

Salvation or Suffering?

*Analyzing the Impact of UN Peacekeeping
Operations on Health and Safety of Women
in Post-Conflict Environments*

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Abstract

Drawing from the experiences of the United Nations Peacekeeping Mission in Liberia (UNMIL) and United Nations Peacekeeping Mission in Sierra Leone (UNAMSIL), this study examines the impact of UN peacekeeping operations on the health and safety of women and girls in post-conflict environments. By combining findings from the four indicators of access to the provision of health care, state of maternal health, disarmament of women and girls, and the prevalence of sexual exploitation and abuse, this study will illustrate that neither mission led to disproportionately better outcomes for women and girls following mission deployment.

Chapter 1

Introduction

Over the past several decades, countries across West Africa have been plagued by a contagion of devastating civil conflicts and political turmoil. From 1989 to the early 2000s, Liberia and Sierra Leone experienced startlingly violent civil wars, leaving hundreds of thousands dead and much of the infrastructure destroyed across urban and rural regions. Against the backdrop of systemic gender inequality and historically poor advancement of women's welfare in both countries, consequences for women and girls were predictably terrible, even after fighting subsided. Following years of weak, under-funded regional efforts to establish peace among warring factions, the United Nations (UN) formally intervened in the civil wars of Liberia and Sierra Leone in 2003 and 1999, respectively. As each war came to a gradual close, the UN deployed multi-dimensional peacekeeping operations to assist each country in their transitions to peace. While the UN's role in consolidating peace is often characterized as generally positive in both cases, the extent to which peacekeepers directly shaped the experiences of local women—who are disproportionately victims of war—remains largely understudied. This issue has a number of implications for UN peacekeeping overall, as the outcome of the missions in Liberia and Sierra Leone can reveal weaknesses in the frameworks that guide mission development and execution and personnel accountability. To what extent did peacekeepers improve or worsen conditions for women in Liberia and Sierra Leone? Moreover, what is the impact of UN peacekeeping operations on the health and safety of women and girls in post-conflict environments?

Building off of the experience of Liberia and Sierra Leone, I argue that, while the UN is generally effective in promoting peace, which has a number of positive implications for civilian

populations, there are practically no disproportionately positive benefits for women and girls in the aftermath of war that stem directly from the policies and practices of UN peacekeeping operations. The restored, but precarious, national security and stability that follows peacekeeping operations can create an environment conducive to the rehabilitation of damaged infrastructure, including hospitals and health care centers. In the case of Liberia in particular, the UN's presence in the conflict attracted an influx of foreign aid, which was directed to rebuilding the nation's health care sector and implementing government health plans. Both Liberia and Sierra Leone also experienced positive changes in women's health indicators throughout and following mission deployment, including a rise in life expectancy at birth and a decrease in maternal mortality rates. Though these indicators continue to lag far behind much of the world today, the relative progress could not have been made in either country in the absence of greater peace and security in the post-conflict period.

However, the UN is capable of doing more to address the needs of women and specifically target women and girls for assistance through their peacekeeping policies and practices. Furthermore, the UN Department of Peacekeeping Operations and relevant bodies can take more proactive rather than reactive steps to ensure the behavior of individuals deployed in post-conflict settings reflects an authentic dedication to peacekeeping best practices. Though some strides have been made on an organizational level through resolutions and mandates that integrate a gender perspective, most women and girls in the areas of intervention have yet to feel the impact of these strides on an individual level. For example, Sierra Leone's disarmament, demobilization, and reintegration (DDR) program failed to consider the barriers to access for women and girls and, consequently, reached a far greater portion of men than women previously in the armed forces. Additionally, sexual exploitation and abuse allegations against peacekeepers correlate with the rise

in prostitution and transactional sex that occurred across the period of mission deployment in both Liberia and Sierra Leone. As the findings from these two relatively effective missions reveal, the UN can take more active measures to promote the health and safety of women and girls in conflict and strengthen its dedication to policies and practices intended to guide the mission overall and behavior of individual peacekeepers on the ground.

Why Does This Matter?

In nations in conflict, domestic instability often perpetuates existing inequalities and issues of access, resulting in disproportionately unjust conditions for individuals in at-risk communities. Women in areas of crisis may be particularly vulnerable to such human rights violations and face existing injustices magnified by the local conditions of conflict, including inadequate access to reproductive health care and incidences of sexual exploitation and abuse. As the organized body representative of a nation, the state has a duty to protect and preserve the well-being of its citizens to ensure all are able to attain a decent quality of life. However, nations experiencing civic unrest, political turmoil, and violence face obvious challenges in maintaining the institutional structures and rule of law necessary to advance national security and human rights. While domestic forces play an evident role in shaping the local quality of life, recognition of the conflict by international actors and external attempts to facilitate peace may also shape conditions.

The UN is among the international bodies that have historically responded to ongoing domestic conflicts by devising strategies aimed at stabilizing conflict, consolidating peace, and assisting in long-term recovery and development (UN 2008: 23). In 1948, UN peacekeeping missions were established as a form of multilateral intervention intended to restore and maintain peace in nations confronting sustained conflict. Since the conception of peacekeeping, the predominant strategy has evolved from a military model to incorporate the role of police and

civilians in not only laying the foundations for sustainable peace, but also responding to humanitarian crises. Today, peacekeepers are among the global leaders of international conflict intervention, acting on their UN-mandated duty to help countries navigate the challenging journey from violence to peace. They enter some of the most fragile communities in the world and interact with countless civilians, many of whom confront continuous threats to human security and lack access to the most basic resources necessary for survival. It is, thus, critical to examine how individuals the international community trusts to enter such vulnerable communities shape the livelihood and day-to-day experiences of victims of conflict.

Though peacekeepers possess an incredible potential to advance human security in host countries, their actions can also reinforce existing inequalities and even contribute to human rights violations against vulnerable individuals, particularly women and girls. Women and children are disproportionately victims of displacement, abuse, and suffering in times of war and conflict. In fact, approximately 75% of those displaced by crises worldwide are women and children who are consequently forced to confront the life-threatening circumstances of resource deprivation and insecurity on a daily basis (Cottingham et al 2017: 301). The simplistic view of peace as the absence of conflict fails to recognize the severity and widespread nature of war's effects on individual human life, particularly on the most vulnerable populations in a given society. Thus, the specific experience of women and girls must be integrated into our understanding of peacekeeping as a successful, effective model in advancing peace as we know it in areas of conflict.

To date, few studies have successfully traced the specific outcomes for health and safety of women and girls following peacekeeping operations, due largely to inadequate or biased reporting throughout the duration of mission deployment. In this paper, I analyze the frameworks that have historically guided the development and execution of peacekeeping missions and use

data from each case to trace outcomes for health and safety of women following two operations generally characterized as successful. Drawing from UN reports, academic scholarship, and quantitative data, I present a case study of Liberia and Sierra Leone that illustrates a few key effects of peacekeeping operations on the degree of health and safety experienced by women and girls in these post-conflict settings. The variables analyzed across each case include the language of the mission's mandate, changes in major health indicators, including access to the provision of health care and state of maternal health, disarmament of women and girls, and the prevalence of sexual exploitation and abuse. I utilize my findings, in conjunction with existing literature on peacekeeping operations, to suggest ways in which the UN Department of Peacekeeping Operations can improve the policies that guide interventions such that they lead to better outcomes for the health and safety of local women and girls. The findings of this paper will underscore weaknesses in the current peacekeeping practices, particularly the failure to consider the specific needs of women in conflict, and serve as a stepping stone in strengthening the UN's existing gender mainstreaming strategy.

Methodology

Turning to the methodology of this study, Chapter 2 begins with a section outlining the most common health and safety risks faced by women in conflict, as well as the social and political factors that contribute to the escalation of such risks. Next, this chapter explores the evolution of UN peacekeeping over time and highlights existing literature on the impact of peacekeeping on the health and safety of women, identifying blank spaces where connections can be drawn between various theories and modes of analysis. Chapter 3 provides an in-depth case study of the United Nations Peacekeeping Operation in Liberia (UNMIL) and the United Nations Peacekeeping Operation in Sierra Leone (UNAMSIL). Each case study first describes how cultural gender norms

shaped the degree of equality local women and girls experienced in the host country at the time of the conflict and introduction of peacekeeping forces. Next, it offers a detailed account of the history of the conflict and subsequent peacekeeping intervention. The remainder of each case study analyzes four indicators used to determine the extent to which women's health and safety changed across the period of each mission's deployment. These indicators are access to the provision of health care, state of maternal health, disarmament of women and girls, and prevalence of sexual exploitation and abuse. As described in the Discussion section at the start of Chapter 4, the experience of these cases demonstrates the indirect impact of peacekeeping on women's health and safety and can be used to identify areas in which the UN can do more to target women for assistance and protect them from the risks prevalent in post-conflict environments. This study will culminate in a Conclusion section, which explores the implications of my findings from UNMIL and UNAMSIL for UN peacekeeping practices and explores possible strategies that can be used to better integrate the concern for women's health and safety into the Department of Peacekeeping's existing framework of intervention.

When I first chose this topic of study, I determined a number of potential hypotheses about the impact of UN peacekeeping missions on the health and safety of women in post-conflict environments. The first hypothesis was that the specific actions taken by the mission and its personnel in post-conflict environments directly result in disproportionately better outcomes for women and girls. An additional hypothesis compelling at the outset was when a mission mandate specifically acknowledges gender concerns, the country experiencing the intervention will see a greater improvement in the health and safety of women in comparison to an intervention whose mission mandate lacked gender-specific language. More specifically, peacekeeping missions that emphasize addressing issues of gender-based violence and women's insecurity may be the most

effective model for improving the lives of women in the region. Finally, I considered the hypothesis that external factors, such as domestic policy changes, social movements, foreign aid, or support for women fostered by NGOs, play a greater role in improving outcomes for the safety of women than the UN peacekeeping mission itself. Evidence from my case study demonstrates the most compelling hypothesis is that, in the case of the two relative successful missions in Liberia and Sierra Leone, the national security environment established by the mission, in turn, allow damaged health systems to rebuild, but that the actions taken by peacekeeping missions have not been robust enough to appear to have directly led to disproportionately better outcomes for women and girls' degree of health and safety.

Prior to beginning this study, I needed to first determine which mode of analysis would allow me to test specific propositions about the impact of UN peacekeeping on the health and safety of women. The first mode I considered was a largely quantitative approach utilizing statistical data compiled from many UN peacekeeping missions. However, key barriers to conducting a statistical study included limited data availability and bias from easily available measures. The nature of reporting by both foreign and local intervening forces during times of conflict poses a significant challenge to thorough data collection. Because these forces are focused predominantly on ending conflict and achieving sustained peace on a broader scale, reporting individual on-the-ground experiences is typically less of a priority and deprived of necessary logistical and financial support. The secrecy of local government agencies guided by their own best interests in the conflict may also limit the extent to which available data reflect the lived experiences of the populous. Consequently, weak or skewed reporting practices in conditions of conflict tend to compromise the integrity of the data available and pose a barrier to quantifying key variables. This absence of comprehensive data sets suggests a statistical, quantitative approach

would not offer evidence truly indicative of the experiences of women before and after conflict.

Additionally, in a statistical approach, data gathered from a diverse set of peacekeeping missions could, in turn, be used to test specific propositions and hypotheses. As there was no clear initial proposition to be tested and a limited pool of unbiased data available from the outset, this benefit of a statistical approach was not a significant determinant of my preferred methodology. I ultimately chose an in-depth qualitative case study as my mode of analysis because, while a statistical approach would have enabled theory-testing within a diverse data set, a study of a few UN peacekeeping missions can be used as the basis of more robust theory-building. So long as the specific cases being analyzed can be reasonably compared through a set of controlled variables, a qualitative case study allows for deeper exploration of the factors that drove outcomes for women's health and safety.

It is important to note that analysis in this study is driven by a conceptual distinction between positive outcomes of each case of peacekeeping as they relate broadly to successful completion of the UN mandate, and those that relate specifically to the advancement of women's health and safety. Both the UN as an organization and scholars in the field of political science often generalize cases of peacekeeping as a relative success or failure based on short-term measures to halt violence. However, this view of post-conflict peace disregards the ways in which the intricacies of a given conflict impact individual human security, which should play a greater role in shaping our understanding of these contrasting concepts. While my findings do not suggest that either case failed to consolidate peace, they show how unjust realities faced by civilian populations affected by war can complicate the broad understanding of peace as the absence of conflict. It is also important to note that, though the evidence in support of my argument is largely based in two specific cases of peacekeeping, my findings have meaningful implications for the

future of UN peacekeeping as a method of multilateral intervention. The experiences of women following two cases generally characterized as successful due to the completion of their mandates can be aggregated and used in the analysis of frameworks that currently shape peacekeeping policies and practices, particularly weak efforts to strengthen personnel accountability and implement gender mainstreaming strategies.

A second conceptual distinction contained in this study is the difference between the impact of a UN peacekeeping mission as a whole and the impact of individual peacekeepers on the experiences of civilian populations. Throughout my analysis, I do not aim to draw normative claims about the behavior of peacekeepers on an individual basis but, rather, the frameworks, policies, and practices that are intended to guide their behavior, as well as those that shape the desired outcomes for victims of conflict. The individual behavior of peacekeepers in each case will, thus, be generalized and utilized to evaluate the effectiveness of the policies that currently guide the behavior of peacekeepers on the ground. In doing so, my aim is to determine the extent to which the existing organizational framework is successful in ensuring peacekeepers fulfill their moral obligation to prevent the perpetuation of harm against civilians in the context of their specific post-conflict environment.

A key objective in the initial stage of this study was to ensure comparability of cases by controlling for confounding variables and idiosyncratic differences that may have significantly shaped the impact of the mission on women's health and safety. By choosing cases with specified similarities and points of distinction, the role of UN peacekeepers could be isolated and effectively analyzed as an independent factor in determining the degree of health and safety women experienced in their respective post-conflict environment. The similarities between the two cases specified at the outset of the case study include the geopolitical context, the mission's objectives

and point of intervention, and the nature of the conflict. The key point of distinction is the nature of the mandate, with the mandate of one mission (UNMIL) explicitly including a priority of gender mainstreaming and addressing concerns regarding violence against women, and the other (UNAMSIL) addressing the importance of advancing humanitarian assistance more generally with no clear emphasis on gender.

The two cases presented in this case study are the United Nations Mission in Liberia (UNMIL) and the United Nations Mission in Sierra Leone (UNAMSIL). Following fourteen years of ongoing civil war, multidimensional mission UNMIL was launched in September 2003 to assist Liberia in its transition to peace after the national government, rebel groups, political parties, and civil society leaders signed a ceasefire agreement and Comprehensive Peace Agreement. The mission mandate also included supporting humanitarian and human rights activities and assisting in national security reform. The mission came to a close on March 20th, 2018 and was hailed a success by the UN for effectively laying the groundwork for peace (United Nations 2018). UNAMSIL began in October 1999 under similar conditions, with a peacekeeping force deployed to help implement the Lomé Peace Agreement and establish stability after a decade of civil war characterized by hundreds of thousands of armed civilians and ongoing human rights abuses. UNAMSIL was authorized to replace the United Nations Observer Mission in Sierra Leone (UNOMSIL), which was deployed for an initial period of six months in June 1998. UNAMSIL's mission's mandate was completed in December 2005, but it was succeeded by the United Nations Observer Mission in Sierra Leone (UNOSIL) to help consolidate peace.

Following an evaluation of all major peacekeeping operations over the past thirty years, I determined that UNMIL and UNAMSIL are reasonably comparable because they share key similarities and a specified point of distinction. The first similarity is the geopolitical context, with

both UNMIL and UNAMSIL occurring in West Africa at the turn of the 21st century. I considered the context of the intervention in order to control for changes in the nature of international multilateralism and peacekeeping strategies over time, particularly since the 1960 deployment of the first large-scale mission, the UN Operation in the Congo (ONUC). Throughout the Cold War, the UN adopted a principle of “middle-power peacekeeping,” offering a means of “inoculating troubled new states against entanglement in politics of the Cold War” (Macqueen 2012: 3). However, this strategy shifted in the post-Cold War period, wherein multilateral collaboration evolved to project a new vision of intervention dominated by superpower interests in key territories, such as newly-formed states on the African continent. Steven R. Ratner highlights the evolution of peacekeeping strategies by characterizing “old” missions as military operations aimed at enforcing a ceasefire and “new” missions as more politically-oriented and focused on implementing a peace plan already negotiated (Ratner 1995).

However, this evolution of peacekeeping strategies has had a mixed impact on African peacekeeping over time. From the early 1960s to mid-1970s, the African continent was largely isolated from the global ideological competition of the Cold War and, in turn, the interests of the divided superpowers of the Security Council. Yet, as the Cold War began to come to a close in the late 1980s, ongoing conflicts in post-colonial African states entered the national interests of leading superpowers and, as a result, occupied a more significant position in “new world order” multilateralism (Macqueen 2012: 17). African peacekeeping as it is understood today started to develop in the late 1980s and grew rapidly throughout the subsequent decade. While the national interests and concerns of African states have merely played a peripheral role in shaping UN policies, conflicts across the continent have dominated the Security Council’s agenda. As the post-Cold War understanding of global security evolves to include complex issues such as terrorism,

ethno-nationalism, and organized cross-border crime, this reality is not expected to change (Akonor 2017: 30).

While all but three of the twenty-five African peacekeeping operations intervened in civil wars, the nature of intervention on the continent has been rather fluid since the first major intervention in the Congo. Norrie Macqueen notes activities of peacekeepers have ranged “from discreet observation and monitoring carried out with the lightest touches to the enforcement of outcomes by large, combat-configured forces” and goes on to suggest the many interventions in Africa have fallen at distinct points along this spectrum of two extremes (ibid 3). Thus, while interventions to consolidate and establish peace in Africa emerged as a major focus of the UN and its powerful superpowers in the post-Cold War geopolitical environment, the variety of peacekeeping strategies utilized in this time poses a challenge to categorizing African missions under a common category.

The overall mode of UN intervention in Liberia and Sierra Leone was generally comparable because, in both cases, the Department of Peacekeeping Operations’ objectives were to accompany, monitor, and legitimize regional forces that intervened prior to peacekeeper deployment. In the absence of authorized support from the Security Council, a regional external power stepped in to mitigate violence and assist with initial conflict resolution between warring factions. In both cases, the predominant intervening power was the Economic Community of West African States (ECOWAS), specifically the newly-formed Economic Community of West African States Monitoring Group (ECOMOG). ECOMOG was a formal arrangement comprised of troops from various national armies of its member states, including Ghana, Guinea, Sierra Leone, and Mali, though was predominantly supported by the Nigerian Armed Forces (Kabia 2009). ECOMOG was tasked with the responsibility of stabilizing conflict in the region and preventing

the contagion of conflict across West African borders, particularly as rebel groups started to support one another in their respective revolts (ibid). ECOMOG was deployed to Liberia in 1990 and Sierra Leone in 1997 in hopes of minimizing civilian casualties and, eventually, coordinating relevant bodies needed to broker ceasefire and peace agreements. The regional body maintained a presence until UN peacekeeping support was ultimately attracted, as it became clear ECOWAS had neither the logistical nor financial support necessary to bring a clear end to either conflict (Adebajo 2011: 16).

Another desired similarity across the two cases was the point of UN intervention. While fighting had not come to a complete end in either case, the missions intervened in the conflicts to help implement signed peace agreements and pivot each nation toward peace by implementing DDR programs and creating a national security context necessary for the return of rule of law and democratic processes. The mandates of both UNMIL and UNAMSIL expressed support for the efforts of the ECOWAS and the African Union (AU) as “bodies that laid the groundwork for UN intervention” (United Nations Security Council 2003). These missions did not intervene to exert force but, rather, to ensure the priorities established by these regional bodies would be brought to fruition, even as warring factions continued to interfere with external attempts to establish peace.

Finally, UNMIL and UNAMSIL were deemed reasonably comparable because the nature of Liberia and Sierra Leone’s conflicts were rather similar in nature. Both countries confronted inter-related civil wars as rebel warlords exploited political weaknesses within and across their borders to attain riches in the form of political will and natural resources. Liberia and Sierra Leone each confronted over a decade of civil war and ongoing violence at the hands of revolting forces, which undermined the power of local authority and threatened civic life. Innocent civilians and armed combatants—who were typically forced to join armed forces by warlords or out of necessity

as a means of survival—were in desperate need of foreign assistance to alleviate violence as death tolls and human rights abuses persisted on end. William Reno highlights the similar nature of these two conflicts in his analysis of “rule” in the form of “warlordism” in parts of the region of West Africa (Reno 1998). Reno describes that, in the model of warlordism, rulers tend to rise to power through more effective utilization of violence than their rivals, but have little interest in the control of the state “as a means of enrichment.” These warlords legitimize their exploitation of natural resources by seizing state power for material purposes, rather than for the purpose of state rule. Once they have gained material power, these warlords implement a “foreign policy” characterized by commercial agreements with private companies and individuals instrumental to their consolidation of economic dominance in the nation. Reno concludes that this form of “economic warlordism” was interconnected to the missions of Liberia and Sierra Leone, evident in the fact that the UN struggled to find a party in either nation who could take part in the meaningful dialogue needed to spearhead peacemaking.

The key point of distinction between these two cases is the role of gender in the formulation of the mission mandate and expression of gender concerns in the mandate’s language. UNAMSIL, which ran from 1999 to 2005, was established before the 2000 passing of the pivotal Security Council resolution 1325 on women, peace, and security and, consequently, did not integrate a gender perspective into its mandate. UNMIL, on the other hand, considered the gender requirements of resolution 1325 in its mission formulation and was the first UN peacekeeping mission to emphasize the importance of addressing the specific needs of women in the host country. Prior to this policy, UN practices often equated the notion of gender mainstreaming with “increasing women’s rights,” with minimal attention paid to the organization’s own limitations in advancing the quality of life for women in post-conflict environments (Nduka-Agwu 2009: 180).

Since the adoption of resolution 1325, multi-dimensional peacekeeping operations have included units dedicated to raising awareness about the role of gender, a gender advisor appointed to mission headquarters, and pre-deployment training that integrates gender awareness (ibid 182). While this landmark resolution introduced the systematic integration of gender concerns into dominant framework peacekeeping, the effectiveness of gender mainstreaming is contingent on the effort of both the Department of Peacekeeping Operations, and all mission staff carrying out the mission on the ground. A commitment to gender-responsive peacebuilding challenges both of these bodies to incorporate gender perspectives into every aspect of their peacekeeping efforts and support the efforts of NGOs and local government bodies working to include gender concerns in their rebuilding of institutions, administrative order, and rule of law. I chose this point of distinction at the outset of the study in order to evaluate whether the pivot towards more explicitly stated gender objectives in peacekeeping mandates led to improved practices or a better outcome for women in Liberia than Sierra Leone. As the findings of my case study analysis will demonstrate, the explicit inclusion of gender concerns in UNMIL's initial mandate did not produce significantly better outcomes for the health and safety of women in Liberia in comparison to women in Sierra Leone following UNAMSIL's deployment.

Chapter 2

Health and Safety of Women and Girls in Conflict

The health and safety of women and girls are among the most significant concerns in times of war and conflict. As Elisabeth Prugl notes, war and gender are inherently related and, thus, "it is difficult to 'do war' without 'doing gender' and vice versa" (Prugl 2003: 335). Though violence is dangerous in and of itself, its effects threaten every aspect of human security and have severe implications for the health of civilians, particularly women and girls in nations that already fail to

address their specific health needs due to systemic gender inequality and poor infrastructure. Insecurity in areas of conflict creates significant barriers to accessing comprehensive health and social services, compromising the right to health care for individuals in the local populations and leaving them especially vulnerable to the negative impact of poverty, hunger, and illness (Cottingham et al 2008: 301). Most deaths conflict settings are not due to direct effects of weapons and, instead, are a consequence of preventable illness, malnutrition, or lacking emergency medical care (Southall 2011: 735).

Both during conflict and in post-conflict settings, families confront the loss of their homes, weakened or absent health care, and minimal functioning health facilities with access to essential medicines. Indirect effects of armed conflicts that cause significant fatalities in mothers and children include food deprivation, the spread of disease, psychological trauma from witnessing war, and disability. Hospital settings necessary to treat such health conditions may be dysfunctional or dangerous to reach due to the conflict as well. Increasingly, patients are being targeted by warring factions through attacks on health care professionals, health facilities, and medical transport vehicles containing life-saving medical resources (ibid 737). Such attacks that prevent injured combatants from accessing health care may be engineered specifically to gain military advantage. Thus, it is clear conflicts characterized by ongoing violence against civilians interfere with local populations' ability to exercise their basic rights to health services and safe living conditions.

Such effects of conflict can be particularly damaging to the livelihood of women. For example, lack of proper nutrition and safe water supplies can be life-threatening and exacerbate pregnancy-related or childbirth complications. Unfortunately, pregnant women in settings of conflict can rarely access emergency obstetric care, increasing their risk of maternal mortality if

complications are not treated in a timely manner. With the absence of obstetric care also comes a lack of family planning options and preventive care, leading to a greater prevalence of STI transmission, unwanted pregnancies, and dangerous non-professional abortions (Cottingham et al 2008: 301). The disruption of effective and accessible health and education services to prevent such circumstances from arising is also expected in this context.

In addition to public health crises, women and children are particularly at risk of confronting the dangers of violence in the form of sexual exploitation and abuse in times of war and conflict. The World Health Organization (WHO) defines violence broadly as “the intentional use of physical force or power-threatened or actual-against oneself, another person or against a group or community that results in or has the likelihood to result in injury or death, psychological harm, mal-development or deprivation” (2018). Women and children are often the victims of sexual exploitation and abuse, a form of intentional force used against innocent bystanders made possible by the shift in power dynamics common to settings of conflict. Sexual exploitation and abuse can result in a wide range of health consequences, including sexually transmitted infections, unwanted pregnancies, unsafe abortions, chronic pelvic pain, and other gynecological problems. Long-term effects include vesico-vaginal and rectal fistulas particularly prominent in the health of victims of multiple rapes (Cottingham et al 2008). Psychological consequences can also manifest in the form of depression, anxiety disorders, lack of self-esteem, eating disorders, and sexual risk-taking behaviors (ibid 301-2).

However, it is important to analyze not just the consequences of public health inadequacies and violence against women and children, but also the social and political dynamics that enable this kind of abuse to emerge and persist, sometimes even after the initial conflict has been resolved. Hutchinson et al describe how times of conflict lead to a breakdown of social cohesion and societal

norms, which may, in turn, increase women's risk of facing negative sexual health outcomes (2017). Their analysis of women's health in armed conflict reveals a number of factors related to balance-of-power dynamics that shape women and children's likelihood of being victims of sexual exploitation and abuse. They suggest armed conflict can have a significant impact on the way women and children access and benefit from protective governance structures. The effectiveness of legislative justice mechanisms, stable governance and policing that, in theory, intend to prevent women and children's subjection to sexual violence and coercion are frequently compromised significantly in times of conflict (Hutchinson et al 2017: 3). While education is considered a protective factor in conflict, school environments in times of insecurity may actually be an additional place of risk for young women and children due to abductions by rebel and government forces or subjection to sexual exploitation and abuse in the journey to and from school (ibid 5). Finally, the persistence of fighting limits the effectiveness of institutional structures intended to protect civilians and ensure their safety.

A common consequence of weakened institutions is the use of sexual exploitation and abuse—particularly rape and human trafficking—as instruments of war. Such acts of sexual exploitation frequently target local minority populations through abduction, torture, slavery, and forced child soldiery (Southall 2011: 737). Women and girls are often vulnerable to these risks in camps, in-flight upon displacement, and even in their own homes. In addition to the trauma of the experience itself, a victim may also be shunned, ostracized, or further stigmatized for their connection to sexual exploitation and abuse (ibid 735). The fact that many perpetrators are, in fact, civilians reflects the normalization of such exploitive and violent behavior in times of conflict (Hutchinson et al 2017: 5). Local women and children may also engage in transactional sexual relations with men locally understood as powerful as a method of survival. Transactional sex often

continues in post-conflict settings due to a lack of alternative options or to provide supplemental material income, as conflict leaves countless individuals in desperate circumstances with little to no access to money, food, water, or shelter (ibid).

It is evident that the health and safety of women and children are often compromised due to local effects of conflict that limit access to health care and education, weaken institutions, alter social norms, and enable the rise of sexual exploitation and abuse. As Adibeli Nduka-Agwu notes: the outbreak of war “pre-supposes a process of social militarization, which is not limited to the fighting soldiers, but equally affects women’s lives” (Nduka-Agwu 2009: 184). The widespread normalization of violence and war within the host country significantly disrupts the social and political frameworks that are responsible for ensuring the protection of women. However, the role of outside forces in shaping lived experiences of the civilian population is an understudied topic critical to developing a more holistic understanding of the factors that contribute to women and girl’s degree of health and safety. In particular, the role of UN peacekeepers in either mitigating or worsening women and girl’s health and safety concerns should be analyzed. The remainder of this background section will provide a brief overview of the evolution of UN peacekeeping and draws attention to key efforts taken to adopt a gender mainstreaming perspective.

History of UN Peacekeeping

In 1948, UN peacekeeping was established to build forces of volunteers serving the UN and united by a commitment to maintaining or restoring world peace and security. Over the past 70 years, peacekeeping operations have developed from monitoring ceasefires to protecting civilians, disarming ex-combatants, protecting human rights, promoting the rule of law, supporting free and fair elections, and minimizing the risk of land-mines (United Nations 2018). Peacekeepers are comprised of military, police, and civilian personnel from a wide range of UN member states.

UN member states that volunteer citizens to form the personnel are known as troop-contributing countries and are compensated on a monthly, per-peacekeeper basis and host countries are the nations in which the operation will be executed. The responsibility of the UN civilian police (CIVPOL) in peacekeeping is to provide security and help establish trust of the force as an institution within the host country's population (Mazurana 2003: 65). Specifically, the CIVPOL is tasked with documenting and attempting to prevent abusive behavior in the mission area and taking steps to strengthen the local rule of law

However, Donna Bridges and Debbie Horsfall emphasize that, while there are bodies of personnel with differing functional purposes, the central framework of the missions as they exist today are based in military action (2009). Military components of peacekeeping are responsible for the supervision and enforcement of ceasefires, regrouping and disarming of forces, destroying weapons, and demining. Yet, military personnel have increasingly been contributing to the protection of civilians, including through the facilitation of safe returns of refugees and internally displaced persons, as well as the oversight of humanitarian assistance (*ibid*). It is, thus, critical to explore the mechanisms that have been established by the UN over time to shape interactions between military personnel and civilians, as they have likely shaped the impact of peacekeeping on the well-being of women in conflict settings.

The 2007 Memorandum of Understanding (MOU) and 1990 Status of Forces Agreements (SOFA) are the two key agreements developed by the UN to guide jurisdiction over the actions of military personnel. The MOU states troop-contributing countries have “the primary responsibility to investigate alleged misconduct by their military personnel,” while SOFA notes the host nation is obligated to “waive jurisdiction over peacekeepers for violations of host national law” (United Nations 2007: 1990). While intended to serve as regulatory mechanisms, the MOU and SOFA

have introduced important questions of responsibility for the actions of military personnel who cross borders to enter conflict zones armed to restore peace. Though troop-contributing countries are expected to take responsibility for military contingents stationed in a host country, there is no legal obligation and minimal incentive for them to exercise jurisdiction over their actions. This has produced a condition of peacekeeping missions in which military personnel enjoy “nearly absolute immunity” with very little concrete power for the UN to actionably enforce the standards they have implemented (Bleckner 2013: 343). The only legal mechanism of accountability the UN has over military personnel deployed in peacekeeping is repatriation. Yet, once an individual is repatriated, the troop-contributing country is not required to take hard action or update the UN on its prosecution of the repatriated peacekeeper and the UN can only request to be updated (ibid 344). A compelling rationale for these standards offered by Julia Bleckner suggests the UN has deferred to state sovereignty and incorporated immunity into the mandates of peacekeeping to secure contributions of troops from its Member States.

The UN has recognized this lack of effective accountability as one of the many factors that have contributed to impunity within peacekeepers. Bleckner suggests that this impunity “reflects and in part enables a larger culture of impunity related to sexual violence in conflict” (ibid 344). UN peacekeepers and peacekeeping operation staff earn up to 50 times more than members of the local population, producing dangerous dynamic in which mission personnel have access to basic necessities the local populous lack (ibid). The contextual circumstances of conflict, including poor governance, corruption, and weak enforcement and rule of law, coupled with a lack of accountability create an environment where many women and children resort to “survival sex,” or sexual bartering, in exchange for food or protection peacekeepers can offer them (ibid). Soldiers have been reported for contributing to sexual violence against women and children during their

deployment by exploiting prostitution, contracting and spreading HIV/AIDS, and engaging in or facilitating human trafficking. Bernd Beber et al describe transactional sex as connected not only to individual dangers of sexual exploitation and abuse, but also to broader public health concerns and risks of creating a “peacekeeping economy” whereby host nations are more focused on catering to the consumption needs of UN and NGO workers than on their own long-term economic development (Beber et al 2016: 2).

In 1998, the UN reacted to allegations of sexual exploitation and abuse and spread of STIs at the hands of peacekeepers by establishing the peacekeepers Code of Conduct. This Code requested that peacekeepers not “indulge in immoral acts of sexual, physical or psychological abuse or exploitation of the local populations or United Nations staff, especially women and children” (UN 2010). While this document intended to prevent peacekeepers from mistreating civilians, scholars later determined that the Code implied consensual acts between peacekeepers and local women would not be problematic. For example, Sandra Whitworth argues the Code ignored the consequences of sexual interactions between peacekeepers and members of local communities in both absence and presence of consent and did not adequately recognize how peacekeepers impact the rise of prostitution, spreading of STIs and women’s vulnerability to ostracism or violence within their own communities (Whitworth 2004: 13).

In 2000, UN Security Council resolution (UNSCR) 1325 was implemented in an effort to tackle ongoing impunity within peacekeeping personnel. Resolution 1325 introduced the importance of considering specific needs of women and girls in all stages of conflict management, particularly by underscoring the “consequent impact [women and children being targeted by combatants and armed elements] has on durable peace and reconciliation” (UNSCR 1325: 1). According to Bridges and Horsfall, this resolution was significant in the evolution of peacekeeping

because it addressed the two key issues of the impact of wars and conflict on the lives of women and the need to increase the number of women personnel in peacekeeping missions (2009). These scholars also interpret this resolution as the UN's recognition of the necessity to incorporate a gender mainstreaming perspective into peacekeeping operations, as it addressed the fact that the special needs of women in conflict can only be authentically understood through specialized training. The Department of Peacekeeping Operations later defined the concept of gender as "the social differences and social relations between women and men" and that "it, therefore, refers not to women or men, but to the relationship between them, and the way this is socially constructed" (UN Department of Peacekeeping Operations 2004: 45). This understanding of gender recognizes the complexity of gender relations and that gender can be experienced differently depending on the contextual conditions that underpin the environments, actions, and judgments of men and women in a given society (Nduka-Agwu 2009: 181).

The adoption of resolution 1325 had implications for key programs and institutions of the UN's global security agenda, including disarmament, demobilization, and reintegration (DDR) programs. Regarding DDR, article 13 of resolution 1325 "encourages all those involved in the planning of disarmament, demobilization, and reintegration to consider the different needs of females and male ex-combatants and to take account of the needs of their dependents" (UNSCR 2000). The nature of DDR was expanded to include inclusive eligibility criteria, increased consultations with target populations, revisions to service delivery, and greater consideration of the context of the DDR program (Basini 2013). This shift in DDR best practices came to light in the creation of the 2003 DDRR program in Liberia, which included an additional rehabilitation stage and was the first to make explicit reference to gender concerns. The effectiveness of the gender mainstreaming efforts of DDRR in UMMIL will be analyzed more closely in the case study

of Liberia in Chapter 3.

A third standard established by the UN was the creation of the 2003 “zero tolerance policy” with respect to sexual exploitation and abuse, defining such activity as “any actual or attempted abuse of a position of vulnerability, differential power, or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another” (UN 2003). This policy underscores that acts of sexual exploitation and abuse violate “universally recognized international legal norms” and prohibits specific conduct including sexual activity with children and exchange of “money, employment, goods or services for sex” (ibid). This policy characterizes such relationships as based upon inherently unequal power dynamics and, thus, behavior that discredits the integrity of the United Nations. In 2005, the Department of Peacekeeping Operations established a Code and Discipline Team tasked with training peacekeepers on the policy and process of managing allegations, later extended to all UN personnel in 2007.

In July 2004, Secretary-General Kofi Annan requested that the Permanent Representative of Jordan, His Royal Highness Prince Zeid Ra’ad Zeid al-Hussein, prepare a report for the UN Special Committee on Peacekeeping Operations formally called *A Comprehensive Strategy to Eliminate Future Sexual Exploitation and Abuse in United Nations Peacekeeping Operations*, but commonly referred to as the Zeid report (Martin 2005). Having served as a civilian peacekeeper and UN ambassador of Jordan (a major troop-contributing country), Zeid conducted a thorough evaluation of peacekeeping practices to produce recommendations for rules and standards of conduct, investigative processes, organizational, managerial, and command responsibility, accountability. In particular, the report urges troop-contributing countries to establish the legal mechanisms necessary to hold individuals accused of sexual exploitation and abuse accountable,

including formal memoranda of understanding prior to deployment and professional investigative capacity.

In analyzing the manner in which international institutions have gradually started to integrate gender-related expertise into their discourse around security, Audrey Reeves describes that such “technologies of government deployed by these institutions have increasingly turned into conscious (though often incomplete) attempts at transforming gender relations in the host country” (Reeves 2012: 350-51). She goes on to note that framing sexual exploitation and abuse as an issue of conduct or health (as standards created by the UN often do) may result in it being left out of debates informed by the lens of gender. Additionally, much of the policies and programs of the UN and international funding agencies focus on the reconstruction of physical, political, educational, and economic infrastructures, rather than on people’s lives. Though the improvement of infrastructure in post-conflict settings is a crucial building block to enhance the overall quality of life, such initiatives should be advanced in tandem with developing community capacity and collective human security (McKay 2004: 20).

Existing Literature

Existing literature in the field of political science relevant to the specific role of UN peacekeeping missions on the health and safety of women in conflict can be separated into two main categories. The first category of scholarship critiques the existing frameworks applied to explain why public health crises often correlate with continued violence. Most of this scholarship does not explore UN peacekeeping specifically and analyzes the potential connections between conflict intervention and threats to women’s well-being more broadly. However, the findings of the scholarship in this category can be utilized to understand the contextual factors independent of the intervention that may shape its impact on local women and children. For example, J.

Cottingham et al hold that sexual violence is understood as common-place in contexts of conflict, yet most countries lack the framework necessary to prevent and respond to its continuation on their own (2008). They attribute weak or absent frameworks to inconsistent monitoring of sexual violence, inadequate studies measuring the impact of certain response strategies to sexual violence, and the failure to incorporate the role of risk factors into the analysis of violence (Cottingham et al 2008: 302). Their study concludes that the provision of sexual-violence-related services is a key action that needs to be integrated into the tactics of emergency responses to humanitarian crises.

Aisha Hutchinson et al expand upon these ideas, presenting methods for how to strengthen the effectiveness of practical responses and policy measures taken by responders to improve health outcomes during or following armed conflict. They suggest an important starting point is to accept that one formula to describe risk and protection patterns cannot be generally applied to understand young women's conditions in every conflict, as the very concepts of risk and protection are dynamic, fluid, and contextual (Hutchinson et al 2017: 8). The authors claim there is not enough documented evidence to discern what kinds of decisions young women make when confronted with no positive and safe choices, raising the question: "is it possible for young women to be regarded as agentic beings while using their sexuality to access food and temporary security?" (ibid 9). Their analysis adds to the understanding of health and safety risks in conflict by considering the impact conflict can have on the processes of risk and protection, such as the role of trade-offs. Hutchinson et al argue it is important for professionals whose work includes responding to issues of conflict to recognize the interconnectedness of women's health and education, gender equality, and human rights. They suggest that, too often, humanitarian responses center around meeting the needs of basic survival for locals, with little concern for the causes of their vulnerability to risk in the first place (ibid 10). Thus, their study adds to the existing literature

by emphasizing one cannot characterize young women's experiences without considering the risks and protections they as specific to their conflict environment.

The second category of existing literature relevant to understanding the extent to which peacekeeping operations shape health and safety outcomes for women focuses on ways in which the framework of UN peacekeeping has failed to consider and integrate women's perspectives in the devising and execution of its operations. This body of literature also does not directly connect UN peacekeeping to indicators of women's degree of health and safety, as it focuses on flaws in peacekeeping practices more broadly. Scholars in this category tend to analyze high-level efforts to advance UN gender mainstreaming strategies, rather than individual outcomes for civilian women in host countries. But, the theories developed by these scholars in the field are instrumental in identifying how such flaws in peacekeeping strategies and practices may prevent an operation from directly leading to positive health and safety outcomes for local women in the aftermath of intervention.

For example, Elisabeth Porter's study suggests that, though women are active peacebuilders, their contributions are often informal, behind-the-scenes, unpaid, collaborative, and unrecognized as actual peacebuilding. Consequently, women are often excluded from formal peace negotiation processes and public, political decision-making (Porter 2007: 5). She argues it is critical that the integration of women's perspectives must go beyond coexistence and tolerance and be expanded to involve deeper notions of mutual understanding and respect. Scholar Lesley Pruitt applies a lens of feminist theory to expand upon this notion, suggesting international organizations must consider how their practices marginalize women and make them vulnerable to facing extra burdens of "second shift" work, even in the realm of the security sector (Pruitt 2007: 83). She is critical of the UN's existing framework, suggesting the organization operates with an

instrumentalist approach to integrating women that disregards underlying inequality and includes women in a manner that can be seen as “tokenistic, empty gestures that are additive as opposed to transformative” (ibid 3).

Pruitt goes on to contend that, while it is challenging to measure the potential impact women’s involvement may have, the presence of women in peacekeeping can help expose the inadequacies and biases that characterize existing practices (ibid 5). She holds that war has historically been associated with men and the masculine characteristics expected of men (ibid 18). Consequently, institutions tasked with military, defense, and security activities have traditionally been treated as “men’s property and dominated by men’s bodies, a feature that has necessarily influenced the policies, politics, and agenda of security institutions” and led to their internalization of masculine characteristics (ibid). Pruitt concludes that there has been limited progress on the UN strategies to achieve gender mainstreaming and gender balance, but that dominant approaches currently favor gender neutrality above all (ibid 9).

While they are significant contributions to the field, neither of the two dominant categories of scholarship related to the impact of peacekeeping women’s health and safety has satisfactorily determined what accounts for differences in outcomes following mission deployment. To date, many scholars have found women in war-torn nations are particularly vulnerable to facing risks to their health and safety and developed critiques of existing frameworks used to analyze public health crises of conflict. There are also a number of scholars who have analyzed internalized norms that shape UN peacekeeping practices, particularly as they relate to gender mainstreaming strategies in the Department of Peacekeeping Operations. Such theorists have also started to develop potential solutions for aligning gender mainstreaming strategies with the perspectives and experiences of both women peacekeepers, and local women in the area of intervention. However,

there have been minimal studies that draw connections between these two realms of analysis and devise theories describing how existing practices shape the health and safety of local women or how altered practices could create more a positive impact. The remainder of this paper will be dedicated to drawing this connection through a comparative case study in order to understand how peacekeepers impact the gendered aspects of human security in the post-conflict context of Liberia and Sierra Leone.

Chapter 3

Case Study 1: Liberia

In general, peacekeeping missions are considered successful when they achieve their core security objectives and prevent the contagion of conflict by reducing the prevalence of battlefield fatalities and civilian casualties. Upon its March 2018 closure, UNMIL was hailed one of the most successful peacekeeping missions by the UN and members of the international community (United Nations 2018). Across its fifteen years of deployment, the mission helped create the state of national security needed to reinstate the power of Liberian authorities and establish free and fair elections of the first woman head of state in Africa, President Ellen Johnson Sirleaf, in 2005 and George Weah in December 2017 (Liebling-Kalifani et al 2011: 3). In the aftermath of fourteen years of war and brutality, UNMIL also helped disarm civilians, attract foreign aid and NGO assistance, and respond to a crippling Ebola epidemic that further damaged an already weak health care system. In fact, UN Foundation Senior Vice President Peter Yeo noted the mission was a milestone moment for West Africa because it shows “if you invest in a partnership between the government, UN peacekeepers, and other bilateral donors, you can create a situation where you have democratic elections and return to some sense of stability” (Roby 2018). The following section will explore the impact of UNMIL on access to the provision of health care, the state of

maternal health, women and girls' involvement in Liberia's disarmament process, and freedom from sexual exploitation and abuse, most notably in the form of transactional sex.

Gender in Liberia

Across Liberia's recent history, a dominant cultural model has normalized the subjection of women's reproductive potential and labor to the control of men, particularly husbands (Fuest 2008: 206). Male dominance has operated as the predominant ideology in both private and public spheres of Liberian society. Obligations stemming from bride wealth, patrilineal social structures, and the norm of early marriage to older men have locked Liberian women and girls in an inferior position to their male counterparts. Children are considered to belong to the lineage of a husband and women may even lose access to their children and property if they seek a divorce (ibid). Particularly in the center and northwest regions of the country, socio-political relations were determined through a hierarchical order wherein elder chiefs secured power over ranked lineages (ibid). Women did have some degree of political power in this traditional socio-political structure, as they were allowed to serve as chiefs and form councils of female elders in secret gender-divided societies within the ranked lineage system (ibid).

Though women in Liberia have started to secure more power relative to men throughout the past century, the degree of gender equality individual women experience varies depending on region and status. For example, Americo-Liberian communities have long had their own socio-political structures in place that differed from the majority of Liberian society. Americo-Liberian women were not legally deemed equal to men and, at first, were restricted professionally to teaching and secretarial duties (Fuest 2008). Yet, women in this community began to occupy more positions of power beginning in the 1950s, including leadership roles in ministries and branches of government (Stanton 2006). The gender division of labor was also a key determinant of

women's roles in the pre-war period. In rural regions, "feminization" started to characterize agricultural production in the 1960s, with women taking over traditional tasks as the labor migration of men increased (Currens 1976). Unfortunately, women's relative lack of access to formal education minimized their ability to deviate from dependency on traditional roles as new openings emerged in professional sectors and only a minority of educated women could depend on male-dominated spheres for steady employment and pay (Fuest 2008). Though the roles of women gradually progressed in the decades preceding the war, Liberian women continued to confront barriers to accessing education, job opportunities, and basic services in a male-dominated society.

Throughout the fourteen years of continuous war, Liberian women assumed a variety of roles out of sheer necessity. Many women took over traditional tasks from men that became implicated in the violence, such as brick making, building and roofing houses, and clearing farms (Fuest 2008). Women and girls had to resort to becoming "bushwives," prostitutes, and even combatants, both as a mechanism of protection from violence or murder, and as a means of generating some income (Baksh et al 2005). The number of female combatants is challenging to estimate, ranging from 2% to 20% of the total fighting forces (Fuest 2008: 210). The experiences of women involved in the war were also vastly different; some were forced into sex slavery or relationships with warlords and received brutal treatment, while others rose to powerful positions within their warring factions and reaped benefits of success in a male-dominated war network (Utas 2005). Regardless of their role in the conflict, women involved in armed forces had a much harder time reintegrating into society than their male counterparts after the war. They were often seen as "damaged" and, in turn, experienced more severe exclusion and mistreatment from their communities. This treatment undoubtedly had negative consequences on the well-being of women

that survived the conflict and limited the extent to which they could participate and access opportunities in their respective communities.

Nonetheless, there are some indications that Liberia has made progress in combatting its underlying gender inequality. The women's political group, WIPNET, helped register many women voters and empowered them to mobilize in the elections of 2005 and 2011, both won by Ellen Johnson Sirleaf (Pruit 2016). President Sirleaf's government devised a number of high-level plans to advance women's rights throughout her time in office, but the scope of their implementation and reach was complicated by persisting ethnic tension within and between traditional rural and urban communities. Women in Liberia have undoubtedly secured a more consolidated role in the public sphere, comprising 31% of senior government ministers as of 2013 (Sirleaf 2013). Yet, it is difficult to measure the extent to which political gains in the public sphere have translated to greater equality in the day-to-day lives of Liberian women. Their limited access to education, job opportunities, and social services, coupled with the fact that one-third of Liberian girls become pregnant before reaching eighteen years of age, limit the extent to which they can achieve individual agency and power relative to men in their communities (Naughtie 2013).

Fourteen Years of Brutal Violence (1989-2003)

The Liberian civil wars stemmed from intertwining and multi-faceted socio-political and economic factors that produced a struggle for power among opposing warlords. Although Liberia was never officially colonized, the country had a unique experience with colonization that shaped its historical trajectory tremendously. At the start of the 19th century, descendants of freed slaves were resettled from the United States and West Indies to a territory in West Africa. These so-called Americo-Liberians founded the first African republic in 1847, which would become present-day Liberia (Dunn 2000). Though descendants of Americo-Liberians were estimated to

comprise only 6% of the population at most, this ethnic group ruled political, social, and economic life in the territory for over 130 years (Fuest 2008: 205; Basini 2013). The Americo-Liberians interacted with communities through trade, but exhibited corrupt rule in their unchecked exploitation of natural resources to serve predatory international business interests, exclusionary policies limiting the political participation of indigenous communities, and monopolization of power (ibid). Frustration with the minority Americo-Liberians' rule of over Liberian society ultimately culminated in a 1980 military coup led by warlord Samuel Doe (Basini 2013: 540). Doe's authoritarian and brutal regime subsequently ruled Liberia for nearly a decade, though the tension between various political groups continued to brew domestically and in neighboring countries of Sierra Leone and Côte D'Ivoire, where similar circumstances of corruption existed.

In December 1989, warlord Charles Taylor led the National Patriot Front of Liberia (NPFL) from Côte d'Ivoire into Nimba County, Liberia in a military coup to overthrow President Doe (Sesay 1996: 37). Doe's Armed Forces of Liberia (AFL) utilized a counter-insurgency strategy in response to the NPFL invasion, inflicting brutal treatment against the civilian population of Nimba County (ibid). Taylor proceeded to launch an armed rebellion against the AFL, which left Doe killed and the country on the brink of civil war (ibid). Violence erupted across the nation as eight militant factions emerged and battled in the streets, indiscriminately killing civilians, looting public spaces, burning villages, and displacing communities. Fighting reached the capital of Monrovia within six months of Taylor's invasion, at which point he had secured power over 90% of the nation (ibid).

From 1989 to 2003, Liberia was plagued by two devastating civil wars, which drastically destabilized the nation and resulted in humanitarian crises across every region. By 1996, nearly half of Liberia's population of 2.5 million were either internally displaced, or forced out of their

communities into neighboring nations (Swiss et al 1998). Approximately 250,000 Liberian lives were lost across the fourteen years of continuous violence (Mvukiyehe 2018: 1694). Taylor remained in power for eight years, during which he exhibited utter corruption in his poor management of the economy, rigging of elections, and use of brutal violence as a tool of suppression (Basini 2013: 540).

In 1990, the Economic Community of West African States (ECOWAS) deployed its first-ever peacekeeping force, the Economic Community Cease-Fire Monitoring Group (ECOMOG), to the capital city of Monrovia in an attempt to save civilian lives and stabilize the conflict until UN Security Council support could be attracted. The 1975 creation of ECOWAS sought to establish a Pax West Africana whereby African leaders could define their own subsystem of international law and conflict mitigation independent of UN oversight (Adebajo 2011). In the case of Liberia, ECOWAS assumed the role of mediator among the warring factions in response to growing concerns that the Security Council would not respond with sufficient action to the ongoing violence.

However, ECOWAS confronted issues related to unity, capacity, and resources, which significantly limited ECOMOG's ability to manage local crises and establish peace in the face of warring rebel forces. On July 25th, 1993, a peace agreement was reached by three Liberian parties in Cotonou, Benin. Though Taylor gave in to the political pressure to negotiate the agreement, it would later become clear that he took advantage of this temporary lull in fighting to re-arm his forces (Sesay 1996: 38). On September 22nd, 1993, Security Council resolution 866 authorized United Nations Observer Mission in Liberia (UNOMIL), which deployed 303 military-observer personnel to help ECOMOG monitor the implementation of the ceasefire and peace agreements (UN 2018). UNOMIL represented a coordinated strategy between ECOWAS and the Security

Council in which West African nations contributed the core of UN peacekeepers and political and military heads, while the Security Council primarily provided financing and political oversight when needed (Adebajo 2011: 140). The mandate of UNOMIL was renewed in November 1995 and again in November 1997, with a gradual decrease in military observers and increase in local civilian staff. Though a minor multi-lateral peacekeeping presence had been established, the civil war continued to engulf the nation and afflict a humanitarian crisis.

After delays in the peace agreement's implementation, elections were ultimately held and won by Taylor in July 1997, bringing an end to the first civil war with successful completion of UNOMIL's mandate in September 1997. Yet, the nation remained unstable and violence persisted, even after the conflict drew to its first formal close. Just two years after the election, a rebellion led by Liberians United for Reconciliation and Democracy (LURD) broke out in the northern region and ignited a second civil war in April of 1999 (Kieh 2009). Unsurprisingly, Taylor launched counterattacks against this insurgent group and fighting continued between the government and warring factions until summer 2003, when Taylor was finally forced into exile in Nigeria.

The Path to Peace

During the second civil war, women attempted to assert their rights and push Liberia towards peace as violence continued to plague the nation. When the peace process began in 2001, women united to promote peace, meeting with warlords, protesting, organizing strikes and sit-ins, and attending international peace meetings (Fuest 2008; Pruitt 2016). The Mano River Women Peace Network (MARWOPNET) and Women in Peacebuilding Network (WIPNET) had worked to expand their membership and were instrumental in integrating women into Liberia's ongoing peace process (Pruitt 2016). For example, WIPNET helped coordinate the Women of Liberia Mass

Action for Peace campaign dedicated to bringing in women from across the nation to engage in sit-ins and formal peace negotiations (UN 2010). MARWOPNET also gained observer status in ECOWAS peace negotiations and was even a signatory to the agreements reached (ibid). As peace agreements stalled through 2003, members of the Women of Liberia Mass Action for Peace actively pressured their male counterparts to remain committed to the negotiations until a peace agreement was ultimately reached (ibid).

On June 17th, 2003, the Liberian ceasefire agreement was signed in Accra, Ghana, followed by the Comprehensive Peace Agreement reached by Liberia's government, warring factions, political parties, and civil society leaders on August 18th. The Agreement formalized the end of the war and ushered in the interim National Transitional Government (UN 2018). It also included gender quotas for the Transitional Legislative Assembly, solidifying a commitment to creating gender balance in the renewed political order (Sirleaf 2009: 305). After fourteen years of continuous violence, the Liberian infrastructure, economy, and political system were in desperate need of external assistance to recover. Rebel forces had ravaged basic necessities and public health services, such as hospitals, clinics, electricity, and water sources (Lori and Boyle 2011: 455). Hundreds of thousands of Liberians fled the country during the conflict and many communities were left with helpless young people who lacked education, skills, and access to jobs (UN 2013: 13). The wounds inflicted by over a decade of violence ran incredibly deep, creating massive obstacles to post-conflict rebuilding in nearly every sector of Liberian society.

Unfortunately, Liberia lacked the capacity to respond to its nationwide devastation on its own. On September 19th, 2003, the Security Council unanimously adopted resolution 1509 establishing a multi-dimensional peacekeeping operation in response to the dire consequences being faced by civilian populations in Liberia, including refugees, displaced persons, child

soldiers, and women. Resolution 1509 authorized the United Nations Mission in Liberia (UNMIL) for a period of 12 months and asked the Secretary-General to transfer authority from the ECOWAS-led forces to UNMIL on October 1st, 2003 (UN Security Council 2003). With an initial budget of \$344 billion, the force was to consist of up to 15,000 United Nations military personnel, including up to 250 military observers and 160 staff officers, and up to 1,115 civilian police officers, “including formed units to assist in the maintenance of law and order throughout Liberia, and the appropriate civilian component” (ibid). UNMIL established its headquarters in Monrovia in October 2003 and integrated roughly 3,500 West African troops from ECOWAS as UN peacekeepers (Akonor 2017).

UNMIL as a Success

Overall, the United Nations, Liberian government, and civil society leaders consider UNMIL to be a successful mission and model for peacekeeping practices going forward. By late 2004, UNMIL and its NGO partners had assisted in demobilizing over 101,000 former fighters, including over 22,000 women and nearly 11,000 children, and collecting 28,000 weapons and 33,000 munitions (UN 2013). These forces assisted not only ex-combatants, but also porters, cooks, caretakers, and sex slaves who had been part of the warring factions (ibid). By 2013, nearly 500,000 internally displaced persons who previously resided in over-crowded camps had been safely returned home, thanks to the support of UNMIL and humanitarian agencies. On June 30th, 2016, the mission handed security responsibilities to the Government of Liberia and initiated its phased drawdown of troops (UN 2018).

UNMIL’s characterization as a success is largely attributed to its completion of the DDRR program and pivotal role in stabilizing Liberia from a political and national security standpoint, as war did not resume following the phase-out of the mission. Measuring the extent to which it was

successful in meeting its commitment to gender mainstreaming, however, is much more challenging. From its inception, UNMIL included an Office of the Gender Advisor (OGA) responsible for training incoming personnel on how to determine the impact of gender on the mission practices, particularly to ensure gender perspectives were guiding policies, evaluations, and programs. Incoming staff attended required two-day gender training sessions (Nduka-Agwu 2009: 190). While the establishment of the OGA reflects UNMIL's advancements in meeting gender mainstreaming priorities, the office suffered tremendously from staff shortages. In a research study conducted for Refugees International (RI), Sarah Martin notes the gender advisor responsible for ensuring Liberia's DDRR program included female combatants did not start work until December 2003, three months after UNMIL's had initiated the first phase of DDRR (Martin 2005). At this point, 15,000 military troops were present and the OGA only had one volunteer, who Martin describes as "too junior to have meaningful influence on leaders of the mission" (ibid 9). By 2008, the office still suffered from insufficient staffing, with only seven of nine designated positions filled (ibid).

In an effort to better integrate women into peacekeeping, the first all-female formed police unit (FFPU) was deployed from India to Liberia in January 2007. The members of the FFPU were contributed from an Indian parliamentary police organization and were expected to "act as the key bridging unit between the military component of a peacekeeping mission and lightly-armed, often institutionally weak police" (Pruitt 2016: 16; Anderholt 2012: 6). UNMIL's police force became comprised of 16.67% women and the unit was deployed for an initial period of six-months, then renewed several times (Pruitt 2016: 1). The work of the first all-women FFPU seemed to be successful, both in operational terms and its ability to break down gender norms within peacekeeping practices and in Liberia (Pruitt 2016: 47). In 2010, UNMIL conducted a study

comparing this FFPU to other predominantly-male FPU's and found the women of the FFPU saw their work more so in terms of human security than their male counterparts and expressed a stronger desire to serve as role models for local women (UNMIL 2010: 44). Domestically, Liberia saw a significant increase in the number of women in the Liberian National Police following the FFPU's deployment (Pruitt 2016). UNMIL went on to praise the FFPU as a model of peacekeeping best practices, though it is difficult to measure the number of Liberian women directly impacted by this innovative initiative (UNMIL 2010).

Access to the Provision of Health Care

Much like preceding peacekeeping operations, UNMIL was not designed to directly assist in the rebuilding of Liberia's health system or react to public health emergencies. Resolution 2116, which reauthorized the continuation of the mission, reaffirmed that "UNMIL's primary tasks are to continue to support the Government in order to solidify peace and stability in Liberia and to protect civilians" (UNSC 2013). While civilian protection was included in the mission mandate, the new resolution did not explicitly require the delivery of medical aid or other forms of humanitarian assistance and emphasized that UNMIL was to play a facilitating rather than direct role in the provision of humanitarian aid "by helping to establish the necessary security conditions" (ibid). The subsequent section will evaluate a number of qualitative studies and official reports to determine the extent to which UNMIL was successful in achieving this objective. It will also compare these findings to Liberian women's life expectancy at birth from one year prior to the war to the end of mission deployment as a metric to measure specific outcomes for women's health.

From 1989 to 2003, the civil wars of Liberia caused near-total destruction of the nation's infrastructure and produced post-war conditions threatening to human life and basic security. By the time UNMIL, humanitarian agencies, and NGOs entered the nation in 2003, Liberia's health

system was dysfunctional. Looting and destruction left hundreds of hospitals in critical condition and forced to recover from destroyed or stolen equipment, lack of electricity, little access to clean water, no communication networks, poor access roads, and inadequate supply stocks of necessary drugs. Tremendous resource scarcity throughout the war forced many health workers to seek compensation in the form of food supply instead of monetary salaries (Varpila et al 2011: 2). Large numbers of displaced individuals quickly began to move back into Monrovia after the war, doubling the city's population and quickly outgrowing its ability to offer comprehensive health care (ibid). Of the 293 public health facilities that were operational before the war, 242 were deemed non-functional in 2004 by the National Transitional Government in the *Joint Needs Assessment Report* (2004). By 2005, two years after the signing of the Comprehensive Peace Agreement, an estimate of only 40% of Liberians had access to basic health services (WHO 2005).

Though the capital city of Monrovia was slightly better off as the primary host of humanitarian aid providers, both urban and rural populations across Liberia faced the severe consequences of the weakened health system. Margaret E. Kruk et al's 2008 survey analysis of health facilities in the predominantly rural Nimba county uncovered the residual effects of this issue on the nation's second-most-populated county five years after the end of fighting. Kruk et al's study collected data from 36 clinics, three health centers, and four hospitals, over half of which were managed by NGOs and two by the government. Due to the physical distance to Monrovia, Nimba's population of over 460,000 people were dependent on nearby resources to meet their essential health needs. Unfortunately, even local accessibility was a major issue; nearly 40% of the 1,434 individuals surveyed had to walk for over two hours to reach a functional health facility (Kruk et al 2010: 529). On average, Nimba's villages were 7.2 km from the nearest health facility and individuals would have to travel 136.1 minutes on foot to reach any health services (ibid).

Kruk et al's findings reflect Liberia's overall slow rate of progress towards a fully functioning and restored health system in the post-conflict environment.

In January 2011, Lisa Marie Knowlton et al conducted a thorough evaluation of eleven county hospitals in urban and rural Liberia, which reached roughly 2.3 million individuals, or 67% of Liberia's population of 3.4 million at the time. The researchers found a number of findings indicative of the state of Liberia's public hospital facilities eight years into the period of post-conflict rebuilding. The county hospitals had 13 major operating rooms with 34 physicians—1.5 per 100,000 patients—delivering all surgical, obstetric, or anesthesia care (Knowlton et al 2013: 721). Out of the 34 physicians, only two had completed formal post-graduate specialty programs (ibid). A number of resource shortages were also identified across almost all of the surveyed hospitals, including inconsistent supplies of running water, electricity, oxygen, and blood. A continuous water supply was reported as “always available” at only two out of the eleven hospitals and only five of the hospital facilities had 24-hour electricity (ibid 725). All eleven hospitals reported blood shortages as a major barrier to providing safe emergency surgical care, largely attributable to Liberia's lack of a national blood bank and dependence on living donations for the availability of blood. Eight out of the eleven hospitals reported they had hosted outside groups, predominantly international NGOs, to help provide short-term surgical care within the past three years and the study determined the mission-supported hospitals faced fewer resource shortages as a result of this aid. Despite such shortages, the study concludes a significant volume of surgical care was being delivered across Liberia in county hospitals. However, it also reveals the critically-low density of physicians with formalized education in Liberia's public hospitals and the human resource crises that characterized the post-conflict years.

This low density of specialized physicians can be explained, in part, by the massive decrease in the number of health workers during and after the civil wars. In 1988, just before warlord Taylor entered Liberia, 3,526 individuals worked in the public health sector (MHSW 2014). Within one year of the war, the majority of Liberia's medical specialists had fled, leaving only general practitioners to meet the population's health demands. By 1998, the number of health care workers had dropped to 1,396 with an estimated 89 physicians and 329 nurses employed (ibid). By the time Liberia held its 2005 elections and inaugurated President Ellen Johnson Sirleaf, there were less than 20 physicians remaining to service a population of 3 million, as compared to nearly 237 in the pre-war health sector (Msuya and Sondorp 2005: 31).

Not only were there much fewer trained medical professionals left, but the institutional structures able to educate the next generation of health workers and grow the health force to pre-war numbers had also suffered tremendously. Ongoing violence forced training institutions to close during the fighting and reopen their doors during calm periods (Varpila et al 2011: 2). The inconsistency in education availability, limited educational resources, and lack of qualified professors in the country meant fewer individuals could complete their training and that no programs were able to match the quality of education available prior to the civil wars. By 2002, five of seven prewar schools were deemed operational by USAID and the Ministry of Health in Social Welfare (MHSW) (ibid). In 2007, out of the five operational schools still training medical professionals and nursing students, just two were equipped with sufficient and appropriate resources such as textbooks, teaching laboratories, and demonstration models. Some of the key barriers to developing well-equipped and comprehensive programs included insufficient funding, overcrowded classes, outdated curricula, and minimal regulation or capacity to train new instructors in the absence of qualified professors (Varpila et al 2011: 3).

As a result of the major flight of health care providers, weakened medical training and education, and physical destruction of facilities, post-conflict Liberia confronted a massive challenge in rebuilding its collapsed health system. In conjunction with the incapacity of domestic governmental health agencies, these factors produced a dependence on humanitarian aid to provide the most basic services across urban and rural regions. Liberia's aid-centric strategy to rebuild its health system was due, in large part, to the nation's low health care budget, with the Liberian government spending \$21 USD of total expenditure on health per capita, approximately 2/3 of the recommended spending on essential health services (MHSW 2008). NGO and faith-based aid organizations responded to the inadequacies of the health care system and the shortage of providers by entering the nation to help offer access to the most basic services and assist UNMIL's on-the-ground efforts. Within just a few years of post-conflict rebuilding, international agencies and NGOs were implementing nearly 90% of health service delivery and supporting 81% of the nation's functioning health facilities (WHO 2005; MHSW 2008). By 2007 and 2008, approximately 80% of the country's total health spending was financed by foreign donors (MHSW 2008).

Though external forces were willing and able to help alleviate civilian suffering in the short term, Liberia's local agencies recognized the need to establish a health care sector that could be sustained long-term and accessible to all. In response to the post-war health challenges, the MHSW drafted a five-year National Health and Social Welfare Plan to address immediate needs for the period of 2007 to 2011. The primary goal of the MHSW was to expand access to basic primary health care, particularly to the most vulnerable populations in rural Liberia. The Plan outlined a basic package of health services that would be provided without charge at clinics and hospitals across the nation and set a goal of ensuring 70% of clinics integrated the package by 2010 (Kruk

et al 2010: 530). The preventive and curative interventions offered in the package were crafted to target the disease burden and high rates of maternal and child mortality, while the basic health services included communicable disease control, expansion of immunizations, strengthening of emergency care, and mental health services (MHSW 2014). This Plan was succeeded by the MHSW's National Health Policy and Plan for 2011 to 2021, which has a special emphasis on creating greater equity and equal access to quality health services across Liberia.

Once again, external organizations were instrumental in supporting the MHSW in the development and execution of both health plans. The Minister of Health even oversaw the establishment of the Health Sector Coordination Committee (HSCC), the body responsible for governing the health sector comprised of UN agencies, donors, NGOs, and civil society organizations, which, to date, contributes close to half of the sector's total funding (WHO 2018). This figure demonstrates that, while the MHSW has taken important steps to strengthen and build a more robust health care sector, its dependency on foreign humanitarian aid for financial and logistical support persists.

UNMIL's Role in Shaping Civilian Health

It is important to note that a number of health care facilities were established in the UNMIL mission area with the primary purpose of addressing the medical needs of deployed UN personnel. In April 2009, the UN Office of Internal Oversight Services (OIOS) conducted an internal audit of these facilities to determine the effectiveness of the delivery of medical services to peacekeepers. The audit analyzed medical provision in all UNMIL facilities responsible for treating 15,214 personnel including eight civilian clinics; 24 military Level I clinics, which provided first aid and preventive medicine; three Level II military hospitals for in-patient treatment and surgery; and seven Level IV medical facilities, three each in Accra, Ghana and Johannesburg, South Africa,

and one in Freetown, Sierra Leone, to offer specialist medical treatment to peacekeepers not available in the mission area on required basis (OIOS 2009: 6).

Overall, these facilities rarely offered services to the local population and focused almost exclusively on the provision of medical services to mission personnel. However, the OIOS concluded the mission facilities' poor governance led to weak compliance with international standards of accepted medical facility operating procedures and resulted in negative consequences for the health of both peacekeepers and the local community. For example, the audit found chronically-ill peacekeepers had been deployed to Liberia despite their risk of spreading communicable diseases in the mission area. UNMIL medical personnel's failure to adequately identify and treat such illnesses was most likely a consequence of the incapacity and under-funding of mission facilities.

However, the audit also confirmed that a number of contingent members diagnosed with chronic and serious illnesses, such as HIV/AIDS and tuberculosis, had developed such conditions prior to deployment for mission duty. This reveals UNMIL's deviation from the norms of peacekeeping best practices, as the MOU between the UN and each troop-contributing country states that the troop-contributing country is responsible for conducting the medical examination and authorizing the clearance of its volunteer troops (OIOS 2009: 5). The UN has also established minimum standards for the medical examination of each individual peacekeepers and requires certifications to validate the findings of the evaluation. But, the audit report suggests a number of UNMIL troops had left their home countries for mission duty despite their contraction of dangerous and highly contagious illnesses, which, in turn, posed health threats to the other peacekeeping personnel and the local population they came in contact with.

In 2014, Liberia was hit with a devastating outbreak of Ebola (EVD), which significantly interrupted the nation's provision of health care and reduced the delivery of essential health services by skilled and trained staff to only 39% (MHSW 2014: 7). In response to the outbreak's detrimental effects on the health sector, the MHSW employed 1,410 additional health workers on the Government of Liberia payroll, increasing the number of public health workers to 5,537 (ibid). From 2014 onwards, the key challenges in rebuilding the health system included eradicating EVD from Liberia, reducing maternal mortality and advancing maternal health, and improving human resources for health by employing more trained workers. The outbreak forced the MSHW and aid organizations to adapt their operations in order to address the health crisis afflicting hundreds of communities across rural and urban Liberia and impeded their ability to deliver the standard of health care they had been striving towards over the past eleven years.

The EVD outbreak of 2014 sparked controversy among the international community and raised questions about the evolving role and expected duties of peacekeepers in addressing civilian crises. At this point in UNMIL's deployment, the mission was in the midst of a gradual drawdown and was planning for full withdraw and turnover to Liberian security forces by 2016 (Snyder 2014). Though military personnel had been reduced from a peak of 15,520 troops in 2006 to just 4,500 at the time of the outbreak, UNMIL had a presence in eleven of 15 Liberian counties and plenty of military and civilian contingents capable of intervening (UNSC 2014: 14; Snyder 2014). When the WHO declared the EVD outbreak a Public Health Emergency of International Concern (PHEIC) on August 8th, the disease had taken the lives of 294 Liberians (WHO 2014). By September, this number had soared to 1,459, prompting Secretary-General Ban Ki-moon to urge the Security Council to delay the drawdown and roll over the existing mandate by three months (UN Mission for Ebola Emergency Response 2014).

In response to criticism of the UN's delayed response to the EVD outbreak and resulting health crisis in West African nations of Liberia, Sierra Leone, and Guinea, the Council decided to make the best use of its UNMIL forces already present at the time of the outbreak. The Council met on September 18th and authorized resolution 2177, declaring that the "unprecedented extent of the Ebola outbreak in Africa constitutes a threat to international peace and security" (United Nations Security Council 2014: 1). The resolution called on many actors to do more to directly address the crisis, including the governments of the affected nations, the African Union, ECOWAS, the European Union, the WHO, and a number of UN Member States. It also encouraged the regional governments to lift border restrictions that had been imposed as the disease spread and expressed support of the Secretary-General's intention to "urge an exceptional and vigorous response to the Ebola outbreak," signaling approval of the creation of the United Nations Mission for Ebola Emergency Response (UNMEER) (United Nations General Assembly 2014).

In September 2014, Head of UNMIL, Karin Landgren, reported to the Security Council that the mission was working in four areas relevant to the public health emergency: "security and rule of law, logistics, communications and outreach and coordination at the central and country level" (United Nations Security Council: 7260th Meeting). Yet, it became apparent almost immediately that UNMIL's support was limited to indirect involvement in the public health crisis. The force responded to the outbreak by donating vehicles, providing medical training to local health workers, and offering public communication on Ebola prevention via UNMIL radio and community outreach (United Nations 2014). For example, doctors at PakMed Level II Hospital in Monrovia held a workshop in late July as part of UNMIL's campaign against the spread of the virus (ibid). Sixteen doctors and paramedics received certificates following successful participation in

the workshop on disease management and how to prevent the spread of the disease, quarantine patients, and use medical kits (ibid). The Liberian Government's Division of Transport received 241 new vehicles from partners and national governments, donated exclusively to enhance Ebola activities and aid in the fight against the spread of the disease (MHSW 2014: 53). Of the 241 vehicles, 26 came from UNMIL. However, after the donated vehicles were distributed across Liberia to carry out Ebola-response activities, 12 of the UNMIL-donated vehicles were recalled due to serious mechanical flaws (ibid 54).

Though the mission did exhibit attempts to offer assistance in Liberia's time of need, it did not play an active role in treating Ebola patients—aside from UNMIL personnel—and explicitly sidestepped involvement in the government's disease containment-related security plans, including quarantine population of Monrovia's West Point district. In the wake of the outbreak, many of UNMIL's troop- and police-contributing countries, including Bangladesh, China, Ghana, India, and the Philippines, openly pressured the Security Council to accelerate the drawdown of the peacekeeping operation, if not evacuate (United Nations Security Council 2014: 16). The Philippines even announced in August that it would withdraw UNMIL troops due to safety concerns (Snyder 2014). In response to concerns of the troop-contributing countries, the mission took robust measures to ensure the safety of peacekeepers and civilian staff by restricting all personnel to essential movement only and establishing an isolation center to screen for infections (ibid). Such actions reveal pressure stemming from the best interests of the troop-contributing countries certainly may have shaped the UNMIL's limited response to the EVD public health crisis.

In more recent years, the UN has promoted peacekeepers as part of a broader social mission, which may include medical assistance. But, the notion of peacekeepers as humanitarian

agents is controversial. Firstly, it raises questions about the actual duties of peacekeepers, both within the context of Security Council-authorized mandates, and the broader norms determined by the Department of Peacekeeping Operations. Secondly, the evolving role of peacekeepers may also lead to the UN over-promising and under-delivering the provision of healthcare due to limited budgets and resources (Davies and Rushton 2016). The political objectives that have been increasingly characteristic of peacekeeping operations also make it harder to maintain neutrality and impartiality and this may result in tension between peacekeepers and humanitarian agencies that try to defend the apolitical nature of humanitarian assistance. Luckily, it does not seem that these concerns significantly influenced UNMIL's ability to respond to the EVD outbreak and help Liberia as it started to rebuilding its health care sector. Though the mission did not directly implement health care plans or provide many health services to civilians impacted by war, it was able to attract international aid and help establish the national security conditions that promoted domestic rebuilding and regeneration of the demolished health care sector.

Though the outbreak temporarily interfered with the MHSW's path towards implementing its plans and policies, it is evident Liberia made progress in strengthening its health system in the post-war years. Between 2010 and 2016, the number of functional health facilities increased by 27% and the MHSW reported 682 functional health facilities had been established across the country by 2014 (WHO 2018; MHSW 2014). The accessibility of facilities also improved; the portion of Liberia's population that needed to travel over an hour to access a health facility decreased from 41% in 2008 to 29% in 2015 (WHO 2018). Finally, Liberia and its partners were increasingly able to invest in the health sector overall, reflected in the rise in per capita expenditure on health from \$21 USD in 2008 to \$46 in 2014 (ibid). As these figures indicate, Liberia made

gradual, but substantial, progress in improving the quality and access of health care available to its incredibly vulnerable populations in the post-war years.

State of Maternal Health

The poor living conditions and severe resource scarcity that characterized post-conflict Liberia produced an environment prone to the dangers of maternal mortality and morbidity. With nearly 84% of Liberians living below the international poverty line, women and adolescent girls became incredibly vulnerable to the risk of dying during pregnancy or childbirth in the years that followed the civil wars (UNICEF 2007). According to the WHO, maternal mortality is “the death of a woman while pregnant or within 42 days (or one year for late maternal death) of termination of pregnancy, irrespective of duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (WHO 1992). Historically, Sub-Saharan Africa has suffered from the highest maternal mortality rates in the world, with nations such as Sierra Leone, Niger, Chad, Rwanda, and Liberia confronting rates of maternal mortality over 1% of the total population across the past few decades (UNICEF 2009). The table below displays the average number of recorded maternal deaths in Liberia per 100,000 births each year from 1990, the second year of the civil war, until 2013, ten years after the signing of the Accra Peace Agreement and deployment of UNMIL troops.

Table 1:

Year	1990	1995	2000	2005	2013
Maternal deaths per 100,000 births	1,200	1,600	1,100	880	640

Sources: WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Years based on the estimates available.

As Table 1 illustrates, Liberia had starkly high rates of maternal death throughout the conflict and post-conflict years, particularly in comparison to the international maternal mortality ratios of 341 and 226 deaths per 100,000 births in 2000 and 2013, respectively (UNICEF 2017; World Data Bank 2014). Fortunately, these figures suggest Liberia's maternal mortality ratio started improving significantly in the post-conflict period. However, it is important to note that the maternal deaths counted are limited to the deaths that were recorded by Liberia's professional health workers and reported to the MHSW and, as a result, provide a slightly skewed representation of the frequency of maternal death. The MHSW found that only 42% of projected child deliveries were reported in 2014 and has recognized the need to address the lack of accountability measures in place to ensure all deaths are recorded in its national health plans (MHSW 2014). The decline in reported and institutional deliveries is, in part, attributable to the EVD outbreak, but predominantly a consequence of inadequate access to skilled birth attendants across the nation, coupled with various societal factors that influence urban and rural mothers' health care decisions.

Looking more closely at the socio-political and cultural context of childbirth in Liberia can help reveal the extent to which the maternal mortality rates recorded across the nation's recent history underestimated the frequency of maternal death. For example, traditional healing and midwifery are still a major part of Liberian culture and many women choose to seek traditional care over biomedical care offered in public or private health facilities. Jody Lori and Joyceen Boyle suggest rural Liberian women in particular often visit indigenous healers throughout childbearing and childbirth because they are believed to have a stronger understanding of community norms and customs than standard health workers (Lori and Boyle 2011: 469). Liberia's National Population and Housing Census of 2008 estimated that roughly 61% of births occurred in the home, while only 39% of urban births and 26% of rural births occurred in health centers and

hospitals equipped with trained professionals (LISGIS et al 2008). These data confirm that a significant portion of Liberian mothers at this time was not receiving maternal health care, delivering their children in facilities held accountable for preventing maternal death, nor reporting these horrific incidences when they occurred under their supervision. The MHSW's understanding of other aspects of maternal health—such as the prevalence of disease or contraception use—may also be tainted with errors as a result of many women's unlikelihood to visit a hospital for obstetric care.

The discrepancies between rural and urban childbirth practices, coupled with the fact that many health facilities may underreport maternal complications and instances of death to prevent repercussions, indicate the rate of maternal mortality may be higher than suggested by the figures in Table 2. Yet, the significant decrease in the maternal mortality ratio reported over the past several years suggests the situation is improving and that Liberia has made strides in addressing the specific needs of pregnant women and mothers in the post-conflict period. For example, access to contraception is also a key factor in advancing women's health and preventing maternal deaths and Liberia's contraceptive prevalence rate has been gradually increasing over post-conflict years, rising from 11% in 2007 to 19% in 2013 (MHSW 2014: 20). However, the unmet need (36%) for family services is still rather high and, unfortunately, an exacerbation of inequity in access between rural and urban Liberian women persists (*ibid*). Though Liberia has improved in addressing maternal health concerns, greater access to family planning and contraceptive methods is especially important to help reduce maternal mortality rates and empower women with greater fertility control.

In any society of the world, the interplay of disease, limited access to basic emergency obstetric services, low utilization of family planning services, unskilled birth attendants, delays in

or weak emergency referral systems can pose life-threatening risks to pregnant mothers. Rampant instability and the dire consequences of poverty that threaten basic human life in post-conflict nations exacerbate key barriers to seeking care for pregnant women, on both a systemic and individual level. In Liberia, specifically, the majority of maternal deaths have been due to postpartum hemorrhage, obstructed or prolonged labor, complications from unsafe abortions, eclampsia, malaria, and anemia, and some women are more at risk of confronting maternal mortality than others (MHSW 2014). While fertility rates are higher in rural areas of Liberia and nearly double for adolescent girls in rural areas than those in urban areas, health facilities with specialized obstetric care are typically far less accessible to rural communities (Knowlton et al 2013: 722). As a result, the groups of women who historically bear the most children in the nation are also the least likely to receive adequate maternal health care, making it even more imperative that Liberia addresses its maternal mortality crisis.

The point at which pregnant women seek care plays a pivotal role in determining the outcome of childbirth or pregnancy complications that arise during childbearing. S. Thaddeus and D. Maine's seminal Three Delays Model identifies the main operational factors that may lead to maternal death as delays in: deciding to seek care, reaching an adequate health facility, and receiving adequate care once at the health facility (1994). Application of the Three Delays Model is key to understanding the high rates of maternal mortality in Liberia during the civil war and in the post-conflict period of rebuilding the incapacitated health system. The first delay of deciding to seek care is particularly relevant, as many Liberian women would, and still do, opt for traditional or in-home care rather than specialized obstetric treatment. Rodolfo Carvalho Pacagnella et al note that the majority of women who develop pregnancy complications have no recognizable risk factors, making the duration of time between identification of the complication and its subsequent

treatment critical in determining the mother's fate (Pacagnella et al 2012: 156). While traditional healers and midwives can certainly address pregnant women's needs and be a strong basis of support, the functional health facilities that are sufficiently equipped with resources can handle more severe cases that require testing for particular diseases and infections, or emergency surgical intervention. In Knowlton et al's survey of 11 county hospitals, obstetric surgical cases constituted 50% of total operation cases, illustrating that complex pregnancies continued to occur regularly across the nation and required specialized care (Knowlton et al 2013: 726).

The delay in reaching an adequate facility posed another challenge for women in post-conflict Liberia, as long distances, poor roads, and lack of transport options made facilities hard to access for both regular check-ups and critical appointments for delivery or emergency care. The combination of long walks and waiting times in a clinic meant an appointment could take the entire day and this known reality became a deterrent for both rural and urban women (UNICEF 2016). In regions with unpaved or rugged roads, the six-month-long rainy season could further obstruct access to facilities, as many roads turn to soggy mud and prevent even well-equipped vehicles from navigating them successfully (ibid). Liberia's Demographic and Health Survey (DHS) reflected the impact of travel difficulties on women's likelihood of seeking care, with nearly 70% of women naming distance to facilities as a major barrier to access (LISGIS et al 2008). Thus, the gradual creation of greater access to essential and emergency maternal health services for both urban and rural women in Liberia is likely to have played a role in decreasing the rate of maternal mortality in the post-conflict period.

Disarmament of Women and Girls

Disarmament, demobilization, and reintegration programs (DDR) primarily implement measures necessary to ensure civilians can return safely to a state of non-violence in their

communities and prevent ex-combatants from re-sparking violence once precarious peace has been secured. Though men comprised the majority of Liberia's warring factions, women occupied diverse roles throughout the fourteen-year conflict and were in critical need of assistance as they navigated the path to reintegration into civil society. Due to the variety of ways in which women and girls contributed to the war and lack of self-reporting of involvement, DDR programs in civil conflicts can fail to adequately meet the specific needs of women that differ from those of ex-combatant men (De Watteville 2002; Mazurana and McKay 2003; Farr 2002). However, Liberia's disarmament, demobilization, rehabilitation, and reintegration (DDRR) program was created after the UNSCR 1325 established gender mainstreaming requirements for peacekeeping and was the first to explicitly reference gender concerns, symbolizing a shift towards greater inclusion of women in post-conflict rebuilding (Basini 2013). But, did this explicit concern for women's experiences amount to disproportionately better outcomes for women and girls following the implementation of Liberia's DDRR program? The remainder of this section will analyze the strengths and weaknesses of the gender mainstreaming efforts spearheaded throughout the six years of Liberia's DDRR program.

The Comprehensive Peace Agreement of 2003 authorized the DDRR program for an initial period of December 2003 to June 2008, expanding upon the traditional DDR model to include a specified stage of rehabilitation prior to reintegration. The program was divided into two phases. Phase one included disarmament and demobilization from December 2003 to November 2004, while phase two encompassed rehabilitation and reintegration and ran from November 2004 to June 2008. An additional step of the program, the residual caseload program, was added in July 2008 to meet the needs of 7,000 additional cases, which were not reached in the initial attempt at reintegration. This residual caseload program ran until April 2009, during which time 38% of

participants were women (Tamagnini and Krafft 2010). In the disarmament phase, 101,495 ex-combatants participated, including 22,000 women (Jennings 2008: 20). Demobilization occurred in eight different sites that offered separate facilities for men, women, girls, and boys (Basini 2013). Roughly 88% of phase one participants moved on to phase two, which included education and vocational skills training and cash payment each month (Escola de Cultura de Pau 2009). UNMIL's Joint Implementation Unit oversaw much of the planning and implementation and coordinated with international humanitarian organizations to execute DDRR programming (Paes 2005). Furthermore, the mission coordinated with other UN offices present in the country, including the United Nations Fund for Women (UNIFEM), UNDP, United Nations Population Fund (UNFPA), and UNICEF (Basini 2013).

In her analysis of Liberia's DDRR program, Helen Basini highlights key weaknesses in both top-down and bottom-up indicators of gender mainstreaming in the program. She considers the overall gender sensitivity of the planning, design, and coordination of the program in conjunction with findings from interviews with 59 ex-combatant women—a mixture of those that took part in DDRR and those that self-demobilized—throughout various phases of the 2004-2007 main program and residual caseload program in 2008-2009 (Basini 2013). Basini contends that, while the program devised an agenda very much in alignment with the gender priorities of the resolution 1325, the disarmament and demobilization stages of the program did not sufficiently embody the program's expressed dedication to gender mainstreaming. Firstly, UNMIL did not have a gender advisor throughout the duration of the DDRR's planning process, which led to many of the gender concerns and lessons learned from previous DDR experiences, including that of Sierra Leone, to be disregarded in the early stages (O'Neill and Ward 2005: 50).

Though UNMIL representatives ensured the program sufficiently allocated resources needed to reach women ex-combatants, the Office of the Gender Advisor (OGA) appears to have never been given a budget (ibid). James Pugel also raises the concern that the lack of baseline data gathered prior to the start of the program meant there was no way to monitor and evaluate the extent to which the program actually met its goals, including gender mainstreaming objectives (Pugel 2009: 76). In addition, Basini notes the DDRR program did not appear to utilize the expertise of the many women in Liberia who had been instrumental in the peace process. The contributions of NGO leaders were reportedly rejected throughout the planning stages, including that of Nobel Peace Prize-winning activist Leymah Gbowee from the WIPNET (Gbowee and Mithers 2011). Rather than integrating the voices of Liberian women, UNMIL introduced “experts” from Sierra Leone and Kosovo and rushed to begin the program by the end of 2003 with minimal regard for gender mainstreaming (UNIFEM 2005: 2).

Furthermore, the 2003 program initially included a “no weapons, no entry” rule, which would have interfered with the eligibility of many women, and only offered the option for women to register as “camp followers,” thereby excluding the women who actively took part in armed fighting (Basini 2013). Luckily, the OGA at UNMIL managed to revise these recruitment criteria before the program was officially launched in 2004 and expanded it to allow women with no weapons to register under the title of “women associated with fighting forces” (UNMIL 2010: 12). Though this nature of the program certainly enabled more women to participate (21,086 total), the influx in participants had not been accounted for prior to budget allocation and resulted in resource constraints, forcing the demobilization stage of phase one to be shortened from two weeks to five days (Basini 2013: 544).

On the other hand, some positive progress was made to address the gender mainstreaming priority of the DDRR program. Aisha Fatoumata (2005) notes UNMIL's OGA conducted assessment missions intended to monitor phase one of the DDRR program in six locations and their findings were shared with partners in the mission area. The OGA and Ministry of Gender and Development also oversaw a country-wide sensitization program, which did, in fact, integrate WIPNET's capacities and contributions. The campaign engaged in consultations, radio broadcasts, and print media coverage to encourage women to participate in the program and benefited from WIPNET's ability to raise wide-spread awareness through its network of women and birth attendants, in particular (Basini 2013). This effort was of critical importance, as Basini's interviews uncovered a trend among local women having received inaccurate and negative information about the program and, hence, avoided UNMIL assistance in disarmament and attempted to reintegrate on their own. The women interviewed cited the possibility of stigmatization and practical barriers, such as not meeting the "no weapons, no entry rule," which did not even exist once the program commenced (ibid 546). While this kind of misinformation may have deterred some women and girls, the high participation of women in the program proves this was not the case universally. Yet, the fact that this gender sensitivity campaign appeared to be UNMIL's only clear attempt to coordinate with women's community groups suggests the mission may have been wary of working with civil society groups, or unable to provide the resources needed to engage with the many groups that were vital to the reintegration of women into Liberian society.

Thus, UNMIL exhibited mixed attention to gender concerns throughout phase one and took a number of reactive measures in the moments when the program obviously wavered from the priority of gender mainstreaming. Following successful demobilization and disarmament, the

rehabilitation phase of DDRR aimed to include psychological counseling and reconciliation efforts that specifically considered the experience of women ex-combatants. Drawing from interviews with 59 ex-combatants, Basini suggests the reintegration phase focused more so on teaching women how to be “good citizens” than on addressing their unique psychological conditions in the aftermath of war (ibid 551). Turning to the final stage of reintegration, Basini observes that, though the skills training offered had a positive economic impact on women participants, it was gendered in nature and developed in a “default male” context (Basini 2013; Jennings 2009). A key weakness identified was the failure to conduct sufficient job market analyses, which would have enabled planners of the program to realize many of the skills training offered to women required significant capital and materials to serve a functional purpose in their lives once they transitioned to day-to-day life as tailors, masons, bakers, or auto mechanics. Though the RR phase reached roughly 88,000 ex-combatants total, it is challenging to measure the effectiveness and tangible impact of this wide-spread programming on the lives of women in the absence of a more thorough investigation into their daily experiences in post-conflict Liberia.

Prevalence of Sexual Exploitation and Abuse

In conflict settings around the world, the effectiveness of legislative justice mechanisms, stable governance, and policing intended to protect women from being subjected to sexual violence or coercion is often compromised. The prevalence of gender-based violence and the victimization of women have characterized recent conflicts in West Africa, including the civil wars of Liberia and Sierra Leone. Both Liberian civil wars were plagued with high rates of rape and gender-based violence against civilians, particularly as the armed forces utilized forms of sexual exploitation and abuse to brutalize recruits and create division among families. There is evidence of the armed forces on both sides abducting girls, using women as “bush wives” or sexual slaves, and even

pressuring child combatants to rape their mothers and sisters (Martin 2005: 3). Women accused of belonging to a particular ethnic group or being affiliated with a fighting faction—including women who were forced to cook for soldiers who seized their villages—were at an increased risk of facing physical violence and attempted rape (Swiss et al 1998: 628). Because the fighting factions of the Liberian civil wars were largely divided along ethnic lines, civilians were brutally confronted by soldiers and forced to identify their ethnic group by speaking their native tongue frequently (ibid). Both women and men could be victims of violence in such instances, though it is unclear if individuals from particular ethnic groups were at heightened risk. Within the context of ongoing instability across urban and rural regions of Liberia, such human rights violations persisted throughout the fourteen years of fighting and typically went underreported and unaddressed amidst such chaos.

Rawwida Baksh et al describe the prevalence of violence against women in conflict settings as reflective of the ways in which armed conflicts have transitioned over history from battlefields into local communities and the homes of non-violent civilians (2005). They note that the “expressions of frustration—economic and social—in armed conflict take on forms that are gendered,” particularly in the mobilization, training, and deployment of troops, and in the way in which armed conflict is experienced by non-combatant men and women (Baksh et al 2005: 14). The scholars argue the use of rape against women in wartime reveals the destructive impact of certain aspects of boys’ socialization in peacetime within their given society (ibid 23). The problematic nature of their socialization is revealed in the establishment of hierarchical systems within armed forces and militaries that promote dangerous ideals of men as strong and hyper-masculine and have gendered impacts on their local community.

In periods of rampant conflict, large populations of young men often move to urban areas in search of work and turn to violence to support their basic subsistence. Consequently, they become immersed in military culture and fall victim to its harmful norms of masculinity. Military life and culture traditionally focus on the separation between public and private life which, in turn, removes combatants from their social networks and leads to a gendered division of labor within familial and communal structures. In this context, the development of extreme types of gender stereotyping allows hyper-masculine ideals to extend beyond the individual, permeate communities, and promote women's subordination. The harmful impact of these norms, coupled with the break-up of social networks in times of conflict, can make women even more vulnerable to abuse. Kelly Neudorfer describes "uprooting of large groups of people such as the case with IDPs results in a breakdown of the social networks," which otherwise function as both a place where one can watch out for others, and provide a net of support if an individual needs it (Neudorfer 2014: 5). Women in conflict are often victimized as objects of war and used for their productive labor, reproductive potential, or ability to offer sexual favors, and can even be transferred between factions as assets (Baksh et al 2005: 23). Depending on local social norms, women who are victims of sexual exploitation and abuse may be at risk of being killed by their family or members of their community due to loss of honor, chastity, or marriageability (ibid 24).

This unfortunate reality perpetuated in conflict settings has a residual effect in post-conflict society and, as a result, shapes the nature of interactions between locals and external forces. The internalization of dangerous norms of male dominance and women's subordination throughout the duration of the conflict has been found to influence the behavior of peacekeepers upon deployment (Prugl 2003; Martin 2005; Defeis 2008) Peacekeeping personnel enter areas in which the social fabric has been damaged due to civic conflict, wavering concern for human rights, and minimal

adherence to the rule of law. They occupy a position of trust in the host state; yet, it is unsurprising that they may abuse this trust and take advantage of their relative power when interacting with the local population during mission deployment (Defeis 2008: 202). In response to the asymmetrical power relations between peacekeepers and local populations, the Zeid report emphasized the United Nations “should not in any way increase the suffering of vulnerable sectors of the population, which has often been devastated by war or civil conflict” (UN General Assembly 2005: 8). But, the sexual exploitation and abuse allegations against UNMIL peacekeepers during deployment displayed in Table 3 reveal peacekeepers did, in fact, violate the standards set in the Zeid report and contributed to the prevalence of sexual exploitation and abuse in post-war Liberia.

Table 2: *Sexual Exploitation and Assault Allegations Against UNMIL Peacekeepers*

Year	2006	2007	2008	2009	2010	2011
Allegations	71	12	15	18	15	12

2012	2013	2014	2015	2016	2017	2018
9	7	5	6	7	8	5

Sources: United Nations (2019). Years based on the allegations publically available.
Available from: <https://conduct.unmissions.org/sea-overview>

The risk factor of a subculture of sexual violence in the mission environment could offer an explanation for the high number of sexual exploitation and abuse allegations against UN personnel at the outset of the time frame (Table 2). Though reported instances of allegations against peacekeepers decreased from 2006 onwards, UN public data indicates a number of cases were still brought to the attention of Conduct and Discipline Unit (CDU) of the Department of Field

throughout the duration of mission deployment. Despite the fact that there were fewer than ten allegations against peacekeepers per year starting in 2012, a number of studies evaluated in the remainder of this section reveal that the number of allegations are a gross misrepresentation of the frequency of sexual exploitation and abuse and not fully reflective of the nature of peacekeeper-civilian relations in Liberia.

The prevalence of sexual exploitation and abuse is likely a consequence of power dynamics inextricably linked to the interplay of mission corruption and contextual conditions of poverty and desperation. In 2007, roughly 84% of Liberians lived under the poverty line and, by 2010, 90% of the Liberian population still lacked a secure source of food (UNICEF 2007; Reddick et al 2010: 17). With UN peacekeepers and peacekeeping operation staff earning up to 50 times more than locals, the extreme disparity between their degree of access to sufficient means of survival and those of the local population can give rise to harmful power dynamics (ibid). Peacekeeping personnel enter poverty-stricken post-conflict zones and may quickly recognize members of the local population are willing to exchange sexual favors for money or food, merely to survive. The resulting power imbalance also limits women and girls' ability to control the terms of their interaction with foreign forces. For example, they may not feel able to negotiate condom use and, in turn, give into the preferences of the peacekeeper and increase their risk of pregnancy or contraction of a sexually transmitted infection (Bleckner 2013: 243).

In addition to official allegations of sexual exploitation and abuse against peacekeepers, the day-to-day exchange of transactional sex between local women, children, and peacekeepers was another problematic aspect of Liberia's post-conflict path to peace and order. For generations, transactional sex has been so common across Sub-Saharan Africa that women affected by it rarely self-identify as sex workers and may even argue sex work demonstrates a sense of agency as a

way to gain enough material means to survive (Beber et al 2016). However, it is important to recognize that the factors that lead to local women engaging in sexual acts in exchange for money, favors, or gifts are interconnected with broader issues of public health, economic development, and power dynamics between local and foreign communities. Such factors include severe economic deprivation, peer pressure, pressure from parents, seeing other children with material things, and risk-taking activities as a consequence of boredom (UNHCR and STC 2002: 11). Local post-conflict conditions, coupled with peacekeeping military culture of occupational stress and isolation, excessive alcohol consumption, boredom, and impunity, can lead to unprotected sex and the spread of STIs and HIV/AIDS between UN personnel and locals (Higate 2009). To suggest participation in commercial sex industries in post-conflict environments is rooted in a sense of agency disregards the way in which the hyper-masculinity contained in peacekeeping culture aggravates the economic pressure local women experience and shapes the decisions they will make when in the presence of foreign personnel.

A 2002 report conducted by the United Nations High Commissioner for Refugees (UNHCR) and UK non-profit Save the Children (STC) surveyed 1,500 individuals in West African refugee camps to determine the prevalence and nature of sexual violence and exploitation of refugee children in Liberia, Sierra Leone, and Guinea. The report found an extremely low “exchange rate” for sexual services between local girls and perpetrators of sexual exploitation, with girls in Liberia receiving as low as 10 US cents for each exchange of sexual favors (UNHCR and STC 2002: 10). In the context of Liberia’s severe resource scarcity, this sum was barely enough for a full meal and could afford girls a couple of pieces of fruit or a handful of peanuts (ibid). Across all three West African conflicts, payment was more often in-kind than in cash and typically in the form of essential goods, such as a few biscuits, a bar of soap, plastic sheets, clothes, shoes,

books, or pencils (ibid). The report also uncovered that, though members of local communities were aware of and concerned by ongoing sexual relations between girls and peacekeepers, many parents felt exploitation of their daughters was the only option to make ends meet for their families and did little to interfere with the continuation of such relations (ibid). This reality reveals the exploitative nature of sexual relations between peacekeepers and locals that resorted to offering their bodies in return for resources merely to survive.

In 2012, Beber et al conducted a survey analysis of 1,381 households in Monrovia by gathering data from 475 women age 18 to 30 to determine whether there was a stable transactional sex market present in Liberia prior to the arrival of UNMIL troops. The researchers aimed to create a comfortable environment for the local women surveyed and sent an all-female team of Monrovia enumerators to conduct verbal interviews with their randomly-selected subjects. Beber et al found that over half of the women sampled had engaged in transactional sex and 44% had done so with UN personnel, corresponding to 78% of those who had engaged in transactional sex overall (ibid 1). The most commonly cited form of payment was money, with over 92% of women having reportedly received money in exchange for sex. The study concludes that a conservative estimate “links each additional UNMIL battalion, which consists of about 1,000 troops, to a 3% increase in the probability that a woman will engage in her first transaction sex in a given year, with an estimate rising to 6% for a battalion of African troops, which have generally made up the majority of forces in Monrovia” (Beber et al 2016: 3). Using this mathematical estimate, the study estimates over 12,000 women in Monrovia entered the transactional sex market who would not have done so in the absence of UNMIL peacekeepers (ibid). While it is possible that the growth of the transactional sex market across the period of UNMIL’s presence was coincidental, the large-scale participation of well-paying UNMIL personnel in the market suggests otherwise.

The findings of Beber et al's study suggest UN personnel exploit the vulnerability of the population they are deployed to protect and can even deepen the traumatic effects and psychological impact of the conflict. Jennings et al (2009) found that peacekeepers in Liberia defended their participation in the transactional sex market by claiming they engaged in behavior that would have been unacceptable in their home countries, but was considered normal in Liberia. The scholars note this view of transactional sex markets promotes stereotypes about the local population as "naturally" subservient or not guided by the same kinds of moral standards that would prevent them from exchanging sex for material gains in a post-conflict environment (Jennings et al 2009: 9). Holding such opinions of the local population likely makes the existence of a relatively robust sex industry in Liberia appear organic to the international community, rather than a problem inherently linked to lacking economic opportunity, power inequality, and violence (ibid). The "sex for help" culture that tends to emerge in post-war communities due to resource scarcity may have reinforced the international community's understanding of sex work as a commonly occurring aspect of Liberian society, rather than a market growing in response to the increased presence of foreign troops.

The work of Jennings et al reveals the prevalence of sexual exploitation and abuse and transactional sex in post-conflict settings is, in part, a consequence of the broader issue of peacekeeping economies. Their analysis contends that peacekeeping economies result when mission deployment spurs short-term economic development and the creation of local infrastructure tailored to meet the demands of peacekeepers, including restaurants, bars, clubs, or brothels. Such economies are often well-developed in urban areas and capital cities that supply mission headquarters, such as Monrovia, and include those who are employed formally or informally by the mission, and any individual who is not employed by the international personnel,

but whose livelihood is contingent on their presence and local economic contribution. Often, the peacekeeping economy is the condition under which locals have their main, and, sometimes only, contact with UN personnel and tends to result in a gendered division of labor, as unskilled and service sector jobs or sexual service providing become disproportionately considered “women’s work” (Jennings et al 2009: 8). These economies are “characterized by, and to a certain (unquantifiable) extent dependent upon, the sexual availability of local residents for international actors: whether freely, for a contracted fee, or some form of in-kind payment(s)” (ibid 9).

Due to widespread and diverse sex work across these economies in the form of individual encounters, contractual sexual relations in establishments like brothels and massage parlors, and organized trafficking, peacekeepers may leave a distorted economy following personnel phase out, with over half of local women dependent on trading sex to support themselves and left with no means of income in the aftermath of the mission (ibid). The positive stimulus effect of peacekeeper presence on the local economy has harmful consequences for local women that are often overlooked by both peacekeeping forces, and the international community at large. The peacekeepers leave an inflated sex industry with thousands of women out of work who are forced to find alternative means of subsistence in the post-conflict. Young girls that participate in the sex work of the peacekeeping economy may miss opportunities to complete their education or develop other skills that could be used to generate income, depending on the state of infrastructure and degree of access in their given community. They may try to return to the normalcy of daily life but face harmful and exclusionary ostracism from members of their community for having participated in sex work, a culturally unacceptable practice in traditional gender norms of Liberia. Additionally, these women are incredibly vulnerable to contracting STIs such as HIV/AIDS, particularly since

the asymmetrical power imbalance between them and their peacekeeper clientele limit their ability to negotiate condom use and safe sexual relations.

It is important to note that accurately measuring the prevalence of sexual exploitation and abuse both during the conflict and in the post-conflict period presents numerous challenges. Firstly, while data gathered by local health care providers or security forces is sometimes available, such individuals may have an incentive to underreport instances of sexual exploitation and abuse due to fear of retaliation. Consequently, data collected by local forces responsible for the protection of communities in conflict may not be indicative of the existing conditions. Secondly, the nature of conflict typically interferes with thorough survey analysis conducted by external organizations. Threats to the safety of research teams and participants can limit both the depth and accuracy of research in war-torn environments. Members of the local community may be at an increased risk of being targeted for participating in research studies, especially if their confidentiality were to be compromised, and may be deterred or prohibited from providing information. In addition to human security risks, the unpredictability of war and instability in local communities further restrict the logistics of survey design and sampling (Swiss et al 1998: 629).

In the case of Liberia in particular, findings predominantly from Monrovia may be skewed, as is the case with Beber et al's study. Throughout mission deployment, a significant portion of UN peacekeeping personnel was stationed in Monrovia's dense metropolitan environment where it was relatively easy for foreigners and local residents to interact without drawing suspicion. Consequently, it is possible the unsuspicious nature of interaction resulted in higher rates of transactional sex compared to rural, more physically removed settlements in Liberia. Given that a large portion of UN personnel in Monrovia was deployed from other English-speaking West African nations, it is also plausible that cultural and linguistic similarities made the exchange of

transactional sex simpler and more commonplace than in other missions with greater barriers to communication between the local population and peacekeeper personnel.

UNMIL's Response to the Allegations

There is evidence suggesting UNMIL was aware of the fact that sexual exploitation and abuse of women and girls was a common occurrence in post-war Liberian society and did, in fact, engage in work to uncover the frequency of this impunity among the civilian population. In December 2015, UNMIL and the UN High Commissioner for Human Rights (OHCHR) released a joint-report called *An Assessment of Human rights Issues Emanating from Traditional Practices in Liberia*. The report focused only on rape and the ongoing challenges in enforcing accountability measures and bringing perpetrators to justice within Liberia's weak justice system (UNMIL 2015). The report built off of a thorough study conducted by UNMIL's Human Rights and Protection Service (HRPS) between January 2015 and March 2016. The Ministry of Gender, Children, and Social Protection (MoGCSP) *Gender-Based Violence Annual Statistical Report of 2015* found only 2% of all gender-based violence cases reported to health facilities led to conviction of the perpetrator (MoGCSP 2016). UNMIL also received prison data in June 2016 suggesting only 34 cases out of 803 reported led to conviction in court for rape in 2015 (Zarif and Zeid 2016: 7). Out of the roughly 150 cases the HRPS of UNMIL monitored in 2015, 78% of the victims were minors and at least two girls reportedly died from the harmful treatment they had suffered from (HRPS 2016).

UNMIL's formal recognition of this tragic societal issue in Liberia was contained in the Security Council's September 2015 resolution 2239, which extended the mission and its drawdown period by one year. The resolution states UNMIL "expresses *its continued concern* that women and girls in Liberia continue to face a high incidence of sexual and gender-based violence" and

“reiterates its call on the Government of Liberia to continue to combat sexual violence” (United Nations Security Council 2015). While this clause’s recognition of ongoing gender-based violence was certainly a step in the right direction, it reveals the manner in which UNMIL put the burden of addressing the impunity it had uncovered in its host country on the Liberian government, thereby disassociating peacekeeping personnel from this responsibility. UNMIL did go on to partner with UNWOMEN and UNICEF to help the government strengthen protection and prevention mechanisms in place, namely through the government and the UN’s Joint Programme on Sexual Gender-Based Violence and HRPS’ monitoring and advocacy work (Zarif and Zeid 2016: 26)

But, how did UNMIL respond to allegations of sexual exploitation and abuse against its own peacekeepers, which suggested their abuse of power was contributing to this rather normalized impunity in Liberia? In 2015, the UN’s Office of Internal Oversight Services (OIOS) characterized the mission as having a rather high prevalence of sexual exploitation and abuse. From 2008 to 2014, the UN Conduct and Discipline Unit (CDU) of the Department of Field Support had identified 85 cases of alleged sexual exploitation and abuse, though many more undoubtedly went unreported. In response, the mission took a number of measures to prevent the continuation of impunity. Firstly, 5,024 UNMIL personnel received training in the UN’s zero-tolerance policy from July 2015 to June 2016 (United States Department of State 2017: 3). According to the *UN Missions Summary of Military and Police* report of July 2015, UNMIL’s force strength at the start of the training period was 5,142 personnel, including 394 individual police, 995 formed police units, 121 experts on the mission, and 3,632 contingent troops—93% of whom were men (UN 2015). Though this training occurred during the mission’s phase-out period and only 1,952 personnel were still deployed by June 2016, it appears almost all of the personnel deployed at the start of the year took part in the zero-tolerance policy training (UN 2016).

Additionally, the mission issued a new standard operating procedure on reporting and investigating misconduct in October of 2016 (United States Department of State 2017: 3). UNMIL also collaborated with the MoGCSP to launch a training and awareness campaigns as a part of the Anti-SEA Champions program (ibid).

In Secretary-General António Guterres' final progress report on UNMIL, he notes the mission engaged in "proactive outreach" in "all communities where UNMIL troops have been deployed since 2003" (United Nations Security Council 2018: 10). He goes on to claim the mission took a "victim-centered approach" to responding to the medical, psychosocial, and legal needs of those who spoke out against peacekeepers as perpetrators of misconduct, including sexual exploitation and abuse, and references "quick-impact projects" that offered vocational training to victims and community members in Monrovia intended to minimize both stigmatization, and vulnerability to exploitation in the future (ibid). Guterres concludes that allegations against UNMIL peacekeepers were transferred to Member States for investigation and that the mission established an exit plan as of June 2018, which transferred any pending allegations to a discipline team based in MINUSMA, the multi-dimensional peacekeeping operation in the nearby nation of Mali (ibid).

These attempts by UNMIL to address impunity within its host country, and its own personnel, reveal the mission developed a more robust commitment to the gender mainstreaming priorities of the original mandate and subsequent resolutions in the final years of deployment. The efforts noted in UN reports all began in the later years of UNMIL, predominantly from 2015 to 2016. However, it is difficult to measure the actual reach and impact of these initiatives, as the UN has not released data indicative of how many women and girls were reached through these initiatives. Thus, for the purposes of this study, we must evaluate the effectiveness of these efforts

predominantly through their substantive quality and degree of responsiveness, rather than numeric metrics. Overall, though UNMIL did take active measures and collaborate with specialized bodies to respond to allegations of sexual exploitation and assault, these efforts appear to have been reactive rather than proactive and significantly limited in scale. The fact that there is no evidence of UNMIL responding to these allegations with specialized planning prior to the final few years of deployment and the drawdown period suggests the mission reacted inadequately in the earlier years when more active preventive measures could have produced better outcomes for local women and girls in connection to peacekeeper conduct.

Case Study 2: Sierra Leone

War Against the Backdrop of Extreme Gender Inequality

While women in pre-colonial areas of present-day Sierra Leone frequently occupied positions of power, systemic gender inequality and utter disregard for women's rights has characterized Sierra Leone's recent history. Hazel M. McFerson notes the "first colonial experience and then post-independence patrimonial politics followed by civil war severely diminished their political influence and participation" and resulted in a patriarchal and patrilineal social structure that continues to limit women's freedom tremendously (McFerson 2012: 49). Typically, rural families organize along lineages that perpetuate the acceptance of male dominance through notions of a "founder father" and membership, land access, and the passing of property down the male line (Richards et al 2004). Upon marriage, women are considered within their husband's locale due to marriage contracts and the children are believed to "belong" to him (ibid). Women in Sierra Leone struggle to create a livelihood without support from their husbands, yet are unable to exert control over them or over how many sexual partners they have or marry (UNHCR and STC 2002: 60). A husband's power and dominance are reinforced further through

the extremely common practice of polygamous marriages and households. Both “war widows” and rural women not born into families with the ruling or dependent lineages encounter challenges, while women who belong to families have some level of protection from their uncles or brothers against violence and marital abuse (McFerson 2012: 50). The combination of marriage contracts determining a wife’s status, her lack of lineage connections, widespread domestic abuse, and the practice of polygamy leave many Sierra Leoneans in a state of constant vulnerability and insecurity today.

In addition to male-dominated familial and social structures, a number of systemic factors continue to intensify gender inequity in Sierra Leone. Such factors include the exclusion of women from access to financial services and land ownership, extreme women’s illiteracy, high fertility rates, and high maternal mortality rates. Nearly two decades after the end of the civil war, the WHO estimates an adult literacy rate of 45% for men and just 27% for women in Sierra Leone (2018). This gendered literacy disparity further limits women from accessing the same degree of education and job opportunities as men. The Demographic and Health Survey (DHS) of 2008 determined an average birth rate of 5.1 children per woman, varying from 3.8 in urban areas to 5.8 in rural areas for the period of 2004 to 2007 (SSL and IFC Macro 2009). Birth rates across the nation were found to correlate with education rates; women who had more than secondary education reported an average of 3.1 children, while women with no education had almost twice as many children (ibid). Fertility rates were also connected to wealth, with the poorest women having nearly twice as many (6.3) children as women in the wealthiest households (3.2) (ibid). The findings of these various reports illustrate that, when compounded, these various societal factors can limit women’s ability to fuel their individual freedom, growth, and prosperity.

This extreme gender inequality is evident not just in the private realm of women, but also in Sierra Leone's formalized legal framework. The 1991 Constitution, which continues to provide the basis of governance in Sierra Leone, includes a chapter dedicated to the recognition and protection of fundamental human rights and freedoms of the individual (The Constitution of Sierra Leone 1991 Chapter III). In particular, Section 27 of this chapter guarantees protection from discrimination and includes subsection (1) affirming that "no law shall make provision which is discriminatory either of itself or in its effect." However, Section 27 also includes provision (4)(d) that states 'subsection (1) shall not apply to any law so far as that law makes provision: 'with respect to adoption, marriage, divorce, burial, devolution of property in death or other interests of personal law' (ibid Section 27(4)(d)). By justifying women's lack of agency in matters of personal law, the contradictory nature of this provision to the anti-discrimination clause affords women human rights they cannot actually exercise. As provision 27 (4)(d) of the constitution demonstrates, women's second-class status is legitimized in both Sierra Leone's patriarchal and patrilineal social structure, and in the highest law of the land.

The deeply-entrenched gender inequality that limits women's right to access financial means, property, and education undoubtedly worsens the effects of the nation's crippling poverty rate. Despite Sierra Leone's rich extractive resources, the poverty-stricken nation has consistently ranked among the least developed in the UNDP Human Development Index most recently at 184th out of 187 countries (UNDP 2018). Sierra Leone continues to be one of the poorest nations in the world, with a per capita income of about \$700 USD and nearly 70% of the population subsisting below the poverty line of one dollar a day (Government of Sierra Leone 2010). Unfortunately, poverty persists in rural regions and women are especially worse off, indicated by only 5% of

female-headed households own land. Women's income is on average 45% of men's income and 75% of rural women are estimated to live on less than 50 cents a day (ibid).

In recent years of relative peace in Sierra Leone, the country has made some progress in advancing women's empowerment indicators. In 2008, the Demographic and Health Survey (DHS) found that 66% of women had never attended school, compared to 48% of men (SSL and IFC Macro 2009: 33). Men were also more likely to have completed secondary education than women, with 32% of men compared to 19% of women (ibid). Five years later, the 2013 DHS survey reported 51% of women had never attended school, compared to 41% of men (SSL and IFC International 2014: 11). However, the survey also uncovered a stark disparity in access to education among women based on region, as 32% of women in urban areas had never received education compared to 60% of women in rural areas (ibid 24). As of 2013, 85% of married women were employed, but 54% were unpaid for their work. In comparison, 98% of married men were employed and only 36% were unpaid (ibid 247). Additionally, 34% of women age 15 to 19 had control over their earnings, compared to 51% of women age 45-49 (ibid 249). As these data compiled three and eight years following the civil war's closure suggest, women in Sierra Leone have started to attain some degree of empowerment through education and employment opportunities in the post-war period. Yet, individuals of all genders and ages still struggle to achieve individual prosperity against the backdrop of Sierra Leone's rampant poverty and disparities between men and women, and between urban and rural regions are especially prominent.

A Decade of Violence and Human Rights Abuses

As a region rich with natural resources including timber, ivory, palm oil, gold, bauxite, and diamonds, the territory of present-day Sierra Leone fell into British control in the early 1800s

(Mazurana et al 2004: 10). As a part of Great Britain's movement to abolish slavery, the empire allowed freed slaves to seek refuge in the West African territory. This decision, in turn, significantly altered the demographic composition of Sierra Leone, as an influx of diverse ethnic groups including the Kono, Limba, Kissi, and Krio, migrated to the territory. Historically, the Mende and Temne divided the region into chiefdoms in the south and north and dominated each area, respectively. A series of democratic reforms following World War II led to the creation of an assembly headed by Paramount Chiefs (ibid). In response to the growing fear of marginalization, the Krio elite and other chiefs established the Sierra Leone People's Party (SLPP) under Sir Milton Margai, a member of the Mende group. In 1957, the creation of the Temne-dominated All People's Congress (APC) split the assembly's make-up, dividing the governing body between the Mende (SLPP) of the south and the Temne (APC) of the north. In 1960, Margai of the SLPP was elected Prime Minister, a preliminary step in Sierra Leone's path to independence.

Sierra Leone gained independence from England on April 27th, 1961. However, the new nation confronted decades of tension between the two leading political parties of the APC and SLPP, and between the state and citizenry. The SLPP maintained power from 1961 until 1967, when Siaka Stevens of the APC won an inconclusive general election (Zack-Williams 1999: 144). Throughout the Cold War years, Sierra Leone's legacy of colonialism and slave resettlement resulted in systematically poor governance and a weak economy dominated by a few international enterprises and corrupt governing elite (Denov 2006: 322). As the government of Sierra Leone continued the colonial practice of prioritizing export of raw materials over industrial production, the nation struggled to build and solidify a robust national identity—both within its borders and as a member of the international community. The APC depended on its control over naturally-occurring assets to maintain its power, with roughly 52% of the national diamond industry under

the control of President Stevens (Mazurana 2004: 10). The party attempted to build state legitimacy in the 1970s by reinforcing an oppressive state apparatus that excluded the average citizen from access to economic opportunity. Their economic policies of asset stripping and high interests on loans and revenues pushed peasant producers away from the formal domestic market, as much of the funds obtained by the government were distributed to elites within the client-patron network (Reno, 1995). In response to rising opposition from peasants and trade unionists, Stevens decided to consolidate his power in 1978 by eliminating many of the institutions put in place under the British parliamentary system and cutting off access to the nation's natural resources (Paul, 1996).

This host of unjust policies enacted by the APC under Stevens fueled hostility across the nation and “destroyed the enterprise of the people and their will to be governed” (Zack Williams 1999: 144). Public frustration spread from traders to Sierra Leone's youth and student populations, as many felt they were being robbed of opportunities to support themselves and their families. Young Sierra Leoneans—both educated and non-educated—started to build a collective consciousness and political identity rooted in the notion of pan-Africanism and parallels between pre- and post-colonial Sierra Leone (Abdullah 1998). Throughout the 1980s, economic instability coupled with “the corrosive effects of the personalized and monolithic rule of the Congress, which led to the destruction of civil society and democratic accountability,” resulted in institutional fragility of the state (Zack-Williams 1999: 143; Kandeh 1992). Stevens had organized a network of informal markets that distributed patronage to chiefs and individuals willing to agree to the Congress' terms and denied to those who refused (Zack-Williams 1999: 145). Consequently, the nation was on a path to crisis as the negative impact of the faltering economy and rise in diamond smuggling revealed the unjust nature of the APC's rule (Mazurana et al 2004: 10).

In August 1985, the party chose as Stevens' successor Joseph Saidu Momoh, who intended to reinstitute a multi-party government and hold elections in 1991. Unsurprisingly, the interplay of socioeconomic and political instability at this moment in Sierra Leone's history created fertile ground for revolt and quickly derailed Momoh's political vision for the APC. In March 1991, armed rebel forces led by Foday Sankoh invaded eastern Sierra Leone from Liberia with the support of Charles Taylor's National Patriotic Front of Liberia (NPFL) and seized control over much of the region's diamond reserves. The rebels called themselves the Revolutionary United Front (RUF) and were initially comprised of combatants trained in Libya with experience fighting in Liberia, young men from Liberia and Sierra Leone in search of work, and NPFL fighters from Taylor's army (Wilkinson 1996). The RUF assisted Sankoh in smuggling diamonds into Liberia in exchange for weapons, drugs, and supplies to power their violent revolt. Sankoh's control over the diamond mines helped fuel the RUF's growth, as the rebel leader seized the opportunity to recruit young miners and unemployed men and boys from Sierra Leone as combatants, both forcibly and voluntarily (Mazurana 2004: 11). The RUF tried to appeal directly to "deracinated youth with blighted education prospects" who had drifted to diamond districts in hopes of earning enough to subsist within inequitable conditions of the postcolonial economy and severely weakened education sector (Richards 1996: 266).

The conflict quickly spread across national borders through the early 1990s and plagued the West African region with ongoing violence, human insecurity, and resource deprivation. Within just 18 months of RUF's first attack in March 1991, violence had escalated drastically, internally displaced over 400,000 people and forced hundreds of thousands of Sierra Leoneans to seek refuge in neighboring Liberia, Guinea, and Côte D'Ivoire. Sierra Leone quickly came to confront a civil war stemming from the complex, interrelated issues of a weakened state, structural

violence, the economic power of the diamond trade, and a relatively disillusioned civilian population (Denov 2006: 321). With the support of Taylor, the rebels utilized the disillusionment and frustrations of the civilian population to fuel a movement against Momoh's All Peoples Congress (APC) regime and promote a vision of change. But, as Denov notes, "the RUF's so-called democratic revolution appeared to be fought not through the political realm, but instead through the pillage of rural institutions and industrial assets, the mass looting of village property and, perhaps most disturbingly, brutal violence against the very civilians it was claiming to liberate" (Denov 2006: 322). Both rural and urban populations were rapidly militarized via the rapid spread of small arms and the presence of international armed forces, entrenching violence into the social fabric of Sierra Leone's society.

With the support of warlord Taylor, the RUF launched an armed challenge of the APC in pursuit of reform. The APC had dominated Sierra Leone's political leadership for the past 23 years under Stevens and Momoh. But, in 1992, a small cohort of officers who had fought the RUF united as the National Provisional Revolutionary Council (NPRC), orchestrated a military coup, successfully unseated Momoh, and brought the military government of Johnny Paul Koroma to power (Zack-Williams 1999: 150). Parliamentary and presidential 1996 elections brought the civilian regime of Alhaji Dr. Ahmed Tejan Kabbah to power, who strengthened the pro-government Civil Defense Force (CDF) intended to protect government-held areas from rebel forces. However, the RUF refused to recognize the legitimacy of the elections and honor its results and the conflict continued (Peace and Security Section of the Department of Public Information 2005).

Thanks to the assistance of ECOMOG, the Military Observer Group of ECOWAS, the national army of Sierra Leone tried to defend the government as violence erupted between the

rebels and Koroma's government, and between the Koroma's forces and Momoh loyalists (UN UNAMSIL Background; Akonor 2017: 41). Several hundred ECOMOG troops were deployed from Nigeria, Ghana, and Guinea to help Sierra Leone defend its capital city of Freetown. ECOMOG's involvement in Sierra Leone was certainly linked to the organization's peacekeeping efforts in neighboring Liberia (Adebajo 2011: 141). ECOMOG increased their role in the conflict in May 1997, when the Nigerian autocrat General Sani Abacha diverted peacekeepers from the concluding efforts in Liberia to Sierra Leone to try to quash another military coup d'état being led by the Sierra Leone Army (SLA), which forced President Kabbah and his government into exile (ibid). Numerous UN Special Envoys attempted to persuade the military junta to step down, but were unsuccessful. Five months later, on October 8th, 1997, the Security Council imposed an oil and arms embargo and authorized ECOWAS to use ECOMOG troops to oversee its implementation. In February 1998, ECOMOG had successfully ousted the military junta regime that had joined forces with RUF, the Armed Forces Revolutionary Council (AFRC). By March, ECOMOG had helped reverse the military coup and restore the democratically-elected government of Ahmad Tejan Kabbah, an unprecedented step taken by the regional body (O'Flaherty 2004: 30).

Unfortunately, a devastating invasion of Freetown in January 1999 revealed ECOMOG's inability to effectively eliminate the military threat of the rebels who refused to implement the peace accords and continued to commit a series of human rights violations against civilians (Human Rights Watch 1999). Though all armed forces involved in the conflict reportedly committed abuses against civilian populations, the RUF has systematically made civilians victim to murder, rape, and mutilation and conscripted an estimated 20,000 children as soldiers (Smillie 2004). The state of human security across all of Sierra Leone's populations was in critical condition.

Working Towards Sustainable Peace

In June 1998, the Security Council decided to lift the embargo and create the United Nations Observer Mission in Sierra Leone (UNOMSIL) under Indian general Subhash Joshi to assist ECOMOG's efforts on the ground. UNOMSIL was launched in July 1998 with only 70 unarmed observers to disarm combatants and help establish a stable security force for an initial period of six months. The force played a limited role alongside ECOMOG's thirteen thousand troops (Adebajo 2011: 149). Fighting continued and the rebels gained control of over half of the country and overran most of Freetown in December 1998, forcing UNOMSIL personnel to evacuate (Peace and Security Section of the Department of Public Information 2005). ECOMOG later retook the capital and helped bring the civilian government back to power, a first step towards the establishment of peace.

In 1999, against the backdrop of civilian conflict, child soldiers on battlefields, and the absence of a stable government, the international community intervened to help broker a ceasefire (Akonor 2017: 41). The ceasefire led to the signing of the Lomé Peace Agreement, which established power-sharing between the government of Sierra Leone and the RUF and disarmament, and requested the assistance of a UN peacekeeping force to help enforce the terms (Akonor 2017: 41). Controversially, the Agreement also granted amnesty to all combatants for their crimes committed during the civil war (United Nations Security Council 1999). However, the Ugandan UN special representative of the secretary-general, Francis Okelo, entered a hand-written reservation noting amnesty and pardon provided for in this article of the Agreement would not apply to those who committed international crimes of genocide, crimes against humanity, and other violations of international humanitarian law (Human Rights Watch 2002: 13). The Agreement also mandated the creation of a Truth and Reconciliation Commission and the Special Court of Sierra

Leone, which were designed to facilitate reconciliation between perpetrators and victims of the war, while the peacekeeping efforts focused on reconciling peace between warring factions (Elmer 2009: 974).

In October 1999, the Security Council authorized the United Nations Mission in Sierra Leone (UNAMSIL) to replace UNOMSIL, which, at its maximum deployment, included 192 military observers and a small human rights unit of four individuals (Akonor 2017: 41; Human Rights Watch 2002: 13). UNAMSIL initially authorized 6,000 military personnel, including 260 military observers, to maintain peace and monitor the ceasefire. The UN took over ECOMOG's peacekeeping responsibilities from 1999 to 2000 and increased the troop strength to 11,000 in February 2000 and 13,000 the following May (Peace and Security Section of the Department of Public Information 2005).

Despite a consistently-maintained peacekeeper presence, Sierra Leone had a long path to peace rather than immediate transition, due largely to the RUF's continued acts of violence against state and non-state actors. Though UNAMSIL intended to implement the peace agreement, regions of Sierra Leone were still under RUF control in the early stages of the mission's deployment, particularly in the diamond-rich eastern province, and fighting persisted despite the mission's efforts at reconciliation with rebel groups (Mazurana 2004: 16; Smith et al 2010: 295). On May 3rd, 2000, the RUF took 500 UN peacekeepers hostage following numerous smaller-scale attacks against UN troops and refused to acknowledge a ceasefire agreement. This damaged the mission's credibility and interfered with their on-the-ground efforts. The British Special Forces stepped in to help free Freetown from the control of the RUF, restoring enough stability for the UN peacekeepers to return (Mazurana 2004: 16). The international community attempted to pressure

the rebels into obeying the ceasefire by sanctioning RUF sponsors, which then enabled UNAMSIL to spearhead renewed efforts to bring the warring factions together to mediate the ongoing conflict.

By early 2002, UNAMSIL had disarmed and demobilized an estimated 72,000 ex-combatants and child soldiers and the government declared the war officially over (Mazurana 2004: 2). The mission began to phase-out troops but maintained a presence in Sierra Leone over the next few years to help organize Sierra Leone's first ever free and fair presidential and parliamentary elections. The Secretary-General praised UNAMSIL for its completion of most of its core objectives, including assistance in the voluntary return of over 500,000 refugees and internally-displaced persons and strengthening local authority by training personnel and building police stations (UNAMSIL Background). In 2004, the mission helped offer logistical and public information support for local government elections as well (ibid).

UNAMSIL as a Success

Since the end of the conflict and peacekeeping intervention, Sierra Leone's population of 6.2 million have experienced a period of relative peace and stability (DHS 2013: 3). Like UNMIL, UNAMSIL is frequently cited as a model for successful peacekeeping and prototype for the UN's evolving emphasis on peacebuilding efforts as an effective means of preventing the resurgence of war. The mission was instrumental in disarming thousands of ex-combatants, assisting in the holding of national elections, rehabilitating a weakened governance structure and provision of government services, and helping the government stop the illicit trading of diamonds that fueled the rebel's purchasing of arms throughout the conflict. On the other hand, the effects of the war, coupled with the fact that 60% of Sierra Leone's population lives under the national poverty line today and subsist with less than \$1.25 USD a day, have created conditions that threaten the livelihood of (UNDP 2018).

In the context of this extreme suffering and entrenched gender inequality, it is imperative that greater attention be paid to the risks to health and safety of women and the extent to which the actions of peacekeepers shaped their day-to-day experiences. The following section will look more closely at the conceptual distinction between UNAMSIL as a success in terms of its ability to bring about peace and its ability to positively impact women. It will illustrate that, though the initial mandate of UNAMSIL was devised prior to the creation of resolution 1325, the mission did take some steps to integrate gender mainstreaming efforts. Through an evaluation of the four indicators used to measure women's health and safety during and following UNAMSIL deployment, I will show that, despite these efforts, the mission did not directly lead to disproportionately better outcomes for women and girls.

Access to the Provision of Health Care

In 2000, the WHO ranked Sierra Leone as the nation with the least efficient health system out of any country in the world (WHO 2000). At this point, nine years into the civil war, Sierra Leone was suffering from a major civilian health crisis due to its nearly-destroyed health sector. The conflict depleted the number of health workers and, unfortunately, exacerbated the deficiencies that existed in the pre-war health system, including resource scarcity. Health workers were targeted for abduction and forced to offer services to rebel forces, many of whom did not survive the war (Wurie and Witter 2014; Witter et al 2016: 6). Much like Liberia's conflict period, significant portions of health care providers fled Sierra Leone to seek safety and more stable economic circumstances elsewhere (Bertone et al 2014). By 1996, only 16% of health centers were deemed functional due to half a decade of looting and destruction, most of which were located in Freetown (Gberie 2005).

Prior to the war, the private sector employed a minority of the health workforce and most of health care provision came from public sector health facilities run by government staff, and this remained true in the post-conflict period (Bertone et al 2014). However, the low salaries and weak training environments provided by government health facilities led the remainder of health workers to seek the financial and training incentives offered in NGO-run facilities. Unfortunately, Witter et al note (2014) the decrease in NGO presence towards the end of the conflict left government health agencies unable to financially sustain staff who were previously employed by NGOs.

The distribution of health workers was an additional challenge Sierra Leone confronted during and following its period of war. As the conflict persisted, the majority of government health workers appeared to prefer working in Freetown, located in the Western Area District (Bertone et al 2014). This resulted in a consolidation of health workers in the capital city and tremendous understaffing in rural regions in which 60% of Sierra Leone's population lives; an estimated 90% of all surgeons were concentrated in the capital, leaving only 10% to service the rest of the country, particularly rural communities (Weekes and Bah 2017; Kingham et al 2008). Yet, the Western Province was still only marginally better off than the rest of Sierra Leone in the post-war years. The MoHS estimated the staff-to-population density for doctors in the Western Area District dropped to 0.07 per 1,000 citizens in 2005 and just barely improved to 0.12 per 1,000 in 2011 (Wurie and Witter 2014). The Koinadugu District in the Northern Province, a rural and hard-to-reach area, saw its staff-to-population density for doctors grow from 0.03 to 0.05 per 1,000 of the population from 2005 to 2011, respectively (ibid). This reveals that, though the capital city and surrounding area may have been slightly better off, the entire nation suffered from a chronic shortage of health workers in the decade that followed the war.

Unlike Liberia's post-war period, Sierra Leone's path to peace did not include the establishment of a transitional government, and this certainly could have impacted the nation's struggle to rebuild its health sector in the years that immediately followed the war. After the November 2002 signing of the Lomé Peace Agreement, national elections were held to elect a civilian government. Though, in theory, electing an official government so rapidly could have been conducive to infrastructure rebuilding, Maria Paola Bertone et al note these early post-war years were characterized by weak government leadership and inconsistent interventions from development partners, thereby limiting the breadth of openings for strategic reforms to strengthen the health system in the aftermath of war (Bertone et al 2014: 8). Although infrastructure gradually began to improve in the aftermath of the civil war period (1991 to 2002), Sierra Leone continues to exhibit some of the poorest health indicators in the world, particularly life expectancy and maternal mortality (Kingham et al 2009: 122). The nation continues to suffer from the effects of the conflict and, as was the case in Liberia, its strides in improving its health sector confronted a major setback following the 2014 EVD outbreak.

UNAMSIL's Role in Shaping Civilian Health

In a similar manner to UNMIL, the mandate of UNAMSIL and subsequent guidelines for renewal and expansion of the mission did not explicitly specify improvement of civilian health as a priority within the context of addressing humanitarian crises. However, UNAMSIL authorized a number of small-scale efforts to address civilian health needs and prevent the spread of disease between locals and peacekeepers. Unfortunately, a lack of public reporting by UN and peacekeeping personnel has made it difficult to assess the extent to which these efforts directly impacted the health of civilian populations who received the mission's health services or interacted with peacekeepers that took part in these initiatives. This section will explore the limited data

available on the mission's direct involvement in efforts to advance the local populations' health in the context of Sierra Leone's struggle to rebuild its collapsed health system and meet the health needs of its most vulnerable and disenfranchised populations in the aftermath of war.

Evidence from UN reporting suggests UNAMSIL engaged in a number of small-scale health initiatives. Two years into deployment, on April 21st, 2001, a Jordanian Medical Unit of an UNAMSIL peacekeeping battalion offered free medical assistance to 4,000 villagers in Lakka on what would become known as Free Medical Day (UN News 2001). Sierra Leone's Ministry of Health and Sanitation assisted with this initiative by offering health workers on a volunteer basis to help with language translation and act as a liaison with local leaders. The UNAMSIL team targeted women, children, and elderly members of the local community and treated a range of ailments, including urinary tract infections, anemia, chest pains, cataracts, tonsillitis, conjunctivitis, and skin infections (ibid). By August 2002, a Bangladeshi medical contingent servicing UNAMSIL forces known as Ban-Med had expanded its services to cover civilians in five districts in northern Sierra Leone, making it the largest single medical program in the north (Kanu 2002). Ban-Med also established mobile clinic facilities with 26 specialist doctors, 14 nurses, and 24 drug dispensers (ibid).

Public UN reporting indicates an uptick in mission involvement in the mitigation of public health concerns in 2005, the final year of mission deployment. In a January 2005 press release, the Deputy Special Representative of the Secretary-General of UNAMSIL reported the mission had assisted Sierra Leone's Ministry of Health and Sanitation by providing antibiotics, anti-malaria drugs, bandages, needles, and vitamins. The Representative also noted that "UNAMSIL considers the provision of health services a key priority and a basic social right" and recognized the mission's ability to support Sierra Leone's public health sector as it responded to urgent needs of the

population and major budgetary and resource constraints (UNAMSIL January 2005). In April 2005, the mission released an additional update stating over 30 civilian police had attended a two-day HIV/AIDS prevention and gender awareness workshop at the mission's headquarters in Freetown (UNAMSIL April 2005). In August 2005, the UN reported that another Jordanian Medical Contingent was utilizing half of the facilities in a private Freetown hospital to manage a Level II health facility for UNAMSIL and had treated 246 cases in its initial three months. This Contingent pledged to continue treating patients through the phase-out period of the mission (UNAMSIL 2005). Finally, a contingent from Bangladesh deployed for eleven months had financed a fund to build a health care clinic and offer food, clothes, and materials to civilians, which was officially commissioned by UNAMSIL in December 2005 (ibid).

It is worth noting that the majority of these health initiatives were not only limited in scale, but were also mostly devised and implemented towards the end of mission deployment. Though peacekeepers were consistently present in the area of conflict beginning in 1999, the mission's public reports suggest only a few coordinated measures were taken to address health concerns prior to 2005. However, it is possible that, throughout deployment, UNAMSIL's presence helped attract NGOs and aid agencies that went on to assist in the implementation of more large-scale health initiatives in the post-conflict period. For example, the Ministry of Health and Sanitation, UNICEF, WHO, and CCF partnered to launch a Mass Immunization Campaign in six districts as an expansion of the national immunization program, which targeted over 260,000 under-five children and roughly 198,000 women of child-bearing age (UN Office of Coordinated Humanitarian Affairs 2000).

State of Maternal Health

Unfortunately, poor maternal health has been a leading public health and human security issue in Sierra Leone for several decades. Despite the nation's commitment to the UN Sustainable Development Goals (SDGs) to reduce maternal mortality and improve sexual and reproductive health, Sierra Leone has made only marginal progress in addressing women's health concerns since the end of civil war. In 2012, the nation had the fifth-shortest life expectancy for women on the African continent, falling only behind nations severely devastated by HIV/AIDS epidemics (McFerson 2012: 51). Though the maternal mortality rate has wavered over the years, it has consistently been exceptionally high, peaking at a rate 2.7 higher than the overall average for the African continent in 2005 (SSL and IFC Macro 2009). In 2012, the rate of maternal mortality in Sierra Leone reached the highest in the world, with the exception of Somalia and parts of Afghanistan. As these troublesome figures demonstrate, maternal health is an imperative issue, which continues to threaten the health and safety of Sierra Leonean women in the post-conflict years. The following section will analyze the state of maternal health in Sierra Leone in the aftermath of the brutal civil war responsible for hundreds of thousands of deaths, with special emphasis on the years of UNAMSIL deployment.

The findings of the 2008 DHS suggest maternal health indicators experienced very minor changes in the first few years of peace following eleven years of brutal conflict. Firstly, the survey found there was little to no decline in the total fertility rate in the pre-war and post-war period, from 5.7 children per woman in 1980 to 1985, to 5.1 births per woman from 2004 to 2007 (SSL and IFC Macro 2009: 52). Of the 5,811 births in women age 15 to 49 recorded in the survey, between 29% and 35% occurred in health facilities, depending on the region. In urban areas, 57% of births occurred in the home, compared to 77% in rural areas. The survey also found a strong correlation between a mother's level of education and place of delivery. The proportion of births

delivered in a health facility was 47% among mothers who received secondary education, compared to 20% among women with no education (ibid 120). The data also show roughly 42% of births in Sierra Leone were delivered with assistance by a health care professional and 45% by a traditional birth attendant (ibid 122). Turning to access to family planning, roughly 21% of married women reported they utilized contraceptive methods at some time, contrasted with 8% of unmarried women. Over half of women using modern contraceptive methods obtained their resources from public sector health facilities, while just over one-third used the private medical sector to meet this need. And, finally, roughly 36% of women had an unmet need for family planning by 2008. These data suggest that, seven years after the war was officially over and three years after UNAMSIL phase-out, Sierra Leone's population still suffered from critical maternal health indicators.

In summer 2008, Koyejo Oyerinde et al conducted a survey investigation of health facilities in Sierra Leone offering delivery services to uncover the state of maternal and newborn services in the nation six years after the phase-out of UNAMSIL peacekeeping forces. The researchers surveyed a total of 145 health centers, comprised of 38 hospitals, 55 community health centers, and 52 community health posts. The majority (121) of the centers were public, but eight were private, three were NGO-run, and eleven were mission-affiliated. The Western Province had the most positive indicators of the state of maternal health, with 13.6% of births occurring in a health facility and a met need for emergency obstetric care of 12.9%. In contrast, only 6.5% of births in the Eastern Province occurred in a health facility and the region had a met need for emergency obstetric care of 0.3%. The discrepancy in access to maternal health care across the two provinces correlates to the patterns of violence that characterized the civil war. While the Western Province of Sierra Leone most frequently experienced periods of peace in the decade-long conflict, the

diamond-rich Eastern Province of Sierra Leone were most prone to outbreaks of violence and brutality at the hands of the rebel forces. Thus, it is unsurprising that the Western Province had more positive maternal health indicators and greater progress in strengthening access to care in the six years of post-conflict rebuilding.

Among the study's most compelling findings was that there were no basic emergency obstetric care facilities and only emergency services available across all provinces (Oyerinde et al 2011: 171). Moreover, an average of only 10% of expected births were delivered in facilities. The scholars attribute the poor quality of services offered to Sierra Leonean women, in part, to the over-use of emergency care facilities in the absence of basic care available to pregnant women. Drawing from this study, it appears the absence of basic emergency obstetric care was and continues to be one of the factors contributing to the high maternal mortality rate, as delays in reaching an adequate health facility and in receiving adequate care once at the facility are two of the key delays identified in Thaddeus and Maine's Three Delays Model. Oyerinde et al suggest the state of maternal health will only improve if the low number of well-equipped facilities, inadequately skilled birth attendants, and deterrents to the utilization of services, like high user fees and long distances, are addressed to create greater access to quality care. It is important to note that, as described in the case study of Liberia, poor reporting practices and record keeping can interfere with the accuracy of findings from research conducted in post-war Sierra Leone. Nonetheless, the weaknesses in the state of maternal health services identified in Oyerinde et al's study are worth considering as indicators of the nation's disturbingly high maternal mortality rate.

In response to the nation's post-war maternal health crisis, the Government of Liberia announced the launch of the Free Health Care Initiative (FHCI) with the central objective of eliminating health user fees for pregnant women, lactating mothers, and children under five years

of age (Jones et al 2016). Beginning in 2010, the Government and MoHS worked to introduce a series of reforms that would operationalize the priorities of the FHCI, including a rise in salaries for technical health workers, fast-track recruitment of health workers in each district, and greater budget allocation to the health sector (Witter et al 2016). The FHCI intervention was highly ambitious and complex, as it aimed to reach target groups via reforms to the entire national health system. Though the program was deemed a relative success due to its ability to improve incentive packages for health care workers, grow the total number of providers, and improve the provision of maternal health care, Witter et al note it suffered from dependence on donor funding and technical assistance (ibid). Their analysis of the FHCI's implementation reveals the MoHS exhibited strong coordination with donors and partners during the design stage, but less so following the launch of the program, when "political pressure for rapid reforms was reduced, leaving room for fragmented policy-making and implementation" (ibid 15).

However, this weakness in domestic financing and capacity constraints should not minimize the overall positive impact of this policy initiative on the well-being of women in Sierra Leone in the post-war period. The Demographic and Health Surveys (DHS) of 2013 suggests the nation made slight progress in advancing maternal health indicators from 2009 to 2012, the initial years of FHCI's implementation. Though the fertility rate declined only marginally from an average of 5.1 in 2008 to 4.9 in 2013, the number of reported births that occurred in a health facility increased from an average of 32% across all regions to 54% (SSL and IFC International 2014). In addition, 60% were attended by a skilled provider, mostly a nurse or midwife (44%) or MCH Aide (14%), though only 2% of cases attended by a doctor (ibid 109). The FHCI, above all, seems to have been successful in recruiting and retaining health workers, with the total staff in the national health sector rising from 3,017 in 2005 to 9,347 in 2011 (Wurie and Witter 2014: 18).

Table 3:

Year	1990	1995	2000	2005	2010
Maternal deaths per 100,000 births	2,630	2,900	2,650	1,990	1,630

Sources: WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division. Years based on the estimates available.

As the figures in Table 3 reveal, the maternal mortality rate in Sierra Leone has decreased significantly over time, but still remains starkly high, even ten years after the end of civil war and violence. The WHO estimates that maternal deaths account for 36% of all deaths among women age 15 to 49 in Sierra Leone (WHO 2015). In response to the dire health conditions and evident inadequacies in meeting the health needs of women specifically, the government of Sierra Leone established a National Health Sector Strategic Plan for 2010 to 2015 aimed at attaining health-related Millennium Development Goals (MDGs). In 2010, in alignment with this Plan, the government introduced the Free Health Initiative, which guaranteed free health care services for pregnant women, including an essential package of health care services delivered to meet maternal and child health needs (SSL and IFC International 2014: 4). Though these initiatives reflect a dedication to advancing women's health, it is difficult to measure the extent to which they succeeded. Maternal mortality reduction remains a priority in post-war Sierra Leone under its more-recent dedication to Sustainable Development Goal (SDG) 3: to "ensure healthy lives and promote well-being for all at all ages" and establish a target of maternal mortality ratio to 140 maternal deaths per 100,000 live births. The WHO estimates an annual reduction of 19.8 % is needed for Sierra Leone to meet its 2030 target (WHO 2016). With such high maternal mortality rates, an estimated 6% of women in Sierra Leone will die from maternal causes during their

reproductive lifetime, unless more impactful and effective measures are taken to address risks of maternal death (SSL and IFC International 2014: 189).

Disarmament of Women and Girls

The conditions of extreme poverty and resource disparity that plagued Sierra Leone prior to and during the civil war drove thousands of men, women, and children to join armed forces as a means to support their basic subsistence. Many Sierra Leonean women of all ages were implicated in the civil war's decade of violence through either voluntary or forced involvement with pro-government or rebel forces. Due to low reporting and the challenges of data compilation in wartime, the exact number of women and girls involved in the conflict and affiliated with the various factions is unknown, with estimates ranging from 10% to 50% of the total female population (MacKenzie 2009: 245). Despite frequent denial by government officials, young women took part in the CDF's military agenda as spies, commanders, and fighters, while those that remained unarmed supported the war effort by serving as cooks, medics, spiritual leaders, and herbalists (Mazurana et al 2004: 2). In the RUF rebel forces, girls and women were often captive "wives" of commanders, forced to distribute weapons and food to fighters or partake in looting during village raids. In some cases, women were even responsible for commanding fighting units of young girls or boys and committing heinous acts of crimes against humanity that characterized RUF's war strategy (ibid). The majority of women were trained in how to load and use a gun and commanders' "wives" were the women combatants most likely to gain authority within the force (McKay 2004: 22). Though girls and women were integrated into the war effort at different ages and for varying lengths of time, the widespread involvement of civilian women in the conflict resulted in a dire need for social programs to help restore a sense of normalcy in their post-war daily lives.

As M. Denov al note, the “tangled realities of victimization, participation, and resistance” characterized the lived experiences of women and girl soldiers in Sierra Leone at the turn of the century (Denov 2006). Regardless of their role in the conflict or affiliate group, there is no doubt that suffering was universal for women throughout the ten years of ongoing violence. All those involved in the armed forces were forced to travel long distances and sleep in the bush and many girls became ill or disabled, or even died, by merely trying to survive in civilian combat (McKay 2004: 22). To make matters worse, the psychological, physical, and social effects of war on women and girls were reinforced by the discriminatory gender norms that remained deeply entrenched in the nation throughout and in the aftermath of the conflict.

The disarmament, demobilization, and reintegration (DDR) program was a cornerstone of Sierra Leone’s post-conflict transition to peace, as the government, ECOMOG, and the United Nations collaborated to assist civilians as their nation recovered from the war. The program’s partners established the National Commission for Demobilization, Disarmament, and Reintegration (NCDDR) under President Kabbah to spearhead the DDR process and oversee the execution of its primary objectives: demobilize soldiers; remove arms from circulation; and enable ex-combatants to become reintegrated in civilian life (Leff 2008). UNAMSIL’s DDR unit supported the NCDDR as it conducted the disarming and demobilization in three phases from 1998 to 2000, followed by the reintegration program through 2003 (ibid). In his 2000 report to the Security Council, Secretary-General Kofi Annan reaffirmed the role of DDR in the effectiveness of peace-building in the peacekeeping environment, noting DDR “has repeatedly proved to be vital to stability in a post-conflict situation; to reducing the likelihood of renewed violence, either because of a relapse into war or outbreaks of banditry; and to facilitating a society’s transition from conflict to normalcy and development” (United Nations Security Council 2000:1).

Given the widespread involvement of civilians in armed forces on all sides, the DDR program was vital to restoring a sense of normalcy in communities across Sierra Leone. The program's progress was limited in the first few years due to outbreaks of violence and a generally weak system of governance. At the start of the program, UNAMSIL estimated there were roughly 45,000 combatants among the total population, 12% of whom were thought to be women (De Watteville 2002). Yet, by the end of phase one, the UN Department of Peacekeeping reported over 72,000 individuals had been demobilized, revealing that armed violence had reached many more communities across the nation than initially estimated (Mazurana 2004: 2). Of the individuals disarmed, 71,043 were demobilized and 56,751 registered with the NCDDR (Ball et al 2004). Benefits offered under the NCDDR Training and Employment Programme (TEP) included training in the areas of carpentry, mechanics, tailoring, and agriculture intended to help ex-combatants achieve social and economic reintegration.

Ultimately, 84% of demobilized individuals were adult men, while just 6.5% (4,751) were women (ibid). The number of girls who participated in the demobilization program was also significantly lower than expected: only 0.4% of the estimated 1,772 girls in the CDF, 6% of the RUF's estimated 7,500 girls, and 2% of the AFRC's estimated 1,667 girls participated in the DDR process (Mazurana 2004). Though the program was hailed a success by its partners and the international community, the low percentage of women reached by the program suggests up to tens of thousands of women and girls were left out of the official DDR process and, thus, unable to access its generally effective benefits (Mazurana 2002). Women who did participate in the program were often trained in traditional skills, such as hair braiding and tailoring. However, they were frequently excluded from programs offering training for non-traditional skills that were more economically viable—such as construction and welding—but fell outside of accepted gender roles

for Sierra Leonean women and girls (Burman 2007: 320). Overall, the program suffered from shortage supply, such as inadequate sewing machines, which limited the number of individuals who could participate and develop a skill with even some economic value (ibid).

A number of factors can explain the low participation of women and girls in the DDR program. First and foremost, the program's framework and implementation were incredibly gender blind, rendering women practically invisible in the understanding of Sierra Leone's civil conflict. Though the Lomé Agreement included provisions to ensure child soldiers were included in the DDR process, no such attention was paid to women ex-combatants (Denov 2006: 330). The conventional view of war as occurring predominantly within the domain of men seems to have informed the creation of this post-conflict social program that failed to see the degree of women's direct involvement in battle (Date-Bah 2006: 26). The DDR's framework minimized the role of women of the conflict by categorizing them as "sex slaves," "wives," and "camp followers," rather than recognizing the prevalence of women on the frontlines of fighting forces as "real soldiers" (MacKenzie 2009: 245).

This limited view of women and girls' role in the war led to the adoption of many gender-discriminatory criteria for program eligibility. Among these was the requirement that women appear with a man in order to claim benefits (Sesay and Suma 2009). However, few women were able to do so, even if they wanted to, as they were usually unaware of the program's existence and forced to depend on male military commanders for information on how to access the program (ibid). In the early phases of DDR implementation, ex-combatants were required to produce a gun at official reception centers across the nation and demonstrate their ability to assemble and disassemble an AK-47, but men often claimed weapons from women before they had the opportunity to seek eligibility (Denov 2006: 330; Date-Bah 2006: 26; Sesay and Suma 2009).

Though the program's criteria in and of themselves were undoubtedly exclusionary, the socialization of gender hierarchy in the armed forces gave men the power to prevent women from earning eligibility to the program and participating in the reintegration training.

Secondly, the physical organization of the program further discouraged girls and women from accessing its benefits. The fact that many of the DDR sites were centrally located and visible to the public was a deterrent for women who did not want members of nearby communities to know they had been associated with the RUF, whether by choice or as captives (Burman et al 2007: 319). The sites also lacked sufficient medical and hygienic facilities to help all ex-combatants recover from diseases, malnutrition, and war-related injuries inflicted during battle (McKay et al 2004: 26). Women suffered even more from the lack of facilities, as many had returned with sexually transmitted infections, injuries related to pregnancy and childbirth in the bush, or recovering from gender-based violence and in critical need of reproductive health services in their reintegration (ibid). Another major barrier to women's participation in the reintegration phase of the program was lacking someone who could look after their young children while they attended the skills training, as the NCDDR did not include any services to assist mothers or childcare on-site (Burman et al 2007: 320). Thus, women's inability to access the benefits of the "successful" DDR program was inherently connected to both the widespread denial of their participation in the war, and the way the program's formulation and implementation were rooted exclusively in the needs of boys and men.

The degree of marginalization experienced by women returning from the armed forces made it nearly impossible for them to assimilate back to the normalcy of civilian life. Women ex-combatants were met with criticism and judgment from family members and strangers alike who viewed their experiences in the war as antithetical to the cultural norms that shaped expectations

of womanhood. The field research of M.E. Burman et al found women most likely to confront marginalization were girls who returned with children, often labeled “girl mothers” (Burman et al 2007: 317). While some women could successfully hide their past experience and blend into the community unnoticed, this was nearly impossible for young mothers and ex-“wives” of commanders. The presence of children exposed their time spent in the bush and increase their risk of being ostracized for having engaged in under-age, unmarried, or forced sexual experiences (McKay 2004: 25). In some instances, ex-combatant women were treated so poorly that they were forced to leave their communities, set up their own households, or seek refuge in urban centers (Burman et al 2007: 317). Villagers and parents whose daughters had returned from war were often feared due to their connection to war and violence and this (ibid). On the other hand, the behavior women became accustomed to throughout their many years of fighting led to self-induced isolation for some, particularly if a woman exhibited aggression or violence, abused drugs, or actively disregarded traditional gender roles.

Women’s limited integration into Sierra Leone’s DDR program surely limited their ability to safely transition back to their communities. In response to criticism of the DDR program’s gender insensitivity, the UNAMSIL DDR unit encouraged NGOs to work with the program and help expand the activities women could participate in (Date-Bah 2006: 26). However, UNAMSIL and their partners did little to advise women to focus on developing skills of high demand in the labor market and much of their training for traditional skills were about six months long, an insufficient duration of time to develop skills necessary for long-term employment. A report prepared for the Department of Peacekeeping Operations after the program’s implementation states 60% of participants were able to use the skills acquired through training to earn a living (ibid). Yet, given such a small percentage of total program participants were women, it is safe to

assume the 60% were largely comprised of men. UNAMSIL also could have played a larger role in ensuring DDR reintegration incorporated programming to help tackle the discrimination and exclusion vulnerable women and girls, particularly “girl mothers,” commanders’ “wives,” and survivors of sexual exploitation and abuse, faced upon returning to their communities. It is clear neither the leaders of DDR, nor UNAMSIL peacekeeping forces sufficiently considered the specific needs and experiences of women within the context of the dominant culture, value systems, and norms that characterized post-war Sierra Leone when devising and implementing the DDR’s reintegration phase, in particular.

Prevalence of Sexual Exploitation and Abuse

Throughout the decade of on-going civil war in Sierra Leone, women and girls of all ages, ethnic groups, and socioeconomic classes were frequently subjected to systematic sexual exploitation and abuse by armed men of warring factions. These acts of violence against women rarely occurred in isolation and were often followed by other horrific human rights abuses against the victim, her family, and her community. Both sides of the conflict committed dehumanizing, violent acts against women in the form rape and gang rape, sometimes even with the use of objects such as weapons, firewood, umbrellas, and pestles (Human Rights Watch 2002: 3). This inhumane treatment took the lives of many young girls and women and left survivors across the nation suffering from severe bleeding, life-threatening infections, forced pregnancies, and miscarriages. The main rebel groups—the RUF and AFRC—abducted thousands of women and girls throughout the duration of the war and forced them to become “wives” of rebels or sex slaves (ibid). Unsurprisingly, escaping these egregious conditions was extremely difficult. Captors would go so far as to carve the name of their faction into abducted women’s chests to prevent them from escaping, as pro-government forces were likely to kill any woman suspected of being a rebel or

affiliated with the rebel groups (ibid). Through hundreds of interviews with local women, the Human Rights Watch determined the prevalence of sexual violence peaked during active military operations, but that such human rights violations continued across Sierra Leone even in periods of relative peace. Though the civil war was declared over on January 18th, 2002, it is impossible to trace the number of women and girls who remained with their “husbands” and captors in the post-war period and continuously face abuse, even through today (ibid).

In the 2002 report, *We'll Kill You If You Cry*, Human Rights Watch characterized sexual violence as Sierra Leone’s “silent war crime,” as very little was done nationally and internationally to address the widespread abuse of girls and women throughout the decade of political turmoil and civilian conflict (Human Rights Watch 2002: 5). Historically, gender-based violence has rarely been seen as a crime within Sierra Leone’s patriarchal society, so it is unsurprising that this was a key war tactic rebel groups used against innocent civilians (ibid). The silent nature of this war crime on the health and safety of women is undoubtedly linked to the second-class status of women and girls in Sierra Leone. The extreme gender inequality that became normalized across generations during times of peace intensified into an even more widespread and brutal form during the conflict years. The Human Rights Watch notes the near-destruction of the nation’s “already corrupt and inefficient court system and police force during the war, moreover, created a climate of impunity that persists” and enabled perpetrators of gender-based violence against women to commit such crimes, yet escape justice (ibid).

But, to what extent did the presence of UNAMSIL peacekeepers shape local Sierra Leonean women’s experience with sexual exploitation and abuse? Much like the case of UNMIL in Liberia, the influx of foreign troops in Sierra Leone shifted local power dynamics and produced a peacekeeping economy damaging to the nation’s social fabric and particularly threatening to

women's safety. These two factors, in conjunction with underlying gender inequality and the post-war conditions of scarcity, increased local women's vulnerability to sexual exploitation and abuse at the hands of both local and foreign forces during the post-conflict period. In a similar manner to Liberian women, local women in Sierra Leone realized the subjugation of their bodies was, at times, their most likely path to survival during and following the conflict. Numerous organizations uncovered evidence of UNAMSIL peacekeepers taking part in sexually-exploitative relationships with young girls and women in host communities (Human Rights Watch 2002; UNHCR and STC 2002; United States Department of State 2004). Findings reveal UNAMSIL peacekeepers exhibiting a failure to protect women from their vulnerability to sexually exploitative relationships and reinforcing their subordinate positions in their patriarchal society. While UNAMSIL's mandate was created after UN resolution 1325 and did not explicitly mention gender concerns (as was the case with UNMIL's 2003 mandate), it appears the behavior of peacekeepers was equally harmful in both missions and embodied an overall disregard for the unique experiences of women as victims of civil war.

The release of the 2002 UNHCR and Save the Children (STC) report documenting evidence of sexual violence and exploitation of refugee children in Sierra Leone, Liberia, and Guinea exposed an unfortunate reality of UN intervention: the behavior of UNAMSIL peacekeepers was contributing to the growth of Sierra Leone's transactional sex market. The study uncovered a trend of mothers in Sierra Leone bringing their daughters to UNAMSIL personnel, as association with men who locally occupied a powerful position of wealth and status was seen as a privilege in the eyes of some individuals (UNHCR and STC 2002: 49). Such behavior reflected the eroding social fabric and damaging familial relations within the host community that produced tolerance and, at times, acceptance for the deliberate use of local women's and girl's bodies as a

means of generating financial gains. However, the report noted that UNAMSIL personnel interviewed commonly spoke of the “difficulty” in refusing advances from local women and girls (ibid). The evidence of peacekeepers’ failure to reject such advances demonstrates their ability to take advantage of the local community’s experience of poverty to exercise their position of power to receive sexual favors. Findings from Paul Higate’s 2003 fieldwork interviewing civilians and members of civil society in areas of UNAMSIL deployment further revealed peacekeepers’ abuse of this power dynamic. Interviewees recounted experiences in which peacekeepers had “donated” cell phones to local women, offered them rented accommodation in Freetown, and visited them during off-period times and weekends (Higate 2003: 43).

An additional problem uncovered in the UNHCR and STC report was the manner in which peacekeepers and agency workers in both Sierra Leone and Liberia were able to escape justice, even when they committed acts of impunity. Though the Code of Conduct requires peacekeepers to “honour and respect the laws of the host country,” local interviewees spoke of the ways in which men in the peacekeeping forces have been systematically able to “use their financial and status capacities to influence formal and non-formal legal decisions to their advantage” (UN 1998; UNHCR and STC 2002: 59). While the UN peacekeeping policies require personnel accused of committing such crimes to be repatriated and tried in their home countries, most crimes go unreported and, even if perpetrators do stand trial in their home country, no information is provided to the affected family and victim in the host country (ibid). Not only is there a failure to actively and effectively prevent impunity among peacekeepers, but also an issue in addressing impunity when individuals deviate from the standards for conduct and a lack of authentic concern for the negative impact of that individual’s behavior on the victim in the host country.

In a 2007 case study of peacekeeping operations in Kosovo, Haiti, and Sierra Leone, Charles Anthony Smith, and Brandon Miller-de la Cuesta utilized reports from major organizations including the International Organization for Migration, Human Rights Watch, and Amnesty International and the State Department Trafficking in Persons Annual Report to determine whether the presence of peacekeepers led to an expansion of local trafficking networks, including sex trafficking. The scholars' analysis of reports from 1998 to March 2001 found no mention of increases in human trafficking for the purposes of sexual exploitation over these first two years of UNAMSIL deployment (Smith and Miller-de la Cuesta 2007: 295). However, as UNAMSIL began to reach maximum troop deployment, human rights organizations started to observe and report a significant rise in prostitution, with the most incidences occurring in the capital of Freetown. The 2004 Annual Trafficking Report demoted Sierra Leone from its tier 2 classification in 2001 to tier 3, with particular emphasis on the degree of trafficking within and across borders of Freetown. This report uses a three-tier system to track and categorize changes in legislation, enforcement, and compliance with the Victims of Trafficking and Violence Protection Act, with countries classified as in full compliance (tier 1), some compliance (tier 2), and little to no compliance (tier 3).

The scholars traced similar trends in the reports of human rights organizations in the cases of Kosovo and Haiti and concluded that, despite differences in the nature of each conflict, the “economic logic driving the creation and expansion of human trafficking networks is salient across both time and geographic location” (ibid 297). Smith and Miller-de la Cuesta suggest the economic incentives to form and expand trafficking networks are especially powerful in areas in conflict, as the weakened security and governance have already lowered the barrier to entry for traffickers and created an opportunity to respond to the rise in demand for sex work (ibid). They conclude that,

though it is difficult to estimate the increase in the magnitude of trafficking following mission the deployment with confidence, the rise in demand will lead to a growth in trafficking that is relative to the size of the deployed force. The findings of Smith and Miller-de la Cuesta, Higate, the UNHCR and STC, and HRW provide shocking evidence of UNAMSIL peacekeepers contributing to sexual exploitation and abuse of local women and girls on an individual basis rather than working to protect them in their state of extreme vulnerability. The remainder of this section will evaluate the active measures taken by UNAMSIL and the UN to prevent the continuation of this unjust behavior, both prior to and following the publication of the pivotal UNHCR and STC report.

UNAMSIL's Response

Though UNAMSIL did not integrate gender-specific language into its original mandate, it did take a few steps to adapt to the gender mainstreaming standards established by UNSCR 1325 in 2000. The UN Security Council passed resolutions throughout UNAMSIL's deployment that allowed for and encouraged budget planning to accommodate more women leaders (Hudson 2005: 800). UNAMSIL did not include an Office of Gender Affairs and, instead, had a Gender Specialist in the Human Rights section responsible for raising awareness about gender issues and gathering information on the human rights situation to supplement preparations for Sierra Leone's Special Court and Truth and Reconciliation Committee (ibid; Higate 2003: 38). In November 2001, a team from the Training and Evaluation Service of the UN Department of Peacekeeping Operations conducted a two-week training focused on gender in peacekeeping, which reached 1,000 UNAMSIL peacekeepers and civilian personnel (HRW 2002: 72). Local human rights activists and women's organizations were invited to participate as well and, though the nature of this training was a step in the right direction, the fact that only 1,000 of the 17,500 personnel reportedly

deployed as of September 2001 were reached reveals how small the scale of its impact was (United Nations Security Council 2001).

Fortunately, the worrisome findings of the January 2002 UNHCR and STC report heightened the international community's interest in UNAMSIL and sparked wide-spread concern for the UN's poor accountability of peacekeeper conduct. Unlike other missions, where references to the "anecdotal" nature of reports typically interfered with the perceived legitimacy of mission-related scandals, the public response to the 2002 report prompted the UN's acknowledgement of its findings and subsequent action to combat UNAMSIL peacekeepers' abuse of power (Higate 2003: 37). On February 28th, 2002, Acting Special Representative of the Secretary-General, Behrooz Sadry, issued an UNAMSIL report in response to the UNHCR and STC report, noting its overall findings were "extremely disturbing and the related necessary corrective measures require the concerted efforts of all concerned." Sadry emphasized UNAMSIL's commitment to the Code of Conduct and zero-tolerance policy and assured that investigators in Sierra Leone were investigating the information provided, noting the Secretary-General "intends to act forcefully should any of these allegations be confirmed" (UNAMSIL February 2002).

In response to the allegations of peacekeepers perpetrating violence and exploitation, UNAMSIL established a few high-level solutions. Firstly, the Office for the Coordination of Humanitarian Affairs (OCHA) established the interagency Coordination Committee for Sexual Exploitation and Abuse (CCSEA) to develop strategies for raising awareness and drafting policies on personnel recruitment (Higate 2003: 41). But, the CCSEA failed to create a position for an officer who would interact with civilians in the host population and hear their concerns (ibid). Next, UNAMSIL established a Personnel Conduct Committee (UPCC) in March 2002. The UPCC was tasked with promoting greater awareness of the guiding principles of peacekeeping operations,

such as the UN Code of Conduct for Peacekeepers and zero-tolerance policy regarding sexual exploitation and abuse. The committee was comprised of sixteen members responsible for working with civilian and military personnel to prevent the continuation of peacekeepers' harmful participation in transactional sex in Sierra Leone. In a January 2003 UNAMSIL press briefing, Chief of the Human Rights Section in the mission, Rodolfo Mattarollo, described the role of the UPCC as receiving "complaints from persons outside of the Mission on conduct impropriety by members of UNAMSIL" either in writing or via telephone lines established for this purpose.

Though the UPCC symbolized a key effort to curtail sexual exploitation and abuse committed by peacekeepers, its framework contained a number of flaws. Firstly, the military Provost Marshall and Civilian Police of UNAMSIL were the personnel in charge of investigating allegations made against peacekeepers. By vesting this responsibility in peacekeeper personnel, there is a chance that victims in the host community would be deterred from reporting incidences of mistreatment and have minimal confidence that the UPCC would actually be willing to help them and ensure the perpetrator be brought to justice. Secondly, the Committee's dependence on telephone lines to receive grievances likely posed challenges to its effectiveness in meeting the needs of the local population. Lack of access to telephones, unreliability of landlines, language barriers, and fear of speaking to members of the very organization they were disenfranchised by are just a few of the many barriers to reporting that may have been faced by survivors (ibid). In addition, it should be considered that the daily struggle to secure basic resources for survival among the most vulnerable populations in the post-war period such as refugees and internally displaced persons decreased the likelihood that those impacted by exploitation and abuse would be able to safely reach and use a telephone in order to share their perspective. Thus, there were a number of practical implications of the UPCC's framework that appeared to discount the deterrent

power of suspicion and fear in the local population, as well as the challenges to reaching and reporting via a telephone hotline. While these efforts described were certainly powerful symbolically insofar as they reiterated the UN's commitment to high-level gender mainstreaming practices, it is challenging to measure their direct impact. It is even possible that both the reports published in 2002 and the reactive initiatives of the UN pushed ongoing exploitation and abuse underground, though this possibility is extremely difficult to discern with certainty (Higate 2003: 48).

Chapter 4

Discussion

In this section, I will compare and contrast my findings from the main indicators of women and girls' health and safety in post-conflict Liberia and Sierra Leone, which suggest the potential hypotheses I determined prior to conducting my case study are not sufficiently compelling. My discussion will illustrate that, though UNMIL's mandate was the first to include an explicit concern for gender, the impact of UNMIL and UNAMSIL on the degree of health and safety experienced by women in Liberia and Sierra, respectively, were practically the same. Furthermore, though the restored state of national security that resulted from successful completion of their respective mandates enabled both of their host countries to address humanitarian crises—including incapacitated health systems, low life expectancies in women, high maternal mortality rates, and thousands of women ex-combatants among the civilian population—the actions taken by peacekeeping mission were not robust enough to have directly produced disproportionately better outcomes for women.

For generations, both Liberia and Sierra Leone have experienced a number of similar societal factors that compromise the degree of freedom and individual security civilian women can

attain, even in times of peace. Both of these West African countries have been plagued by extreme poverty and resource scarcity and this continues to be an issue as they each strive to meet global development indicators today. The widespread violence that characterized Liberia and Sierra Leone's civil wars undoubtedly exacerbated the burden of these societal barriers to citizens' realization of human security and prosperity. Prior to analyzing my findings, it is imperative to note that these various factors certainly had implications for the extent to which UNMIL and UNAMSIL could advance the well-being and livelihood of women through the humanitarian objectives of their respective mandates in the post-war period. My evaluation of each mission's success in advancing women and girl's health and safety during mission deployment will, thus, be considered in the context of these challenging obstacles to achieving systemic change and robust post-conflict recovery.

Turning first to UNMIL and UNAMSIL's roles in advancing local women and girls' access to the provision of health care, I contend that both missions helped establish the national security conditions necessary for Liberia and Sierra Leone to begin rebuilding their nearly-destroyed health care sectors. In the years that followed their civil wars, both countries struggled to provide access to essential health services to their populations, particularly rural communities that were remotely located in relation to major cities, which had more functional health facilities and greater portions of the remaining health workers. In Liberia, international aid organizations were instrumental to health sector rebuilding and implementing nationwide efforts to improve access to the provision of health care. Not only did these organizations fund initiatives to improve the majority of Liberia's functioning hospitals, they also assisted the MHSW in its coordination and implementation of various national health plans, which were first established in 2007 and continue to set health objectives today.

In the case of Sierra Leone, the work of the Bangladeshi medical contingent that launched the Free Medical Day and offered mobile clinic facilities in five districts was certainly a positive step taken early on in the mission. Though, it is unclear how directly these initiatives impacted women, as the mission did not report on whether it reached its goal of targeting women, children, and the elderly. The uptick in health care assistance in 2005—the final year of mission deployment—reveals peacekeeping missions are, in fact, able to help address the needs of the civilian population when effort is dedicated to doing so. The Bangladeshi UNAMSIL contingent's independent choice to fund and build a civilian facility in an existing hospital was a hallmark effort, though it appeared to stem more so from Bangladesh's dedication to improving civilian health outcomes than from UNAMSIL's organizational priorities (UNAMSIL 2005). The HIV/AIDS and gender mainstreaming workshops offered to 20 CIVPOL in Freetown also suggest UNAMSIL started to adapt to the norm of gender mainstreaming established by resolution 1325 in 2000.

Though there is no evidence to suggest either mission played a direct role in devising nor implementing high-level health plans that targeted the health needs of Liberia and Sierra Leone's populations, there were a number of mission initiatives developed to advance civilian health on a smaller scale. In the case of UNMIL, mission health facilities rarely offered services to civilians in the host country and were narrowly focused on meeting the health needs of mission personnel (OIOS 2009). While UNMIL did respond to international pressure to address the deadly EVD outbreak in 2014, it appears concern for women and girls' degree of health was not a sufficiently strong motivator, as the interests of troop-contributing countries appeared to have limited the rapidness and scope of the mission's responses (United Nations Security Council 2014: 16). Resolution 2116 emphasized UNMIL was not to play a direct role in producing health outcomes.

Thus, I do not believe it is reasonable to argue that UNMIL should have contributed to the implementation of Liberia's national health plans, as this task certainly fell outside the auspices of UNMIL's mandated provision of humanitarian assistance. Nonetheless, the mission certainly could have done more to at least prevent spreading disease to local civilians, including women and girls. The OIOS's discovery of poor pre-deployment medical screening reveals the mission did not take adequate measures to ensure the screening practices utilized by troop-contributing countries met UN-mandated standards, thereby putting civilian populations at heightened risk of contracting untracked illnesses. The UN's responsibility stems to do so from both the shared health risks between peacekeepers and civilians and the UN's moral obligation to take reasonable action when possible to prevent their missions from causing harm to civilians (Davies and Rushton 2016). However, it appears the medical facilities suffered from issues of capacity and accountability that limited UNMIL from honoring this obligation.

While the UN has not released sufficient public data needed to measure the tangible impact of these small-scale efforts on women's access to the provision of health care, the rise in women's life expectancy at birth in both Liberia and Sierra Leone through the years of mission deployment indicates the health of women likely benefitted from the overall state of national security and subsequent improvement in the availability and quality of health care. In Liberia, the life expectancy of women at birth increased from 54.2 in the first year of deployment (2003), to 63.6 in 2016, the most recent year for which there is data and also the year mission phase-out began. In Sierra Leone, the life expectancy of women at birth increased from 38.8 in the first year of deployment (1999), to 44.7 in the final year of deployment (2005), to 52 ten years following the withdraw of UNAMSIL (2015) (World Data Bank 2016). It is important to note that Liberia experienced a steady upward trend in life expectancy of women, even throughout the duration of

the conflict. Thus, though the national security context UNMIL helped establish certainly may have reinforced this ongoing progress in a key women's health indicator, there is not sufficient evidence to conclusively attribute the 12-year rise in women's life expectancy from start to end of UNMIL deployment directly to the mission's impact on access to the provision of health care. Sierra Leone, on the other hand, did not experience a consistent upward trend in women's life expectancy at birth through the years of civil war (1991 to 2001). The nation started to experience a drop in the life expectancy of women in 1983 (40.8) and this downward trend continued until 1994 (35.7), three years into the civil war (ibid). It is possible that Liberia and Sierra Leone experienced differing trends in life expectancy of women at birth because Sierra Leone's war had a more negative impact on civilian women's likelihood of survival. However, the fact that both nations experienced positive and steady growth in women's life expectancy at birth reinforces the notion that the peace and stability established by peacekeeping had positive implications for women's health.

Next, I will evaluate the outcome in the state of maternal health in Liberia and Sierra following the period of peacekeeping deployment. In Liberia, the maternal mortality rate decreased by nearly 50% from 1,200 per 100,000 of the population following the first year of the civil war (1990), to 640 per 100,000 in 2015—the most recent year for which there is data and the ten-year mark of UNMIL's deployment (World Data Bank 2016). Fortunately, there is no evidence suggesting Liberia's maternal mortality rate did not continue to decrease until 2018, the final year of the mission. Sierra Leone also experienced tremendous progress in reducing its maternal mortality rate, which decreased from 2,650 per 100,000 following the first year of the civil war (2000), to 1,990 in the final year of mission deployment (2005), to 1,360 in 2015, ten years after UNAMSIL troops withdrew from the nation (ibid). The findings of the Demographic and Health

Surveys conducted across Liberia and Sierra Leone's post-war years reflect a similar rate of gradual progress made in advancing other indicators of maternal health, such as fertility rates, access to contraception, and delivery in hospital facilities by skilled birth attendants. I believe the fact that these specific indicators of the state of maternal health only made marginal progress in the aftermath of the wars of Liberia and Sierra Leone is a consequence of local cultural practices—such as preference for traditional birthing methods and the reluctance to use modern contraceptive methods—and is not due to any aspect of either peacekeeping operation. The significant decrease in maternal mortality rates reveals the major delays in seeking adequate and timely care thereby preventing maternal deaths were mitigated thanks to the overall improvement of the health care system and women and girls' degree of access to the provision of health care. In the case of Sierra Leone, the nation's success in minimizing the prevalence of maternal death can be attributed to the Government and MoHS's allocation of substantial government funds towards planning and implementing the aspirational 2010 Free Health Care Initiative (FHCI), which sought to reform the very pillars of the national health care system to specifically target the critical health situation of women of child-bearing age.

Though UNMIL and UNAMSL did not offer coordination support nor funding to these domestic attempts to strengthen the health sector or address maternal health, it is very plausible that the missions' continuous presence from 2003 to 2018 and 1999 to 2005, respectively, attracted humanitarian aid organizations eager to complement the mission's peacebuilding efforts with health care assistance. Thus, the hypothesis I initially considered—that external factors, such as domestic policy changes, social movements, foreign aid, and support for women fostered by NGOs, played a greater role in improving outcomes for the safety of women than the UN peacekeeping mission itself—does not appear to be incompatible with my findings. These factors

significantly influenced each nation's ability to launch national health initiatives and, in the case of Sierra Leone's FHCI, specifically target health concerns facing women of child-bearing age. However, I do believe this degree of international support was attracted by the Security Council's authorization of a continued peacekeeping presence, reflective of both the symbolic and practical power of this body's recognition of dire post-conflict circumstances. This belief is supported by the work of Ian Hurd, who notes the "power that the Security Council wields is a function of the esteem in which the body is held by the membership of the United Nations in general" (Hurd 2002: 47). Hurd goes on to suggest that, though the Security Council cannot actually mobilize states, "we should recognize clearly that the foundation of [its] power is the legitimacy that actors confer on the organization" (ibid). I contend that the legitimacy of the Security Council and the symbolic power of the body's actions—including authorization of peacekeeping missions—are instrumental in shaping the global response to the needs of post-conflict societies and attract support from not just Member States, but also dedicated aid organizations.

I will next analyze the impact of each mission on the degree of safety women and girls were able to experience in the post-war period by evaluating their involvement in the DDR and DDRR programs of Sierra Leone and Liberia, respectively, and prevalence of sexual exploitation and abuse. Looking first to the disarmament of women and girls, I identified both areas of evident improvement in the integration of a gendered perspective from Sierra Leone's program to Liberia's, and shortfalls consistent across both cases, despite UNMIL's gender-focused mandate. Though UNAMSIL's DDR program was praised by the United Nations as a success due to its ability to reach 72,000 ex-combatants, I argue the unique experience of women in the conflict and post-conflict was not adequately considered in the planning and implementation of programming. A shockingly low percentage of the estimated total women combatants from each warring faction

participated, ranging from 0.4% to 6%, depending on faction affiliation (Sesay and Suma 2009). The program's sites were also centrally located, which exhibits the program's failure to consider how stigmatization of association with the mission may have deterred local women from participating, particularly among members of groups such as CDF, who outright denied the fact that women had served in their armed forces (ibid). The program also only offered traditional and less economically-viable skills to women. But, this may have been more so due to UNAMSIL's concern that Sierra Leone's gender norms would limit the extent to which women trained in non-traditional skills would be accepted by members of their community than the mission's lack of attention to women's specific needs.

Fortunately, there were a number of improvements in the practices of UNMIL's later DDRR program that demonstrate the mission did take action to address factors that limited the participation of women in UNAMSIL's DDR. UNAMSIL had numerous exclusionary recruitment criteria, which disproportionately impacted women and girls' ability to participate in programming. Among these was the requirement that they be present with a man and disarm a weapon, as well as the fact that only women could register as "camp followers" (MacKenzie 2009). Though UNMIL's initial 2003 DDRR program maintained the latter two exclusionary criteria, the Office of the Gender Advisor stepped in prior to its implementation to revise its problematic criteria that deviated from the norms established by resolution 1325. The fact that they removed these criteria and actively recognized the diverse roles of women in the conflict demonstrates the focus on gender contained in UNMIL's mandate did lead to an overall improvement in DDR practices, particularly in contrast to UNAMSIL. Yet, I argue this was a reactive rather than proactive action to ensure women would be equally integrated and affected by the program.

Thus, it appears UNMIL learned from some of the weaknesses in addressing the needs of women and girls that became clear in UNAMSIL's DDR programming, but that the focus on gender mainstreaming was a peripheral rather than central objective in planning the program. Women were supposedly offered targeted counseling and skills training through the rehabilitation and reintegration phases of UNMIL. Though the number of participants is certainly an important indicator, it does not tell us anything about the substantive value of the programming implemented in these stages of the program. In the absence of thorough investigations into the lived experiences of women in Liberia years after the program's completion, it is difficult to measure the effectiveness of these rehabilitation and reintegration efforts. Perhaps if the Department of Peacekeeping Operations had sufficiently funded and staffed efforts to establish greater interface with civilian populations throughout the DDR's execution, we could have a better sense of the overall impact of these actions on women in Liberia's local communities. I hold that it cannot be reasonably concluded that the gender-focused language of UNMIL's mandate produced substantially better outcomes for women in Liberia than UNAMSIL did in Sierra Leone.

Finally, evidence from various reports, UN data, and survey analyses have led me to conclude that peacekeepers did, in fact, contribute to the rise in pre-existing sexual exploitation and abuse and growth of transactional sex markets. Though there are certainly a number of peacekeepers that, on an individual basis, worked to defend the rights of local women and prevent such behavior, the guiding principles of the zero-tolerance policy, resolution 1325, and Zeid report did not translate to sufficiently robust measures to prevent impunity among peacekeeping personnel. While both UNMIL and UNAMSIL took a number of reactionary measures to address and end impunity in the face of public allegations against their peacekeepers, the majority occurred too late in the deployment of both missions and suffered from underfunding, understaffing, and,

above all, poor accountability mechanisms to measure their tangible impact on local communities. In both UNMIL and UNAMSIL, peacekeeping personnel did not appear to take proactive and preventative measures before deploying their peacekeepers into conflict zones. For example, there is insufficient reporting needed to discern how effective and comprehensive the research and training implemented by the Office of Gender Advisor (OGA) was in the case of Liberia. While the first female-formed police unit (FFPU) deployed from India to Liberia was found to produce positive outcomes for women and increase the amount of interface between civilian women and peacekeeper personnel, more such efforts could have been taken to carry forward the mandate's dedication to gender mainstreaming strategies (Pruitt 2016). Though fighting had subsided at the time of both missions' deployment and the priority of humanitarian assistance contained in their respective mandates was to address ongoing crises, the practices of UNMIL and UNAMSIL do not seem to reflect an authentic understanding of the disproportionately difficult circumstances women faced through their transitions back to normal life in post-war Liberia and Sierra Leone.

Conclusion

In this case study comparison of the United Nations Mission in Liberia (UNMIL) and United Nations Mission in Sierra Leone, I have illustrated that these two peacekeeping operations generally characterized as successful did not have a direct impact on the advancement of women's health and safety in their respective post-conflict environments. At the outset of this study, I considered the possibility that peacekeeping missions whose mandates emphasize issues of gender-based violence and women's insecurity may be the most effective model for improving the lives of women in the region. On the one hand, the first-ever peacekeeping mandate to include a specific emphasis on gender mainstreaming strategies exemplified a landmark shift in peacekeeping practices exhibited by UNMIL and a new standard of introducing concerns for women's wellbeing into human security discourse. On the other hand, the fact that Liberian women

did not experience significantly better health and safety outcomes than women in Sierra Leone throughout their respective periods of peacekeeping reveals the symbolic power of this shift towards gender mainstreaming has not yet amounted to meaningful outcomes for civilian women in host countries. After tracing very similar outcomes in four major indicators of women's health and safety in post-conflict environments following two interventions that differed in this regard, I determined this was not a sufficiently compelling argument.

In conclusion, there are two major implications for the United Nations going forward. The first is the United Nations Department of Peacekeeping Operations can admit it is not their place to address the health and safety needs of civilian populations and disassociate itself more explicitly from this responsibility, as it has occasionally done through resolutions to ongoing missions. Alternatively, it can take more robust measures to first recognize, then understand the uniqueness of women's experiences in conflict zones prior to deployment and integrate this understanding into its practices in a preventative and timely manner. Given that the recent history of UN peacekeeping has seen an evident shift from encompassing strictly-military operations to multi-dimensional operations that serve a more humanitarian role, it is necessary that the UN consider the ramifications of this evolving role in conflict intervention. I believe that, though there are limits to what the UN and Department of Peacekeeping Operations can do, there is room for improvement within its existing framework.

Firstly, the various bodies of a given peacekeeping operation can collaborate more closely with humanitarian organizations and local NGOs prior to deployment to develop a deeper understanding of the needs of the specific populations its personnel will interface with throughout the duration of the mission. These include the local risks to women's degree of health and safety and the societal barriers to gender equity. They can, then, utilize these findings to inform the

creation of more robust and frequent training to ensure peacekeepers are aware of the way in which their behavior can impact the wellbeing of local women. Stronger evaluations of existing health risks within both the troop-contributing country and host country can also be used to take more proactive and thorough measures to strengthen pre-deployment medical screenings and the practices of mission health facilities in order to prevent the spread of illness and disease, both between and among peacekeepers and local women. Finally, the Department of Peacekeeping Operations can increase the number of women deployed in peacekeeping operations. Without the inclusion of women's voices and perspectives in the creation of peacekeeping best practices, it is impossible for the Department of Peacekeeping Operations and affiliate bodies to translate these practices to a positive, tangible impact on the lives of women in host countries. Further, including more women in the execution of peacekeeping operations would ensure the troops, police, and staff working in such proximity to women suffering from the aftermath of brutal wars can feel a stronger sense of connection with the forces deployed from foreign lands to their communities during such times of such severe vulnerability to human insecurity.

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