Post-war Liberia: healthcare in the balance

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In the aftermath of conflict, people’s health and their ability to survive remain fragile, while basic infrastructure may be weak, damaged or non-existent. Serious gaps emerge at the crucial juncture between emergency relief and development aid, with few available and affordable health services to respond to still urgent medical needs.

Working in many such post-crisis contexts, Médecins sans Frontières (MSF) witnesses the ongoing risks to the population’s health in the aftermath of emergencies. As transition and reconstruction phases begin and humanitarians give way to development actors, government and donor priorities shift. During this transition, health care is too often in danger of falling off global policy and donor priority lists, even as the lives and health of vulnerable populations remain in the balance.

Liberia is but one example of many. After fourteen years of civil war, the population remains in a precarious state. Three quarters of the population survive on less than $1 a day and 23% of children die before the age of five. Interviews with patients at MSF-supported clinics on Bushrod Island in Monrovia – which has a population of around half a million – revealed that over half of them had had only one meal the day before consultation. 36% had no direct source of income, while the average income of the remaining 64% was under $0.30 per person per day. With poor access to water, latrines and health services, communicable diseases are widespread – particularly respiratory infections, malaria, diarrhoea and skin infections. The two MSF clinics in the area handle 20,000 consultations per month, including deliveries. 77% of all medical care in Liberia is currently provided by international NGOs and faith-based organisations.

The government, international donors and other decision-makers confront enormous and competing needs during the reconstruction phase. Many questions remain open about which sectors should be supported, the amount and duration of aid and the policies connected with assistance. Yet health often risks being omitted from policy-making and donor agendas. The draft agenda of the long-awaited Washington Donor Conference on Liberia in February 2007 did not even include health care.

Health care becomes increasingly complicated once an emergency has passed and policies of free care and support for secondary health care facilities are no longer a given. In MSF’s experience, the introduction of the principle of cost recovery and the withdrawal of support from secondary health care structures in the name of government responsibility and ‘sustainability’ greatly impact the ability of vulnerable and conflict-affected populations to access medical care in the aftermath of a crisis. We saw first hand the disastrous effects of the introduction of user fees in Liberia in 2001-02, which resulted in an up to 40% drop in attendance at MSF-supported facilities in Monrovia. When fees were suspended in 2003, we saw a 60% increase in consultations. This cancellation of fees impacted not only on curative services but also on attendance rates for preventive services like vaccination. The people of Liberia simply do not have the means to pay for their own health care.

Redemption Hospital is one of Monrovia’s main public hospitals, with a 150-bed capacity. After six years of support and a final renovation and expansion, MSF completed a gradual hand-over of the facility to the Ministry of Health in June 2006. Since then, the situation at Redemption has deteriorated considerably. There are major staffing gaps as the management cannot afford to pay decent salaries. Patients have to purchase their own drugs outside the hospital, and fees for services and drugs have been re-introduced. As a result, the number of patients has dropped dramatically from 1,200 inpatient admissions per month in 2005 to currently negligible levels of bed occupancy. During the transition phase, if no alternatives could be found for Redemption, the only Ministry of Health secondary health care structure in Monrovia, Liberia’s capital, the situation could only be worse in other areas of the country.

Financial and other barriers must be lifted to ensure Liberia’s population can access medical care. The key will be to continue providing a package of essential medical services free of charge throughout the transition period. Asking the country’s vulnerable, violence-affected population to pay for urgently needed health care only erodes their still-fragile coping mechanisms. It also risks contributing to their impoverishment and blatantly contradicts international concerns for poverty reduction.

The Liberian government has demonstrated its commitment by increasing the allocation for health to $10m in its 2007 budget. The Ministry of Health has also expressed its willingness to work toward the provision of a basic health care package to the entire population, while maintaining free care for all, at least throughout the transition phase. As the transition phase advances, humanitarian funding for health care in Liberia will dry up. As an emergency organisation, MSF will now reduce its activities after 17 years of intervention in-country. Faced with the ongoing dire health conditions in the country, in an exceptional move MSF decided to remain engaged in...
Building capacity in Sierra Leone

Capacity building is a catchy phrase, suggesting ideals of national ownership and strengthened local institutions. But how can we avoid it being a North-driven, patronising and unidirectional transfer of knowledge?

Proponents of capacity building often assume there is no capacity to start with and that only after a North-South transfer of know-how can locals stand on their own feet. Few development agencies understand the level of effort and commitment it takes to effectively build capacity and the contextualised understanding that must underlie any effort to add to pre-existing capacity. Agencies are often tempted by the prospect of donor dollars for capacity building, yet ignore the real work that has to be done once funding has been secured.

Given the vogue for capacity building, the International Rescue Committee’s decision to employ a consultant to advise on building local capacity to address gender-based violence (GBV) was hardly surprising. What was a pleasant surprise, however, when I was offered the job was their decision to start by undertaking an extensive capacity assessment. This may seem commonsense but, sadly, is all too often overlooked.

The Rainbo Initiative

During Sierra Leone’s 11-year civil war – which ended in 2001 – there was a high incidence of sexual assault against women and young girls. Return of peace has not meant that women and girls are safe from sexual assault. GBV remains a major public health and social problem.

In support of efforts to sustainably address GBV and to bolster the recovering state’s ability to do so, the International Rescue Committee (IRC) has partnered with the Sierra Leonian government to support sexual assault referral centres – locally referred to as ‘Rainbo’ Centres – and to holistically address GBV issues in the country. This includes not only prevention and response to sexual violence but also advocacy, legal reform, data collection and – of course – capacity building to provide full support to survivors of GBV.

The Rainbo initiative has sought to:

- respond to the multiple needs of survivors of sexual assault through direct service delivery
- raise awareness and educate the community and all partners about sexual assault and other forms of gender-based violence

Centres in the capital, Freetown, and the cities of Kenema and Kono provide free medical and psychosocial and legal support to around a thousand survivors of sexual violence. Most recent new clients have sought support because they have been raped. The majority are six- to fifteen-year-old girls. The youngest was a two-month-old girl raped by a neighbour.

The Rainbo Initiative is an innovation in the field of sexual assault response services. More innovative still is the plan to embed the Rainbo Initiative in national structures, allowing the government to take ownership of the initiative.

Given the success of this initiative and the scale of ongoing needs throughout Sierra Leone, IRC has been determined to help build the capacity of national institutions to assume leadership. Scaling up Rainbo will require strengthened government institutions, a national sexual assault network, joint advocacy and shared learning. IRC has sought to create a multi-stakeholder body