the abandonment of FGM/C in Liberia or cover incidents of violations’ (allafrica.com, 2013c).

INTERNATIONAL ORGANISATIONS

ACTION AID

Action Aid is a UK INGO that has been working in Liberia for over 15 years. Action Aid Liberia has three field offices (Gbarma in Gbarpolu County, Zwedru in Grand Gedeh County, and Fishtown in River Gee) and a head office in Montserrado, Monrovia. Its work extends across some 200 communities throughout the country, reaching some 35,000 beneficiaries.

Action Aid Liberia works from a women's rights perspective and challenges patriarchal systems and structures. Its work focusses on five key areas:

- Economic rights
- Mobilising women
- Violence against women
- Women's control over their bodies
- Women farmers

Through this approach, Action Aid Liberia endeavours to work alongside grassroots organisations, CSOs and the Government to identify and tackle issues such as sexual minority concerns, HIV and HTPs (including FGM).

ASSOCIATION OF DISABLED FEMALES INTERNATIONAL (ADFI)

The Association of Disabled Females International (ADFI) works in Liberia to promote and protect women's rights, with a particular focus on helping women living with disabilities. ADFI works alongside many other organisations and networks to support victims of civil war, the sick, elderly and widows, as well as to raise awareness of HIV/AIDS and HTPs such as FGM. It is a current grantee of the Fund for Global Human Rights and forms the Liberian chapter of the United Religions Initiative. Known as 'Interfaith Cooperation Circles', the members aim to build cooperation among people of all faiths and communities to

address issues like FGM.

ADFI undertakes a number of activities in Liberia to raise awareness of the harms of FGM, including peer group discussions and forums with traditional/community leaders, town Chiefs, local and national government representatives and, most significantly, with practising Zoes. These interventions have taken place in six counties to date (Rural Montserrado, Margibi, Grand Bassa, Grand Cape Mount, Bomi and Gborpolu). However, funding is limited and such work requires huge logistics and funds.

As part of the anti-FGM network headed up by WOLPNET, ADFI feels that there has been success in drawing Government attention to the negative aspects of FGM. ADFI reports that a framework to regulate HTPs is being developed by the forum members to present to the Government. ADFI has also been part of the call to ensure that girls are not removed from school to be initiated.

To date, ADFI has conducted some 45 activities across the six counties. These have educated 173 Zoes and 2,150 residents on the harmful effects of FGM. However, ADFI points out that much more needs to be done, including rehabilitation for victims (many of which were forcibly initiated) and finding alternative sources of income for the Zoes.

CARTER CENTER

The Carter Center is a human rights-based INGO that seeks to prevent and resolve conflicts, enhance freedom and democracy, and improve health. It works to strengthen the rule of law in Liberia and to improve health services. The Carter Center works with the Government at a national level and works in partnership with a wide range of CSOs in local communities, holding workshops, and educating through drama and radio programmes. Partners include the Inter-Religious Council of Liberia (IRCL), South East Women Development Association (SEWODA), Traditional Women United for Peace (TWUP) and the Flomo Theatre.

CONCERN WORLDWIDE

Concern Worldwide has been working in Liberia since 1996, responding to the livelihood, health and education needs of communities in four counties (Montserrado, Grand Bassa, Lofa and Bong County). Activities have alternated over the years between the provision of emergency aid and development work. It has programmes to address HIV/AIDS, access to education, training farmers and building communities.

Regarding education, Concern is working with communities and with the Ministry of Education to encourage parents to send their children to school, especially girls (though this work has halted during the Ebola epidemic). Concern recognises that the provision of adequate facilities and resources is essential. It aims to provide safe learning environments, with trained teachers and adequate facilities (such as separate toilets for boys and girls). It also helps communities to know about their children’s rights and to be aware of the importance of gender equality.

DEFENCE FOR CHILDREN INTERNATIONAL – LIBERIA (DCI-L)

Defence for Children International is an INGO that promotes and protects children’s rights, and has been active in Liberia since 2009. DCI-L is based in Monrovia and also has offices in Bensonville and Tubmanburg in Bomi County. Initiatives include the ‘Defence for Girls Project’ (part of the international ‘Girl Power Programme’ supported and funded by the Dutch Government), to report violations, promote the rights of girls, and create opportunities for their protection.

DCI-L has established a total of 20 Child Welfare Committees (CWC) and 20 Children’s Clubs in Monteserrado and Bomi Counties, with the aim of protecting children’s rights and reporting violations occurring in the community. Training workshops for police, court clerks and community stakeholders have also been conducted in child rights and protection. DCI-L is an active member of a number of networks including the Child

Protection Network (CPN) and the Juvenile Justice working session.

EQUALITY NOW

Equality Now, founded in 1992, is an INGO that advocates the human rights of women and girls. By employing a social change model, it links high level international and legal advocacy to specific cases of abuse against women and girls to ensure change at all levels. Equality Now focuses on four main areas: discrimination in law, sexual violence, trafficking and FGM.

In Liberia, Equality Now supports grassroots organisations working to eradicate FGM and has held high level discussions in the country around the Ruth Berry Peal case. In 2013, Equality Now called upon the Liberian Government to support and protect Ruth, as well as to build on indications made by the Minister for Internal Affairs in 2011 that a law enacting and enforcing a ban on FGM might be considered. Equality Now endeavours to explore interventions that will work in Liberia, including ways to further open up the dialogue with Sande society on the harm of FGM, alternative rites of passage and other sources of income for Zoes.

FORUM FOR AFRICAN WOMEN EDUCATIONALISTS (FAWE)

The Forum for African Women Educationalists (FAWE) was established in 1992 to advocate girls’ education across Africa. FAWE has expanded its activities to cover some 34 countries, including Liberia, and is a leading INGO in Africa for improving access to and quality of education for girls, and for inspiring girls to stay in school and learn. FAWE works alongside a wide range of international partners, and, as a result of its advocacy, many governments have adopted and continue to adopt gender-positive policies; these include free primary education, re-entry policies for adolescent mothers and scholarships for girls.

FAWE recognises that many challenges persist in terms of access to school and the retention

and performance of girls; these include poverty, child marriage, teenage pregnancy and traditional practices and their consequences.

FOUNDATION FOR WOMEN’S HEALTH, RESEARCH AND DEVELOPMENT (FORWARD)

FORWARD is an African Diaspora campaign and support charity dedicated to advancing and safeguarding the sexual and reproductive health and rights of African women and girls. It is led by women and is registered in the UK. It works in the UK, Europe and Africa to change practices and policies that affect healthcare access, dignity and wellbeing. FORWARD operates in East and West Africa in partnership with local organisations to respond to FGM, child marriage, sexual abuse and obstetric fistula. In Liberia, work has been undertaken with the International Planned Parenthood Federation Member Association on a ‘Girls at Risk Project’ targeting pregnant girls, child mothers and vulnerable girls in resource-poor urban settings.

INTER-AFRICAN COMMITTEE ON TRADITIONAL PRACTICES (IAC)

The Inter-African Committee on Traditional Practices (IAC) is an umbrella body with national chapters in 29 African countries. It is an INGO that has been working on policy programmes to stop FGM for the last 28 years. The headquarters of the IAC is in Addis Ababa, Ethiopia, and it has a liaison office in Geneva. The IAC collaborates with a number of international organisations, including partnerships with UNFPA, WHO and UNICEF.

IAC programmes include training for professionals, women’s and men’s groups, peer educators and legal bodies. It undertakes information and sensitisation campaigns, targeting different groups such as religious leaders and traditional rulers, and provides training and credit to ex-circumcisers, utilising them as agents for change. NATPAH is the IAC national committee member for Liberia.

KVINNA TILL KVINNA FOUNDATION

The Kvinna Till Kvinna Foundation is a Swedish INGO that supports more than 130 women’s organisations in regions affected by conflict, including West Africa. The Foundation has worked in Liberia since 2007, focusing on key areas such as empowering people defending women’s rights, creating safe meeting places and encouraging more women in peace processes. A main aim is to promote women’s security and power over their own bodies.

In Liberia the Kvinna Till Kvinna Foundation supports women’s and girls’ rights through the following partners:

- Association of Female Lawyers of Liberia (AFELL) – raises awareness among women and girls of their basic human rights
- Centre for Liberian Assistance (CLA) – runs a shelter for young female victims of violence in Paynesville, Monrovia
- Liberian Women Empowerment Network (LIWEN) – supports and educates women with HIV/AIDS
- Liberia Female Law Enforcement Association (LIFLEA) – works against discrimination and harassment of women in the security sector, particularly the police force
- South East Women Development Association (SEWODA) – advocates on behalf of women’s and girl’s rights in remote rural communities
- The Mano River Women Peace Network (MARWOPNET) – peacebuilding activities for women and young people in the Mano River region
- The West Africa Network for Peace Building (WANEP) – works through its Women Peace Network (WIPNET) programme on conflict resolution and gender-based violence

- West Point Women for Health and Development Association (WPHWDO) – seeks to reduce gender-based violence and teenage pregnancy, and provide education for women in the West Point suburb of Monrovia
- Women’s Secretariat of Liberia (WONGOSOL) – aims for women to participate in all aspects of society on equal terms through its many members
- Women’s Rights Watch (WORIBA) – runs a programme against the sexual exploitation of schoolgirls and domestic violence in Buchanan, Grand Bassa County

MANO RIVER WOMEN PEACE NETWORK (MARWOPNET)

The Mano River Women Peace Network (MARWOPNET) works to facilitate the participation of young people and women in conflict prevention, conflict resolution and peace-building in the Mano River sub-region, which includes Guinea, Ivory Coast, Sierra Leone and Liberia. MARWOPNET’s vision is to see women play a full and equal role in peace and sustainable development processes within the region. It is recognised by MARWOPNET that to achieve this vision and to strive for an area inhabited by healthy, educated citizens who enjoy equal rights, the issue of FGM needs to be addressed.

OPEN SOCIETY INITIATIVE FOR WEST AFRICA (OSIWA)

The Open Society for West Africa (OSIWA) is part of the global network of Open Society Foundations and seeks to promote inclusive, democratic governance, transparent and accountable institutions and active citizenship across West Africa. OSIWA plays a dual role in the region as both an advocate for change and a grant maker. It aims to build partnerships and support organisations working at grassroots level; for instance, it created the West Africa Civil Society Institute (WACSI) in 2005 to pioneer capacity building through workshops, training and conferences throughout the region.



Fig. 32: Poster promoting women’s rights by the Open Society Initiative for West Africa (Osiwa.rssing.com (cc))

In Liberia, OSIWA has collaborated with WOSI to tackle the issue of FGM in traditional communities. The joint project began in 2013 with WOSI leading community conversations and facilitating forums at all levels of the community, which included influential traditional leaders. In the same year OSIWA funded the baseline report undertaken by WOSI to understand attitudes and perceptions of FGM in the communities where it is traditionally practised (see WOSI profile). A series of forums were then held using these results to discuss measures that could lead to the abandonment of FGM. Possible interventions that came from this work include the mandatory registration of practitioners with the Ministry of Internal Affairs and the head of traditional leaders; the imposition of fines for bush school ceremonies; and the establishment of a working group made up of interested parties. From 28 Too Many’s research, it is unclear if these interventions have been implemented.

OXFAM

Oxfam began working in Liberia in 1995, delivering both emergency humanitarian assistance and long-term development projects. Since 2006, the focus has shifted towards working closely with NGOs, community-based organisations (CBOs), the Government and communities to build a long-term strategy for the country. Oxfam’s focus in Liberia is on livelihoods, education and public health. It also includes work on areas that affect both such as, gender and protection, sexual exploitation and the right to be heard.

As part of Oxfam’s global Raising her Voice (RHV) programme, the ‘Raising Poor and Marginalised Women’s Voices in Liberia’ project since 2009 has been promoting the rights of poor and marginalised women to effectively engage in governance at all levels across eight counties. In partnership with Women NGOs Secretariat of Liberia (WONGOSOL) and WOLPNET, activities include lobbying, advocacy, working with public institutions and decision-making forums, empowering CSOs to achieve rights for women, and disseminating best practice through media and communications work.

PLAN INTERNATIONAL – LIBERIA

Plan Liberia resumed its activities in Liberia to help children access their rights to education, health and protection in 2006, following a gap of 13 years due to conflict. Its country office is based in Monrovia, with programme units in both Bomi and Lofa Counties. Plan’s work in Liberia covers five core areas:

- Increasing access to birth registration services
- Supporting the capacity of caregivers
- Improving children’s access to basic education
- Promoting gender equality
- Increasing the capacity of partner organisations

Plan Liberia is currently piloting a ‘girls’ empowerment through education’ project in Monrovia and Lofa County, which aims to provide girls with additional learning support in order to attract and keep them in school. Initiatives include training teachers in gender-sensitive teaching and improving sanitation facilities. As well as life skills training, the project also provides much needed psychological and social support to girls and mothers.

SAVE THE CHILDREN

Save the Children works in 120 countries across

the world, with a strong focus on child rights. Its programmes range from child protection to food security and education, with projects focusing on everything from grassroots aid to high-level policy change. Save the Children currently operates in eight counties across Liberia; Bomi, Bong, Gbarpolu, Grand Gebeh, Margibi, Montserrado and Nimba. Maryland County was also due to be added to the programme in 2014. Save the Children is one of the leading INGOs working with international and local partners to improve the welfare of children in Liberia. Programmes are based on the themes of health, education and protection.

Liberia is also one of the countries where Save the Children works to end FGM. The approach taken is one of women’s empowerment, delivering information and services to help women and girls protect themselves and, in turn, work against the practice. Save the Children also works at a policy level to try to change legislation, in order to ban FGM completely.

THE FUND FOR GLOBAL HUMAN RIGHTS

The Fund for Global Human Rights operates as a development partner in 19 countries. In Liberia, the Fund supports well-established human rights groups and also emerging organisations, many of which are women-led, as they develop their programmes. Many of these organisations work on issues that affect women and girls, including gender-based violence such as FGM.

Current grantees in Liberia include:

- Association of Disabled Females International (ADFI)
- Association of Female Lawyers of Liberia (AFELL)
- Defence for Children International, Liberia (DCI-L)
- Zorzor District Women Care Inc. (ZODWOCA)

UNICEF

While Liberia is not one of the 15 countries that form part of the UNFPA–UNICEF Joint Programme set up in 2008, UNICEF nevertheless works closely with the Government of Liberia, the Child Protection Network of CSOs and the National Children’s Representative Forum for the protection of all children from violence, abuse and exploitation. UNICEF collaborates with agencies at all levels to strengthen community-based protection and response mechanisms, working with child welfare committees, women, and traditional and religious leaders.

UNICEF addresses the issue of FGM in Liberia through the stated aim of enhancing ‘safe and secure environments for survivors and children at risk of violence, harmful traditional practices, exploitation, discrimination, abuse and neglect’.

UNITED NATIONS MISSION IN LIBERIA (UNMIL)

The United Nations Mission in Liberia (UNMIL) was established in 2003 to support the implementation of the ceasefire agreement and peace process following the two civil wars. An integral part of its programme in Liberia is to support humanitarian and human rights activities.

During the research for this report, 28 Too Many was made aware of an UNMIL ‘Quick Impact Project’ that took place in 2011, which attempted to reduce the incidence of FGM in Kortu Town, Montserrado County. In partnership with a local NGO called Dam Opera, the ‘Alternative Livelihood Project for Traditional Women and Zoes’ included: sensitisation activities in the community (focusing on women’s rights, forceful conscription of girls to the sande bush and FGM); the construction of a training centre; and the delivery of skills training for women and Zoes, to encourage them to abandon the practice of FGM and engage in alternative income generating activities (such as fabric weaving and soap making). However, it is understood that this project only lasted a few months and, in the absence of continued support, it is likely that the lack of funds to maintain the training for Zoes, together with the strength of local tradition, meant its impact was not sustainable.

WOMANKIND

Womankind is an INGO which works in partnership with women’s rights organisations across Africa, Asia and Latin America. In West Africa, its work focuses on enabling women to be independent, helping women to understand and use their rights, and supporting women to tackle gender-based violence. With its network of partners, Womankind works to provide long-term sustainable change for women and girls, by ensuring solutions are firmly rooted in local communities.

In Liberia, Womankind recognises that women and girls still face high levels of violence and discrimination, with HTPs such as FGM still being practised, particularly in rural areas. Womankind supports grassroots women’s organisations on these issues in Liberia through initiatives such as the Liberia Women Democracy Radio (LWDR) station set up by the Liberia Women Media Action Committee (LIWOMAC). In partnership, they are trying to expand the reach of the radio station so that more women (and men) can benefit from its educational and informative programmes and to ensure greater coverage of issues that are relevant and of interest to listeners.

WOMEN PEACE AND SECURITY NETWORK AFRICA (WIPSEN - AFRICA)

The Women Peace and Security Network Africa (WIPSEN - Africa) was established in 2006 as a women-focused, women-led Pan-African NGO with the core aim of promoting women’s strategic participation and leadership in peace and security governance across Africa. Activities take place in a structured and informed manner to take account of the specific issues in each country of operation. WIPSEN-Africa collaborates with a range of international, national and grassroots partners to enable, enhance and promote women’s leadership and rights. In Liberia, activities have included assessing the status of girls in Lofa and Nimba Counties as part of the ‘Young Girls Transformative Project’ to enhance girls’ leadership potential, peer education and community/career development.

NATIONAL AND LOCAL ORGANISATIONS

ASSOCIATION OF FEMALE LAWYERS LIBERIA (AFELL)

The Association of Female Lawyers Liberia (AFELL) is based in Monrovia and works across eight counties in Liberia. AFELL works in collaboration with other CSOs, welfare organisations and government departments to deliver training and sensitisation on a number of issues, including raising awareness and providing training for women and girls on their rights, domestic violence and rape, and how to access justice. AFELL is a current grantee of the Fund for Global Human Rights.

The issue of FGM is addressed through activities relating to HTPs. AFELL raises awareness of the harms of FGM through meetings, workshops and group discussions with a range of community members and key stakeholders, including local authorities, town and tribal chiefs and traditional leaders, as well as women and girls. AFELL also uses media channels such as posters, leaflets and radio talk shows to educate communities into recognising that FGM is a violation of women’s and girl’s rights and that it is harmful. Support for those who have undergone FGM is also included in their programmes.

CHILD RIGHTS FOUNDATION (CRF)

The Child Rights Foundation (CRF) has been operating in Liberia since 1998 and advocates child rights and protection. Alongside other grassroots organisations, the CRF is appealing to the Liberian Government to uphold the provisions of the United Nations Convention on the Rights of the Child (UNCRC) and to call a halt to FGM. At great personal risk, members of the CRF attempt to monitor the welfare of women and girls who are at risk of FGM or who have already been subjected to the procedure. The CRF has appealed to the international community to work together on this issue.

LIBERIA WOMEN MEDIA ACTION COMMITTEE (LIWOMAC)

The Liberia Women Media Action Committee (LIWOMAC) was established in 2003 as a media development organisation dedicated to the promotion of women’s rights and development across Liberia. LIWOMAC works to empower women in poor grassroots communities through the following key programmes:

- **Media** – LIWOMAC promotes and reinforces advocacy for women through the use of radio. In 2010, the Liberia Women Democracy Radio station (LWDR FM 91.1) was set up in collaboration with UN Women and Young Women’s Christian Association (YWCA) (with funding from the UN Democracy Fund (UNDEF)). It is the only radio station in the country run by women for women. It works to educate the public by highlighting issues critical to women’s rights and provides a platform for women to express their views and hold leaders to account. LIWOMAC is currently working with Womankind to increase the reach of LWDR.
- **Research** – LIWOMAC carries out studies relating to women’s rights, livelihoods, security and development. This research is used to inform its advocacy campaigns and strategies.
- **Advocacy** – its work includes activism, information dissemination, training and networking on women’s issues. To this end, LIWOMAC has worked with a wide range of partners at both international and national level, including Womankind, WONGOSOL, the Women in Peace Building Network (WIPNET), the YWCA and Action Aid Liberia.

NATIONAL ASSOCIATION ON TRADITIONAL PRACTISES AFFECTING THE HEALTH OF WOMEN AND CHILDREN (NATPAH)

NATPAH was founded in 1985 as the national committee of the Inter-African Committee (IAC). In cooperation with the Ministry of Health, NATPAH has worked to increase awareness of the

medical consequences of FGM through a number of campaigns and programmes, as in the following examples:

- Women and young people have joined the Awareness Action Group (AAG) and received training in strategies to raise awareness of the harms of FGM. By about 2010, it was reported some 70,000 people had been sensitised through this programme and around 385 girls had resisted being cut.
- Through focus groups in 2007, NATPAH reported that, by raising awareness, some 520 survivors of FGM had become anti-FGM advocates due to their negative experiences in the sande bush.
- Anti-FGM advocates talk to young people, parents and other community members in a variety of settings, including schools, churches, mosques and markets. NATPAH has also used a religious-based approach by selecting ten churches on any given Sunday to preach about the harmful effects of FGM.
- NATPAH undertakes intensive sensitisation programmes amongst the Zoes in an attempt to get them to abandon the practice. In 2002, NATPAH introduced, with IAC funding, the Alternative Employment Opportunity (AEO) aimed at offering Zoes an alternative trade. The programme has offered training and grants in soap making, tie-dyeing, crocheting and fish drying. By about 2010, NATPAH reported that 750 Zoes had abandoned the practice and benefited from this programme across eight counties in Liberia.
- NATPAH aims to link community networks, women's groups, health care providers and NGOs through a 'social network' that attempts to coordinate activities and raise public awareness.

NATPAH is headed by the prominent Liberian activist Phyllis Kimba who has been working to

raise awareness of the harms of FGM for some 20 years (see Figure 30 above). At great personal risk, she has led many activities from door-to-door visits in villages to community meetings and educational seminars. Mrs Kimba has also rescued girls from the bush schools and worked with Zoes to find them alternative livelihoods.



Fig. 33: Sewing and tie dyeing as alternative sources of income for Zoes (NATPAH)

SOUTH EAST WOMEN DEVELOPMENT ASSOCIATION (SEWODA)

The South East Women Development Association (SEWODA) was founded in 1995 and is an umbrella organisation with about 100 local women's organisations as members. SEWODA works to increase awareness of women's and girls' rights in the remote rural areas of south-east Liberia. Conditions are difficult, with villages isolated and roads in poor condition. SEWODA reports that some villages they have approached have never been visited by any organisation talking about women's rights before. As such, activists can receive threats and insults from men who claim that they are trying to turn their women against them. SEWODA works in partnership with the Carter Center and Kvinna Till Kvinna on projects in the region, and advocates an end to traditional practices such as 'Trial by Ordeal'.

TRADITIONAL WOMEN UNITED FOR PEACE (TWUP)

Traditional Women United for Peace (TWUP) is based in Lofa County and educates women about the rule of law, empowering them. TWUP, which works in partnership with the Carter Center, also organises agricultural projects to empower abused women. Led by an influential traditional leader, Mama Tumeh, TWUP discusses women's rights and HTPs at both the community and national level.

VOICE OF THE VOICELESS (VOV)

Voice of the Voiceless (VOV) was established in 2005 in Monrovia as an FBO working on women's rights, governance, democracy and peace building issues. It has been involved with raising awareness of legal instruments (both local and international), with the purpose of encouraging women and girls to defend their rights using these laws. VOV undertakes sensitisation and awareness training activities for women and girls, including those abandoned by parents and guardians and those living in ghettos. It also carries out psycho-social counselling for victims of domestic violence and rape.

WOMEN AGAINST FEMALE GENITAL MUTILATION (WAFGEM)

Women Against Female Genital Mutilation (WAFGEM) is a Liberian NGO that has embarked on a major awareness campaign aimed at sensitising women and girls to the harmful effects of FGM, based on a human rights approach. Launched in February 2014, the chief executive officer Maima D. Robinson disclosed that WAFGEM was preparing to petition the 53rd National Legislature to enact a law against FGM and also planned to campaign against FGM throughout the rural areas of Liberia, where it is most prevalent. Madam Robinson explained that FGM is a violation of human rights, and WAFGEM, as well as working to eliminate the practice, will also aim to support survivors to overcome the trauma associated with FGM. WAFGEM hopes to work alongside other NGOs with similar goals.

WOMEN IN PEACE BUILDING NETWORK (WIPNET)

The Women in Peace Building Network (WIPNET) forms part of the programme to empower local women working on human rights in Liberia, and was set up in 2002 by the umbrella organisation West Africa Network for Peacebuilding (WANEP). WIPNET activities to promote peace and reconciliation cover 11 out of the 15 counties in Liberia. Establishing networks and enabling forums for women to share experiences, to identify and articulate their vision and to implement peacebuilding initiatives are key objectives of WIPNET. Various interventions are used to achieve this, including the 'Voices of Women' project – a bi-weekly radio programme for women in seven counties – and the 'Peace Hut' initiative to provide forums for conflict resolution and discussions on women's rights.

WOMEN NGOS SECRETARIAT OF LIBERIA (WONGOSOL)

The Women NGOs Secretariat of Liberia (WONGOSOL) was established in Monrovia in 1998 to coordinate the activities of women's

organisations throughout the country. With over 104 members across 15 counties, WONGOSOL aims to build a strong network among CBOs, FBOs and international and national NGOs to press for women’s rights, stop discrimination, and promote the participation of women in at all levels of society. Partners include the Global Network of Women Peacebuilders (GNWP), the Kvinna Till Kvinna Foundation and UNMIL.

The objectives of WONGOSOL include:

- Coordinating and strengthening links at both a national and international level among organisations, members, donor agencies and the Government
- Sharing research and information
- Establishing training programmes as needs are identified
- Offering solidarity and representing members on gender and development issues
- Maintaining an information database

Through its work on gender issues, WONGOSOL has publicly denounced the practice of FGM in Liberia.

WOMEN OF LIBERIA PEACE NETWORK (WOLPNET)

The Women of Liberia Peace network (WOLPNET) originates from a bond forged among Liberian women in the Buduburam refugee camp near Accra, Ghana, in 2003. Having suffered the consequences of civil war, these women came together and WOLPNET was founded, with the primary goal to tackle violence against women.

WOLPNET is an active member of the national SGBV Task Force and engages in a wide range of programmes to promote the rights of women and girls, including advocacy, peace-building, education (including HIV/AIDS and reproductive health), vocational/skills training and economic

development through micro credit schemes and the formation of cooperatives. It operates across ten Counties – Bomi, Bong, Gbarpolu, Grand Bassa, Grand Cape Mount, Lofa, Margibi, Nimba, Montserrado and Rivercess. WOLPNET works with various partners, including Oxfam Liberia and Equality Now (with funding from Comic Relief).

WOLPNET tackles the issue of FGM through a number of interventions, for instance:

- Lobbying the Government to pass a law against FGM
- A survey taken among local communities in four counties to understand existing knowledge and perceptions of FGM, and to use the findings to plan the most appropriate interventions
- Interviews with girls aged between 5 and 18 years in Lofa, Bomi and Grand Cape Mount Counties to inform the campaign and create a platform for girls in traditional Sande communities to express their views and thoughts on the practice
- Community forums to create awareness of the legal and international instruments that are in place regarding HTPs and provide information on the dangers of FGM. These forums specifically target parents, young girls and Zoes.
- Feedback is sought from Zoes regarding how to end FGM in Liberia
- Girls’ clubs are formed to campaign against FGM in schools and communities
- Relevant institutions are involved as appropriate, including the Ministries of Internal Affairs and Health, representatives at county level and medical personnel
- Engaging media to disseminate information regarding FGM
- A periodic newsletter— the WOLPNET News Update on FGM

- The use of social media (Facebook/Twitter) to raise awareness

Though unable to quantify the success of its programmes, WOLPNET aims to engage at least ten Zoes, 25 male and 25 female parents, and 25 young people to attend each district community forum. Groups are separated to allow discussion on appropriate aspects of their traditions. Such interventions are felt to be successful in that they directly engage and educate the Zoes, and allow community members to voice their thoughts. It is reported that awareness of the negative aspects of FGM has increased through these activities.

WOMEN SOLIDARITY INC. (WOSI)

Women Solidarity Incorporated (WOSI) was established in Monrovia in 2006 by a group of women’s rights activists whose aim is to alleviate abuses and exploitation of women and girls in Liberia. WOSI works to create an environment that will enable equal opportunity, empowerment and respect for all women and girls, regardless of their location and ethnic or religious backgrounds, and to provide them with opportunities to rebuild their lives.

WOSI has become increasingly involved in opposing FGM through its outreach programmes. To understand more about perceptions and attitudes to FGM, WOSI undertook a baseline survey (funded by OSIWA), which involved training and deploying data collectors in six districts across Margibi, Bong and Nimba Counties in March—April 2013. The information collected has been used by WOSI to inform its work of changing behaviour and attitudes to FGM and to inform activities at both local and national levels. Activities undertaken in connection with the International Day of Zero Tolerance to FGM in February 2014, for instance, included:

- A workshop with local civil societies to encourage the greater coordination of efforts to stop FGM

- An inter-generational awareness forum
- Radio programmes, including a call for the Government and duty bearers to take firm action against FGM
- FGM awareness activities with young people

WOSI’s target groups include traditional practitioners, local community leaders, women, girls and boys. Appropriate information is disseminated in traditional settings using exclusive sessions for each of these groups in an attempt to reduce sensitivities around the subject of FGM.

ZORZOR DISTRICT WOMEN CARE INC. (ZODWOCA)

Zorzor District Women Care Inc. (ZODWOCA) was certified as an NGO in Liberia in 1994 and concentrates on four main areas of activity—human rights advocacy and health work, peace building and conflict management, micro credit loans, and agriculture for sustainable development. ZODWOCA works to build awareness of these issues among women in the highly traditional rural areas of Lofa County, where Sande society is deeply entrenched. Programmes address a range of issues including domestic violence, legal counselling, case referral (through AFELL), health education (HIV/AIDS) and skills training. ZODWOCA receives funding from the Global Fund for Human Rights.

ZODWOCA addresses FGM through its human rights work. Operating in very traditional communities, ZODWOCA is unable to tackle the FGM issue as a ‘stand-alone’ programme, but rather incorporates its advocacy work into ‘Human Rights Workshops’. Sensitive to local Sande traditions, ZODWOCA highlights the harm caused by FGM and the fact that it is in conflict with the rights of women and girls. By also inviting Zoes to these workshops, and recognising that they need to be offered alternative sources of income, ZODWOCA feels that it is gradually spreading the message. It aims to hold a workshop for some 40 participants (mainly women) every three months.



Fig. 34: Human Rights workshop participants (ZODWOCA)

CHALLENGES FACED BY ANTI-FGM

INITIATIVES

The foremost challenge in Liberia at present (Dec 2014) is the Ebola epidemic, which negatively impacts every aspect of life. NGOs working in Liberia have reported to us that many of their activities have been diverted to facilitating Ebola education and supporting women's lives in general.

There are many challenges faced by anti-FGM initiatives and a number of activists have faced death threats but continue to work such as Phylis Kimba, head of NATPAH, whose house was burnt down after addressing the UN about FGM in Liberia. This environment makes it difficult for organisations working on FGM to declare their specific interest and advertise their work. 'This is a very sensitive issue, and we need to make sure we are respecting the security and safety of our staff and partners', the country director of global aid agency is reported to have said (*Global Post*, 2012).

The fact that FGM takes place within exclusive societies in Liberia makes eradication efforts challenging. An obstacle for anti-FGM groups is the Zoes from the Sande societies who have a high level of control over women in their communities. There are numerous reports of forced initiation as punishment for speaking out against FGM, and young girls being initiated forcibly after the slightest accusation of breaking Sande law.

The Government is hesitant about making FGM illegal and this is another major obstacle. In 2012, they suspended the practice of Sande for an indefinite time after death threats were made to a journalist (resulting in an international outcry). The Government warned traditional leaders to adhere to the mandate, but there are no reports of any effort at enforcement. There was a further ban on Sande made in the summer of 2014, and this was due to Ebola. Liberia's Internal Affairs Minister Blamoh Nelson said the debate about FGM had been going on for 50 years and that some debates take longer than others (*Global Post*, 2012).



Fig. 35: Liberia has 66,000 miles of road but less than 7% of them are paved (USAID)

Like many African countries, there are numerous infrastructure challenges to the work of campaigners in Liberia. Lack of roads in rural areas, lack of electricity in rural communities, giving no access to computers/internet and incomplete coverage of mobile phones make communication and coordination difficult.

Lack of sustainable funding for organisations is regularly cited as being a major limitation to effective long-term programming.

CONCLUSIONS

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. We propose the following general conclusions, many of which are applicable within the wider scope of international policy and regulation and some specific to Liberia.

ADOPTING CULTURALLY RELEVANT PROGRAMMES

As FGM is a taboo practice associated with initiation into the secret women's society of the Sande, FGM programming often needs to be approached under wider categories of human rights and women's health. For example, ZODWOCA operates in traditional communities in Lofa County, where Sande society is widely practised, and therefore FGM is a vital source of income for Zoes. This makes it necessary to be extra sensitive to the strong Sande traditions for cultural and safety reasons, and for the sustainability of the programmes. In other instances, isolated rural communities visited by SEWODA in the southeast had never had talks on women's health and rights; this was a challenging situation for the organisation as their programmes were met with hostility from the men of the communities.

There is a danger in that culturally relevant programming turns into cultural relativism. Much of the focus in Liberia's work is on the rights of the child and underage initiation, with little talk of rights of the women not to be mutilated by FGM either. The inference from a lot of the commentary is that FGM is acceptable but not on children. This may be to protect NGO workers or even to allow them a space to work in communities, but programmes must not be allowed to lose sight of the larger human rights issue of eradicating FGM completely.

SUSTAINABLE FUNDING

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. Continued

publicity of current FGM practices at a global level, particularly through the UN and WHO, is crucial for ensuring that NGOs and charities are given support and resources long term. Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises. However, as is discussed in this report, FGM is a focal issue connected to these crises and directly relates to several of the MDGs.

It must be stressed that, given Liberia's current challenges with the Ebola epidemic, it is expected that resources and attention will be prioritised to preventing spread of the virus, treating patients, and rebuilding the crippled health and education sectors. It is hoped that as the country recovers from this disaster, due attention will be given to programmes related to women's health and rights, including efforts to end FGM.

FGM AND THE MILLENNIUM DEVELOPMENT GOALS

Considering FGM within the larger framework of the MDGs conveys the significant negative impact FGM makes on humanity. Stopping FGM is connected to promoting the eradication of extreme poverty and hunger, the promotion of universal primary education, gender equality, reducing child mortality, improving maternal health and combating HIV/AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience because it highlights the need for funding anti-FGM programmes and research for broader social change. There has been a momentum for change, with the UN global ban on FGM in December 2012 and the UN CSW 57 focusing on violence against women and girls, including FGM. We hope that this momentum is continued and that violence against women, and FGM, are reflected in the post-MDGs agenda.

For Liberia, meeting the MDGs next year will be unachievable due to the 2014 Ebola crisis. When

the country begins to recover and plan for future post-2015 development goals, it is hoped that FGM will be given due attention in these targets.

FGM AND EDUCATION

As of November 2014, education was stagnated in Liberia, as schools and universities were closed to prevent Ebola transmission and further deaths. When schools re-open, we recommend that the Government continues its commendable efforts to improve education, especially for girls.

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause for perpetuating social stigmas surrounding FGM as they relate to health, sexuality and women's rights. FGM can hinder a girls' ability to obtain basic education and prevents them from pursuing higher education and employment opportunities. This lack of education directly relates to issues surrounding child marriage and teen pregnancies.

FGM, MEDICAL CARE AND HEALTH EDUCATION

Medical attention is currently focused on the battle against the Ebola epidemic. The healthcare infrastructure in Liberia, which was already underdeveloped, has been dealt a severe blow and will take time to re-build. We encourage the Government and international partners to continue to provide resources, and hope that, as soon as possible, doctors and nurses return to treating patients, to avoid a major crisis in maternal and infant mortality.

For those organisations involved in health education, we applaud their efforts and hope they will be able to continue/resume programming once the Ebola crisis has ended.

FGM, ADVOCACY AND LOBBYING

Advocacy and lobbying is essential to ensure that the Government continues to be challenged on its hesitancy to criminalise FGM, and to support programmes that tackle FGM. We applaud the efforts of organisations like Equality Now, Save the Children, WOSI and CRF for their lobbying of the

Government for an anti-FGM law and encourage them to continue their work.

FGM AND THE LAW

There is currently no law criminalising FGM in Liberia, and we advocate that an anti-FGM law be enacted, and support groups lobbying to get legislation passed. Meanwhile, we encourage the Government to enforce more effective legislation related to the Children's Act, bodily harm, kidnapping, women's rights, as well enforcing regulation related to the operation of sande bushes.

FGM IN THE MEDIA

Media has proven to be a useful tool against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with media on FGM, including radio programmes by WOSI and AFELL, and encourages these projects to continue. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women's rights at a grassroots level. Moreover, greater protection needs to be provided for journalists who report on FGM.

FGM AND FAITH-BASED ORGANISATIONS

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. However, in the context of Liberia, there is little evidence to suggest that faith-based organisations are active agents for change amongst groups who practise FGM.

COMMUNICATION AND COLLABORATIVE PROJECTS

There are a number of successful anti-FGM programmes currently operating in Liberia, with the majority of the progress beginning at the grassroots level. We recommend continued effort to communicate their work more publicly and encourage collaborative projects. A coalition

against FGM will be a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success, and efforts in Liberia are headed in this direction.

The strengthening of such networks of organisations working against FGM and more broadly on women's and girls' rights, integrating anti-FGM messages into other development programmes, sharing best practice, success stories, operations research, training manuals and support materials, advocacy tools and providing links/referrals to other organisations will all strengthen the fight against FGM.

FURTHER RESEARCH

There is a need for more robust research into all aspects of FGM as a Sande initiation such as: at what age does it occur, what are the drivers for keeping the practice and what are the consequences for non-membership in modern Liberia.

Research is required to understand the trends seen in the DHS data, the decreasing level of sande membership, contributed to by underreporting of membership but the hardening of support within the current membership for its continuation.

Harmful health effects of FGM interventions would be better supported if there were health studies into the complications of FGM in a country specific analysis.

'Speaking to local organisations on the ground, it is clear that only the government can effectively take on members of the leaders of the Sande Secret society, since even grassroots organizations are too scared to deal with them. All governments which have not enacted a law banning FGM need to do so as a matter of urgency to help create an enabling environment to promote education against FGM and to ensure that this brutality is eliminated once and for all. Africa has many wonderful traditions but FGM is certainly not one of them.'

- Efua Dorkenoo

(Tecee Boley. Two Steps Forward, One Step Back. New Narratives, 2013)

APPENDIX I - LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO DEVELOPMENT GOALS AND WOMEN'S AND CHILDREN'S RIGHTS IN LIBERIA

Note: This is not an exhaustive list of all the organisations working in Liberia. 28 Too Many recognises that there are many more, particularly at a grassroots level, working on these issues.

<p>Action Aid</p> <p>Association of Disabled Females (ADFI)</p> <p>Association of Female Lawyers of Liberia (AFELL)</p> <p>Africa Peace Mission</p> <p>Africare</p> <p>Amnesty International</p> <p>Bosh Bosh Project</p> <p>CARE International</p> <p>CARMMA</p> <p>Carter Center</p> <p>Catholic Justice and Peace Commission</p> <p>Centre for Liberian Assistance (CLA)</p> <p>Child Fund</p> <p>Child Rights Foundation (CRF)</p> <p>Comic Relief</p> <p>Community Aid Liberia</p> <p>Concern Worldwide</p> <p>Dam Opera</p> <p>Defence for Children International, Liberia (DCI-L)</p> <p>ECOWAS Women in Liberia (EWIL)</p> <p>Equality Now</p> <p>Family Planning Association of Liberia (FPAL)</p> <p>Forum for African Women Educationalists (FAWE)</p> <p>Foundation for International Dignity (FIND)</p> <p>FORWARD</p> <p>Foundation for Women Liberia</p>	<p>FPAL</p> <p>Ganta Concern Women Development Association</p> <p>Guardian Care, Inc. - Liberia</p> <p>Give Them Hope</p> <p>Global Fund for Women</p> <p>Hands for Humanity</p> <p>Healthy Women Healthy Liberia</p> <p>Hope for Liberia</p> <p>Hope for the Nations</p> <p>Inter-African Committee (IAC)</p> <p>International Planned Parenthood Federation (IPPF)</p> <p>International Rescue Committee</p> <p>Inter-Religious Council of Liberia (IRCL)</p> <p>Kvinna Till Kvinna Foundation</p> <p>Liberia Coalition of Human Rights Defenders (LICHRD)</p> <p>Liberia Female Law Enforcement Association (LIFLEA)</p> <p>Liberian Women Empowerment Network (LIWEN)</p> <p>Liberia Women Media Action Committee (LIWOMAC)</p> <p>Liberian Women's Alliance (LWA)</p> <p>Living Hope Liberia (LHL)</p> <p>Mano River Women Peace Network (MARWOPNET)</p> <p>Medecins Sans Frontieres (MSF)</p> <p>National Women's Commission of Liberia (NAWOCOL)</p> <p>National Association on Traditional Practices Affecting the Health of Women and Children (NATPAH)</p> <p>National Empowerment Program for Women and Children (NEP)</p>	<p>National Women's Commission of Liberia (NAWOCOL)</p> <p>New Narratives</p> <p>Open Society Initiative for West Africa (OSIWA)</p> <p>Oxfam</p> <p>Paramount Young Women Initiative (PAYOWI)</p> <p>Plan International</p> <p>Provision of Hope</p> <p>Samaritan's Purse</p> <p>Save the Children</p> <p>South East Women Development Association (SEWODA)</p> <p>SOS Children's Villages</p> <p>Special Emergency Activity to Restore Children's Hope (SEARCH)</p> <p>Street Child</p> <p>The Fund for Global Human Rights</p> <p>The Global Network of Women Peacebuilders (GNWP)</p> <p>UN Women</p> <p>United Nations Children's Fund (UNICEF)</p> <p>United Nations Development Fund for Women (UNIFEM)</p> <p>United Nations Development Programme (UNDP)</p> <p>United Nations Mission in Liberia (UNMIL)</p> <p>United Nations Population Fund (UNFPA)</p> <p>USAID</p> <p>Voice of the Voiceless (VOV)</p> <p>West Africa Civil Society Institute (WACSI)</p> <p>West Africa Network for Peacebuilding (WANEP)</p> <p>West Point Women</p>
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Womankind

**Women Against Female Genital
Mutilation (WAFGEM)**

**Women in Peacebuilding Network
(WIPNET)**

**Women and Children Advocacy
(WOCAD)**

**Women and Children Development
Association of Liberia (WOCDAL)**

**Women of Liberia Peace Network
(WOLPNET)**

Women Passion Inc.

**Women Peace and Security Network
Africa (WIPSEN – Africa)**

Women’s Rights Watch (WORIWA)

**Women’s Secretariat of Liberia
(WONGOSOL)**

Women Solidarity Inc. (WOSI)

World Health Organisation (WHO)

World Vision International

Youth Action Network

**Young Women Christian Association
(YWCA)**

**Zorzor District Women Care Inc.
(ZODWOCA)**

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Registered Charity: No. 1150379
Limited Company: No. 8122211
E-mail: info@28toomany.org

