Interagency Health Evaluation

LIBERIA

September 2005

Final Report
ACKNOWLEDGEMENTS

This is the final report of the Interagency Health Evaluation (IHE) in Liberia that took place from 4 September to 1 October 2005. The evaluation was guided by a Terms of Reference formulated by the IHE Steering Committee in Monrovia in May 2005, in collaboration with the international IHE Core Working Group. The in-country evaluation was conducted by two external evaluators, Dr Cleopa Msuya and Dr Egbert Sondorp, who are also responsible for drafting this report. Any comments or additional query may be sent to the authors via email to egbert.sondorp@lshtm.ac.uk.

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LIST OF ABBREVIATIONS:

ACT  Artemesinin Combination Therapy
AHA  Africa Humanitarian Action
AIDS Acquired Immunodeficiency Syndrome
CAP  Consolidated Appeal Process
CCA  Common Country Assessment (UN)
CCS  Country Cooperation Strategy (WHO)
CHAL Christian Health Association of Liberia
CHT  County Health Team
CSB  Corn Soya Blend
CPA  Comprehensive Peace Agreement
DDRR Disarmament, Demobilisation, Reintegration and Rehabilitation
DFID Department for International Development
ECHO European Commission Humanitarian Office
EDF  European Development Fund
EPI  Expanded Programme on Immunization
FFS  Fee for Service
GDP  Gross Domestic Product
GEMAP Governance and Economic Management Assistance Programme
GFATM Global Fund to fight AIDS, Tuberculosis and Malaria
HAC  Health Action in Crises
HCS  Humanitarian Coordination Section (UNMIL)
HIV  Human Immunodeficiency Virus
IASC Inter-agency Standing Committee
ICRC International Committee of the Red Cross
IDPs Internally Displaced Persons
IHE  Interagency Health Evaluation
IMC  International Medical Corps
INGO International Non-governmental Organisation
ITN  Insecticide-treated (mosquito) Net
JFK  John F Kennedy Memorial Hospital
LDHS Liberian Demographic and Health Survey
LRRD Linking Relief Rehabilitation Development
MCH  Mother and Child Health
MDGs Millennium Development Goals
MH&SW Ministry of Health and Social Welfare
MSF  Médecins Sans Frontières
NACP National Aids Control Programme
NDS National Drug Service
NGOs Non-Governmental Organizations
NIDs National Immunization Days
NTGL National Transitional Government of Liberia
OCHA Office for the Coordination of Humanitarian Assistance
OFDA Office of U.S Foreign Disaster Assistance
PEP  Post-exposure Prophylaxis
PHC  Primary Health Care
PRSP  Poverty Reduction Strategy Paper
RFTF Results-Focused Transitional Framework
SCF-UK Save the Children Fund – United Kingdom
SGBV Sexual and Gender-Based Violence
SP  Sulfadoxine-Pyrimethamine
STI  Sexually Transmitted Infections
<table>
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<tr>
<th>Abbreviation</th>
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<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
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<tr>
<td>ToR</td>
<td>Terms of Reference</td>
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<tr>
<td>TNIMA</td>
<td>Tubman National Institute of Medical Arts</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNCHR</td>
<td>United Nations Commissioner for Human Rights</td>
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<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
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<td>UNDP</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<tr>
<td>UNMIL</td>
<td>United Nations Mission in Liberia</td>
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<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
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<tr>
<td>USD</td>
<td>US Dollar</td>
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<tr>
<td>WB</td>
<td>The World Bank</td>
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<td>WFP</td>
<td>World Food Programme</td>
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<td>World Health Organization</td>
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Key Findings and Recommendations

KEY POINTS

- The most immediate humanitarian needs of the Liberian population are increasingly met.
- Basic health services for the majority of Liberians are poor and may soon get worse, primarily due to the imminent withdrawal of humanitarian funding.
- The Government will not be able to meet this gap in the years to come.
- The re-introduction of user fees will not be a solution.
- The international community will have to urgently decide if it wants to engage in longer term health system building combined with more immediate forms of service delivery.
- A pre-requisite will be a strategic planning exercise with all key stakeholders.
- Despite the difficult environment, there seem to be options to rapidly scale up health services, which is an opportunity not to be missed.

- The health status of the Liberian population is amongst the worst in the world. The evaluators’ key assumption is that a basic package\(^1\) of health services should be available to all Liberians to promote stability, to enhance ‘human capital’, and set Liberia on the path to achieving the Millennium Development Goals (MDGs).

- Many areas currently don’t receive a basic package, which affects the health of many residents, and influences refugees and IDPs to postpone their return.

- The situation may further deteriorate if input from donors and international NGOs (currently amounting to at least $15 million US on an annual basis) is significantly reduced, as is expected.

- Even a fully ‘willing and capable’ new government will not be able to fill this health financing gap. The current government budget for health (less than $3 million US) will not be enough and is unlikely to be increased soon through, for example, increased government revenue and/or a larger percentage for health from the total government budget.

- Cost-sharing (i.e. user fees) apart from its regressive nature, disproportionately affects the poor, and will not be a solution. At best, for the majority of Liberians, it will keep some very marginal health services functioning.

- Transitional arrangements, like the Results-Focused Transitional Framework (RFTF), did not stimulate new mechanisms to channel money for the health sector through the

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\(^1\) e.g. primary (basic curative & preventive, child health and immunisation, maternal and newborn health) and basic secondary care, which can probably be delivered for 4-5US$ a person per year (see for instance a recent article by Loevinsohn in the *Lancet* 2005 ; 366:676-681)
government. It is unlikely that ‘normal development assistance and modalities’ will be put in place in the near future.

- Also, for the government and Ministry of Health to play a leading role in a viable public health sector, some difficult human resource issues will have to be tackled. Serious quantitative and qualitative shortages in the health workforce are compounded by insufficient and irregular payments, the need for a complete overhaul of the MoH payroll, and the need to re-establish training and supervision.

- On a more positive note, Liberia has the foundation of a primary health care system in the form of its ‘county health care’ system. This consists of County Health Teams and a network of facilities with designated staffing levels designed to deliver a basic package of health care to all Liberians.

- The key question is: Is there a need to wait for central system building before peripheral service delivery can be resumed or can improved service delivery be done simultaneously? Other post-conflict countries with similar dilemmas increasingly seem to find ways to overcome some of the constraints and scale up service delivery while addressing underlying system problems, e.g. by using forms of contracting.

- A prerequisite to consider such options would be a strategic planning exercise that would bring key stakeholders together to develop a joint policy direction, and subsequent implementation plans.

- Current coordination mechanisms are insufficient to conduct such an exercise. But one or more of the current stakeholders may very well have the leverage to bring stakeholders together and break the current deadlock.
EXECUTIVE SUMMARY

Introduction
1. The inter-agency health evaluation (IHE) initiative aims to stimulate evaluations across the health sector in humanitarian crises and the period afterwards. The IHE for Liberia was initiated in May 2005, when a Steering Committee was formed to guide the process and formulate a relevant Terms of Reference (Annex 1). The evaluation was conducted by two external evaluators during the month of September 2005 through document review, extensive stakeholder interviews and selected site visits including refugee camps in Guinea and Sierra Leone (Annexes 2-5).

2. The main purpose of this inter-agency evaluation of the health and nutrition sector in Liberia is to assist the Ministry of Health and Social Welfare (MoH), and other stakeholders in health and nutrition to ensure improvement of the performance in the health sector. The IHE focuses on the time from the Comprehensive Peace Agreement (CPA) in August 2003 until now, and covers all of Liberia.

3. The ToR identified seven key issues to look at. These seven issues included: general health governance, health financing, service delivery to the community, issues around refugees and internally displaced people (IDPs), and sexual and gender based violence. This report, after a description of the context, uses the seven headings as its main chapters.

Context
4. Although precise and reliable data are scarce, virtually all indicators suggest the Liberia is currently one of the most under-developed countries in the world. While per capital GDP may have fallen to as low as $110 US, the infant mortality rate (134/1000), under-five mortality rate (235/1000) and life expectancy (48 years) show the detrimental effects of conflict, poverty and lack of health services.

5. Liberia's approximately three million people live in extreme poverty; 76% of people live on less than $1 US/day and 90% of people live on less than $2 US/day. The unemployment rate is 85%. Many were displaced inside Liberia (250,000 internally displaced people) or sought refuge in neighbouring countries (300,000 refugees).

6. The 14 years of war, with its alternating periods of acute fighting and relative calm, had a profound effect on all parts of the country. Some parts were particularly heavily affected by warfare and atrocities. All counties were affected by the general collapse of economic activities, government institutions and available services.

7. The upsurge of fighting in early 2003 created massive humanitarian needs, in particular among the IDPs in and around Monrovia. Humanitarian agencies tried to address these needs, and after the CPA was signed in August 2003, gradually accessed other parts of the country. The main emphasis of most agencies was, and still is, on IDPs and on areas that were home to the many IDPs and refugees so as to assist in resettlement. Other areas, equally devoid of basic services, receive much less attention.

8. The CPA came with the establishment of the National Transitional Government of Liberia (NLTG) and the deployment of 15,000 UN troops - the United Nations Mission in Liberia (UNMIL) who managed to restore security and contributed to disarmament and demobilisation of former combatants. The UNMIL also contains a civil affairs arm to
jump-start civilian administration. Based on a Joint Needs Assessment (NTGL, UN, World Bank), a Result-Focused Transition Framework (RFTF) was formulated by early 2004 to guide priorities and resource needs during the transition period. The transition period was foreseen to end with the election of a new parliament and formation of a new government by the end of 2005.

9. The RFTF grouped 13 priority sectors into 9 clusters. Basic Services was one of these clusters, which included the health sector. To cover humanitarian needs, the RFTF was complemented by a CAP (Consolidated Appeal Process), followed by an integrated RFTF Humanitarian Appeal for the year 2005. The RFTF has been successful during the transition period in securing peace, in disarmament and demobilisation (less in reintegration and rehabilitation), in the return of many IDPs (much less in the return of refugees), and in organising broadly free and fair elections. Work in the other clusters was less successful. Part of the problem in implementing the RFTF were increasing concerns about transparency, integrity, accountability and fiscal management issues. By the end of 2005, this resulted in the signing of the GEMAP (Governance and Economic Management Assistance Programme), successful implementation of which would be a pre-condition for international donors for continuation of aid schemes and lifting of sanctions.

Health sector

10. The result of these developments in the transition period for the health sector has been two-fold. On the one hand, humanitarian agencies managed to gradually reach more people, meeting immediate humanitarian needs and starting rehabilitation of quite a number of health facilities, in particular in areas of foreseen return of IDPs and refugees. On the other hand, one sees an almost complete absence of a coordinated effort to start addressing the short and medium term rehabilitation and reconstruction of the health sector. There has been little attention paid to health sector policy and implementation strategy and the underlying problem of health financing. This policy void is not only detrimental to the health sector, but also causes difficulties for current and potential stakeholders in the health sector, in terms of developing plans or formulating appropriate exit strategies.

11. Before the conflict Liberia’s health care system was characterized by:

- Gross inequities between the rural and urban populations.
- A curative bias despite overwhelming need for preventive, promotive and rehabilitative services.
- A predominantly private ownership of health care facilities and private health care providers, accounting for over 60 percent of available health care. Private providers included churches, estates/mines and town-based private practitioners. As a consequence, Liberia does not have a strong tradition of health care management by government, unlike most African countries.
- It was only during the 1980s that the Government increased its involvement in health care provision. Some large scale health development programmes introduced the ‘district health care model’ to Liberia, its counties being the ‘district’ in this case. The organisational principles of this county health system are still in place, ready to be built upon.

12. Although the county health system is in place in principle, there are many problems. During the war, massive looting and destruction of health facilities took place. Counties and facilities that did not receive external assistance hardly functioned; at best, there are
some very minimal services still in place. Staff positions are usually filled, but mostly by people who do not have the qualifications for those posts, with, for instance, many nurse aides taking up senior positions. The war caused enormous attrition of trained health staff of all cadres; a stark example is the reduction of doctors from a pre-war level of 237 to less than 20 now. Of staff that remain, the majority is not on the government payroll, being so-called ‘volunteers’. Those that are on the payroll receive irregular payment of extremely low salaries, if they receive anything at all. The payroll also contains many ‘ghost’ workers, listing staff that have long left the service. Adding to these human resource problems is that training of new staff has almost ceased to exist.

13. Around 200 clinics are running at the moment, supported by NGOs and other agencies. However, these clinics are unevenly spread, with a focus on areas that were worst hit by the war and home to many returnees, i.e. Lofa and Nimba, and around Monrovia. Little thought has been given towards continued operation of these clinics when their current humanitarian funding ceases. The south-east of the country is reported to be the most deprived of health services at the moment. There are only a few functioning hospitals in the country.

14. It is difficult to get reliable data on government health expenditure, but this is likely to be very low, possibly around $3 million US at best. There is a relatively long tradition of cost-sharing in Liberia’s health system. Before the war, a Fee-for-Service (FFS) and Drug Revolving Fund scheme contributed less than 3% of the public health sector expenditure. In June 2003, this scheme was suspended by the MoH for the transition period because of the plight of the hugely impoverished population and the many displaced people.

15. The bulk of funding for the health sector currently comes from humanitarian funding, and as of last year, the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). Humanitarian funding primarily comes from humanitarian donors, namely ECHO and OFDA/USAID. Other sources include bilateral donor and private donor contributions to UN agencies such as UNHCR and UNICEF, as well as funding from the NGO sector, most notably the various Medecins San Frontieres (MSF) sections. It is estimated that for 2005, an amount of at least $20 million US was available for the health sector from these humanitarian actors, with over $30 million US if one adds the GFATM contribution. Such an amount could potentially be enough to provide all Liberians with a basic package of health services. Instead, it only benefits part of the population, perhaps 50% at best.

16. Withdrawal of humanitarian funding in the health sector is pending now that the transitional period has come to an end. It remains unclear how much replacement development funding is forthcoming. A grim picture is emerging of a population that may finally emerge from 14 years of conflict into a situation which is not much better. In poor health and impoverished, it seems people will have to continue to survive with very few functioning and accessible health services, at least for the next couple of years. That will not only be a humanitarian tragedy, but may have far reaching consequences in terms of continued peace building and economic recovery of the country.

17. Hopefully, a new government will be able to leverage the country’s potential wealth for the benefit of all its population, and more funds will become available for the health sector. But this will take years as the economy needs to recover from the war. In the meantime there will be a huge health financing gap. Therefore, it seems the health sector needs its ‘own’, additional transitional period of at least three to five years. Ways will
have to be sought to combine service delivery during that period with the reform and rebuilding of the health care system, including the development of long-term sustainable health financing mechanisms.

Key findings and recommendations around the 7 themes

1. Effectiveness of coordination and collaboration in the health sector
   - Several, mostly operational, coordination mechanisms were found to be in place. However, overall, there is a major gap concerning strategic coordination and none of the major stakeholders is able to take this on. There is also no proper mechanism to jointly (Government, donors, UN, NGOs) address this flaw.
   - The key recommendation of this report is to urgently work on an overarching framework for the development of Liberia’s health system. What direction should service delivery take? What minimum health care should be made available to all Liberians? What will be the role of government, of the not-for-profit non-state providers, of private providers? How should this be implemented, with what resources? How to deal with the numerous human resource issues, their remuneration and their development? How to build the capacity of the MoH and the County Health Teams (CHTs) to take up their stewardship role? How to strike a balance between longer-term need for system building and more direct and urgent service delivery?

2. Appropriateness, sustainability, effectiveness of ‘free health care’ in Liberia today
   - It is known that user fees are regressive, negatively and disproportionately affecting the poor, while exemption schemes usually do not sufficiently work to counterbalance this effect. In addition, user fees may at best cover a relative small portion of total health expenditure. However, user fees may play a role in keeping minimal services running, provided the bulk of costs is covered from other sources.
   - User fees are not a solution to fill the huge finance gap for even the most basic of services for the majority of Liberians. Since the government is not able, even under the best scenarios, to fill this gap in the coming years, the only alternative is an injection of funds from outside Liberia. It is therefore highly recommended:
     - to not re-introduce cost-sharing schemes, at least not for the time being.
     - to urgently find a solution to cover the costs of at least a basic package of health services for all Liberians, to be covered by the international community for the coming years.
     - to address long-term, sustainable health financing as an integral part of the reform of Liberia’s health system.
     - to only discuss possible cost-sharing within this overall framework of longer-term health financing options.

3. Effectiveness and efficiency of strategies during the transition phase from humanitarian relief to development
   - The inability of the RFTF to address longer term recovery and reconstruction of the health sector has left the humanitarian community in limbo. On the one hand, there is the notion of ‘the crisis is over’ and that it is time to hand-over. On the other hand, another health crisis is only now becoming visible; this crisis is an impoverished population in poor health with very limited access to basic health services that are likely to cease to exist when humanitarian support is withdrawn.
   - It is recommended to assume that the transition from relief to development in the health sector is just starting and will take a number of years. A first priority is to have
a strategic planning exercise that will outline where the health system is heading. This exercise should also define the foreseen role of non-state actors, including the international NGOs. Experiences elsewhere have shown some successes in contracting of basic health services to NGOs, for shorter or longer duration, but clearly aligned with government plans and priorities using performance-based contracts.

4. Coherence of health provision in terms of international standards

- Humanitarian assistance to IDPs, refugees and returnees has been provided in a way that largely meets the Sphere Minimum Standards. However, for the majority of people in Liberia who did not receive humanitarian assistance, the Sphere Standards cannot be applied. Even if they were applied, they would not be met as most people do not have any access to basic health services. The attainment of the health MDGs may provide another frame of reference; unsurprisingly Liberia falls far below the MDG indicators.
- Combining direct service delivery with longer term health system building may put Liberia on the path to achieving the MDGs. Immediate service provision should build on the existing basic structure of ‘county health care’, with input from others, namely experienced NGOs.

5. Effectiveness of health strategy concerning returnees

- Many IDPs have returned to their places of origin. For those in refugee camps, health care and educational facilities are well organised, and lead to good health outcomes. The decision for most refugees to return is largely influenced by political and personal security considerations, but the perceived lack of health and educational facilities back home may play a secondary role.
- It makes sense to facilitate return by providing basic services wherever possible. However, planning of facilities for returnees should be balanced with quantity and quality of services for other Liberians and should ideally be part and parcel of an overall nationwide health plan.

6. Appropriateness of the response to Sexual and Gender Based Violence (SGBV)

- While the prevalence of SGBV is expected to decrease now that peace and security are returning, it is recommended that attention be paid to address ‘peacetime SGBV’ as well as to care for the large residual caseload of survivors of SGBV generated during the conflict.
- SGBV is an issue which exceeds the health sector and has many ramifications needing the input of societal groups, the judiciary, the police, as well as a range of other government institutes, including the Ministry of Gender and Development.

7. Appropriateness and relevance of health care according to health priorities

- Health priorities in Liberia are those typical to most tropical, low income countries: childhood diseases, maternal mortality, malaria, tuberculosis, and malnutrition. In addition, sexually transmitted infections (STIs), HIV/AIDS, SGBV and mental health issues contribute to the burden of disease, and should be addressed. Outbreak control of lassa fever, yellow fever and cholera also need to be prioritized.
- Most health priorities can be tackled by a well functioning primary health care system, with community involvement, a network of primary care clinics and basic secondary care. It is therefore recommended to focus resources and energy on the provision of an essential health package that can be delivered by a primary health care system.
1. INTRODUCTION

1.1 BACKGROUND TO THE INTERAGENCY HEALTH AND NUTRITION EVALUATION (IHE) INITIATIVE

The Inter-agency Health and Nutrition Evaluation (IHE) Initiative was created in 2003 by a group of UN agencies, NGOs and institutions involved in humanitarian assistance. It was spearheaded by WHO and UNHCR, and is managed by a core working group. Inter-agency health and nutrition evaluations (IHEs) analyse the sector-wide impact of the collective efforts of the humanitarian community. Such evaluations traverse agency, and where necessary, national boundaries to examine the impact of health and nutrition interventions on all affected populations in a humanitarian crisis. IHEs can help identify gaps and overlaps in programming, share best practices, and analyse the overall performance of the health sector. An IHE can provide the evidence base for re-orientation of the health sector response, and become part of the on-going planning process.

To date, the initiative has conducted evaluations in Nepal, Zambia, Pakistan, Burundi, and Chad. The Liberia IHE is part of this series. While every IHE stands alone and should primarily be of benefit to the local situation, an IHE will also contribute to wider lesson learning for the international humanitarian community. The IHE initiative is now being integrated into the ‘Joint Initiative to Improve Humanitarian Health Outcomes’ of the IASC Humanitarian Health Cluster, led by WHO.

1.2 BACKGROUND TO THE INTERAGENCY HEALTH EVALUATION (IHE) IN LIBERIA

On behalf of the core working group of the IHE Initiative, a pre-visit was staged to Liberia in May 2005 to discuss desirability of an IHE, to set up a local IHE Steering Committee, and to formulate country relevant terms of reference. At its establishment, the IHE Steering Committee consisted of virtually all stakeholders in Liberia’s health sector. A subset of agencies was responsible for finalising the ToR, drafting a work plan and assisting in the logistics of the exercise. The Core Working Group of the IHE Initiative recruited the external evaluators, who paid an in-country visit from 4 September to 1 October 2005 (including field visits to refugee sites in Guinea and Sierra Leone). The evaluation team was hosted by WHO that, together with UNHCR, also facilitated the field trips. The evaluation team met twice with the Steering Committee for an initial briefing and a final debriefing.

1.3 TERMS OF REFERENCE

In line with IHE principles and the particular situation in Liberia, the purpose of the evaluation was formulated in the Terms of Reference (Annex 1) as:

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2 They include, in no particular order: Unicef, ACF, MSF, Liberian NRCS, UNMIL, IMC, EQUIP, Mother Patern College of Health Sciences, MDM, BPRM, ECHO, Save the Children UK, UNHCR, WHO, Ministry of Health, MERLIN, WFP, Africare, USAID, Merci, UNFPA, UNDP, IRC, AHA and ICRC.
The main purpose of the inter-agency evaluation of the health sector (i.e. all health and nutrition programmes, services and initiatives) in Liberia, through a collaborative process involving all relevant stakeholders in health and nutrition, is to assist Ministry of Health and Social Welfare (MoH), and other stakeholders in health and nutrition to ensure improvement of the performance in the health sector. The results from the IHE will feed into health sector-wide strategy development and planning and/or revision and adjustment. In particular, it will enable to optimize the planning for the (new) MoH after the elections foreseen in October 2005. In addition, the results will provide up-to-date reliable evidence on which to base resource allocation and for resource mobilisation in general. The IHE results will also create opportunities whereby all stakeholders in health can learn from identified strengths and weaknesses from their performance as a whole.

Furthermore, the Terms of Reference (ToR) stated that the ‘Liberia IHE encompasses various domains ranging from general health governance, health financing and service delivery to the community, refugees/IDPS, to sexual and gender based violence’ and ‘will not limit itself to specific geographic areas’. In terms of the time frame, the IHE was to focus on ‘the time from the Peace Agreement in August 2003 until now’. The ToR identified seven key issues to look at, each with a subset of questions. This report, after a description of the context, will use the seven headings as its main chapters.

1.4  Methodology

The evaluators did a document review, and conducted numerous interviews and focus group. A questionnaire, divided into the seven topics, was distributed to stakeholders prior to the interviews (Annex 2). The evaluators attempted to see as many of the key players as possible in the short time available and largely succeeded in doing so (Annexes 3-5). Both the document search and the interviews focused on the performance of the health sector since the evaluation’s scope was to provide an overview of the performance of the health sector, now and in the near future. The evaluation did not look at the performance of individual agencies or programmes. The report mentions agencies, but only as examples, not to be judgemental.

Field visits were primarily meant to do some ‘reality checking’, and were not an attempt to visit a representative sample of health facilities. Based on convenience and purpose the following sites were visited: a number of IDP camps in and around Monrovia; secondary and tertiary referral services (Buchanan hospital, Redemption hospital, and JFK hospital); and health facilities in two counties, of which one was relatively well supported (Grand Bassa) and the other one (River Cess) is one of the least supported counties. A prepared visit to Lofa County, where many refugees and IDPs originated from, and are currently resettling, had to be cancelled at the last minute due to logistical problems. To look at a number of specific questions related to refugees, visits were organised to Kenema in Sierra Leone and Nzerekore in Guinea.
2. **THE CONTEXT**

2.1 **LIBERIA: AN OVERVIEW**

Located on the west coast of Africa, Liberia has been engulfed by a fourteen-year civil war that has seen massive population displacements and a serious reversal of all its impressive developmental indices. Due to the war, infant mortality rates reached 134 per 1000 live births currently. The under-5 mortality rate, at 235 per 1000 live births, is way above the Sub-Saharan average of 175 per 1000 live births. The Liberia Demographic and Health Survey (LDHS 2000) calculated a maternal mortality rate of 578 per 100,000, but may well be higher at the moment.³ Life expectancy at birth is about 48 years, down from a respectable 55 years in the 1980s. About 39 percent of under-fives are stunted, indicating chronic food insufficiency.

![Figure 1: Life expectancy and GDP, compared to other areas](image)

Real GDP in 1987 was $914.5 million US but by 1999 it had fallen by almost 50% to $410 million US. Per capita GDP was $169.8 US in 1999, decreasing even further to about $110 US. All these statistics indicate that Liberia is one of the most under-developed countries in the world. In addition, Liberia has a debt burden of $3 billion US.

The seed that eventually gave birth to the conflict was sown during the origin of this Western African nation. Freed Afro-American slaves brought to settle in the Western African coast subjugated the indigenous population they found there, and created Africa’s first, free black-governed republic. In over 150 years of its history, Liberia never had a President from its native population until Master Sergeant Samuel Doe overthrew the government of President William Tolbert and became President in 1980. This continued dominance by a small elite of settlers, exacerbated by internal ethnic disputes, led to “the

³ The LDHS uses the ‘sisterhood method’ to estimate maternal mortality, which in fact reflects the situation of 12-13 years earlier. So, currently, maternal mortality may be higher as some figures seem to indicate.
marginalization of a very large segment of the population particularly in the countryside, the concentration of wealth in the hands of a privileged few and a predatory exploitation of natural resources all of which made Liberia difficult to govern. These are some of the areas that will need attention to preserve a long-lasting peace.

The current population of Liberia is estimated to be 2.9 million and is growing at a rate of 2.5%. A significant portion of this population is displaced, either as refugees or as internally displaced persons (IDPs) living in camps. Before the current repatriation exercise started, it was estimated that due to the conflict there were 300,000 Liberian refugees in the West African countries of Sierra Leone, Guinea, Cote d’Ivoire and Ghana and 250,000 internally displaced persons (IDPs), most of them around the capital, Monrovia. At the time of this evaluation, the estimate of Liberian refugees was 250,000. Of the IDPs, 209,092 have now been resettled.

As a country located in a crisis-ridden sub region, Liberia is also itself host to thousands of refugees (73,000) from elsewhere within the region, particularly Cote d’Ivoire. In the last quarter of 2004, 10,000 refugees from Cote d’Ivoire entered Liberia and with the conflict remaining unresolved in that country, there is likelihood that the number may increase.

Liberia is ranked very low on the Human Development Index, falling from 131st position in 1992 to currently 174th out of 175 countries worldwide. 76% of the population lives on less than $1 US a day, 90% on less than $2 US. Eighty-five percent of Liberians are unemployed. United Nations sanctions in response to Liberia’s alleged support of the murderous regime of Foday Sankoh and his Revolutionary United Front in neighbouring Sierra Leone are still in place. Literacy is very low due to the decimation of educational facilities and disruption of adult literacy programmes.
Politically divided into 15 counties, no area of Liberia was spared the ravages of the conflict, but some counties fared worse than others. The counties of Lofa and Nimba, for example, are said to have suffered more than others in the conflict in terms of loss of life and destruction of property.

Past and recent events still have an important bearing on today’s situation in Liberia. The table (adapted from BBC news) aims to briefly sum up some of those key events.

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1847</td>
<td>Liberia established as independent state.</td>
</tr>
<tr>
<td>1971</td>
<td>Tubman, president since 1943 dies and is succeeded by William Tolbert Jr.</td>
</tr>
<tr>
<td>1980</td>
<td>Master Sergeant Samuel Doe stages military coup. Tolbert publicly executed.</td>
</tr>
<tr>
<td>1989</td>
<td>National Patriotic Front of Liberia led by Charles Taylor begins an uprising</td>
</tr>
<tr>
<td>1997</td>
<td>Presidential and legislative elections held. Charles Taylor wins a landslide and his National Patriotic Party wins a majority in the National Assembly.</td>
</tr>
<tr>
<td>2002</td>
<td>January - More than 50,000 Liberians and Sierra Leonean refugees flee fighting. In February Taylor declares a state of emergency.</td>
</tr>
<tr>
<td>2003</td>
<td>March - Rebels advance to within 10km of Monrovia.</td>
</tr>
<tr>
<td>2003</td>
<td>September/October - US forces pull out. UN launches major peacekeeping mission, deploying 15,000 troops (UNMIL).</td>
</tr>
<tr>
<td>2005</td>
<td>September - Liberia signs an agreement under which the international community will supervise the state's finances in an effort to counter corruption (GEMAP)</td>
</tr>
<tr>
<td>2005</td>
<td>23 November - Ellen Johnson-Sirleaf is proclaimed the winner of presidential elections, becoming the first woman to be elected as an African head of state.</td>
</tr>
</tbody>
</table>

2.2 LIBERIA: TRANSITIONAL PERIOD AND LINK WITH INTERNATIONAL COMMUNITY

The 14 years of war, from 1989 to 2003, have in fact been a series of conflicts, affecting different parts of the country at different times, alternating with periods of relative calm, with or without the presence of peacekeepers. The humanitarian community also had intermittent access to varying parts of the country. With the upsurge of the fighting in early 2003, in particular in and around Monrovia, with so many people fleeing from the country side to town, the humanitarians did what they could, but had little access to places outside Monrovia.

At the end of what is hopefully the last round of fighting, the Comprehensive Peace Agreement (CPA) of August 2003 heralded a number of profound changes that also had an impact on humanitarian work, and on the health sector as described later in the report. The CPA came with the establishment of the National Transitional Government of Liberia (NTGL) that was to lead the country through a transitional period to be ended with the election of a new President and parliament. The 15,000 troops of the international peacekeeping forces, the UN Mission in Liberia (UNMIL), gradually restored order, allowing increasing access to most of the country side and the start of the demobilisation of ex-combatants. The Security Council mandate for UNMIL was a
‘Chapter 7’ mission, with the option to use force to promote and keep peace. Also, the UNMIL was to be an ‘integrated mission’, with next to the peacekeeping troops, the disarmament and support to a new police force, a civil affairs arm ‘to jump-start civilian administration throughout the country’. This included humanitarian issues and to that effect the Humanitarian Coordination Section (HCS) was set up within UNMIL, replacing OCHA. These developments gave rise to undertaking a Joint (NTGL, UN, World Bank) Needs Assessment and formulation of a Result-Focused Transition Framework (RFTF) by early 2004. The RFTF was to guide priorities and resource needs during the transition period. Thirteen priority sectors were grouped into nine “clusters”: Security; Disarmament, Demobilisation, Reintegration and Rehabilitation (DDRR); Reintegration of Internally Displaced Persons (IDPs), Returnees and Refugees; Governance and Rule of Law; Elections; Basic Services (which includes the sectors of Health and Nutrition, Education, and Community Water and Sanitation); Productive Capacity and Livelihoods; Infrastructure; and Economic Policy and Development Strategy. The RFTF has a focus on recovery and reconstruction, and the rebuild of national institutions and was meant to be an important instrument to elicit funds from the international community, to begin with at the Liberia Reconstruction Conference held in New York in February 2004.

The massive humanitarian needs in the country, just after the peace agreement that opened up most of the country, were not covered by the RFTF, but still by the Consolidated Appeal Process (CAP) that had been completed before the end of 2003. The CAP 2004 then got amended in a Mid-Year Review to make it more directly complementary to the programmes outlined in the RFTF, followed by an integrated RFTF-Humanitarian Appeal for the year 2005.

A scheduled revision of the RFTF took place early 2005. It was decided to extend the RFTF till March 2006, when, with a new government in place, the RFTF could dovetail into an MDG-based interim Poverty Reduction Strategy Policy (I-PRSP) process. While giving priority to the elections, the return and reintegration of ex-combatants, IDPs and refugees, and demobilisation, a key concern is expressed in the revised RFTF document regarding ‘transparency, integrity, accountability and fiscal management issues’ which threaten to ‘roll back the progress and confidence achieved in the early days of the RFTF’.

Transparency remained an issue, however, and the attention of key donors went into negotiating an agreement with the NTGL that became known as the Governance and Economic Management Assistance Programme (GEMAP), signed in September 2005.
With the GEMAP ‘donors want to ring-fence key sources of revenue, place international supervisors in major ministries and lucrative sites such as the port, airport, customs office and forestry commission, as well as bring in judges from abroad.’ Successful implementation of the GEMAP is a pre-condition for continuation of aid schemes and the potential lifting of sanctions on diamond and timber exports.

The RFTF has been successful during the transition period in securing peace, in disarmament and demobilisation (less in reintegration and rehabilitation), in the return of many IDPs (much less in the return of refugees), and in organising free and fair elections. Work in other clusters has been less successful and in particular since spring 2005 many considered the RFTF ‘to be dead’, while others maintained it to be just ‘on hold’.

Realising that a successor to the RFTF in the form of a CCA/UNDAF process as well as an interim Poverty Reduction Strategy Paper to be launched in 2006 would take time, the UN Country Team decided to go for another CAP ‘to ensure sustained donor engagement and continued funding for short-term humanitarian needs’. This CAP 2006 has just been launched.

Two issues from this chapter are of particular relevance to this report. First, there was difficulty addressing all the clusters of the RFTF, including cluster six, the basic service provision cluster. No real concerted effort to reconstruct the health sector or joint strategy development seems to have taken place. In addition, as some informants remarked, the fact that health was part of a wider cluster did not help in coordinating the health sector as such. Most health activities during the transition period were driven by humanitarian agencies and humanitarian funding, initially by dealing with obvious humanitarian needs in areas that opened up, then by targeting returnees. However, humanitarian agencies and donors are now starting to think about winding down ‘since the crisis is over’. Secondly, the integrated UNMIL mission, with its inherent risk of becoming embroiled in fighting, initially shied away from many NGO and UN agencies. To make things worse, the ‘handover’ from OCHA to the new Humanitarian Coordination Section (HCS) was poor, meaning the HCS almost had to start from scratch to play a role in humanitarian
coordination. And finally, the health activities of the UNMIL civil affairs were largely restricted to returnee areas.

On the positive side, many people (including the evaluators) were positive about the Humanitarian Information Centre (HIC), which was virtually the only place where at least some basic data could be found in an otherwise remarkably data scarce environment.

3. **THE HEALTH SECTOR**

3.1 **THE HEALTH SYSTEM**

The goal of Liberia’s health system should be to cope with the major burden of disease in the country. This burden is first of all quite similar to what is usually found in tropical, low income countries: childhood diseases (diarrhoea, chest infections, vaccine preventable diseases), maternal mortality, malaria, tuberculosis, and malnutrition. Sexually transmitted infections (STIs) and HIV/AIDS (with a prevalence of at least 12%) are also important. Of concern are also regular outbreaks of lassa fever, yellow fever and cholera. More attention is now being paid to SGBV, as well as to mental health needs, both of which are likely to have increased due to the conflict.

Before the conflict Liberia’s health care system was characterized by:

- Gross inequities between the rural and urban populations.
- A curative bias despite overwhelming need for preventive, promotive and rehabilitative services.
- Predominantly private ownership of health care facilities and private health care providers, accounting for over 60 percent of available health care. Private providers included churches, estates/mines and town-based private practitioners. Therefore, Liberia does not therefore have a strong tradition of health care management by government, unlike most countries in Africa.
- It was only during Doe’s presidency that Government increased its involvement in health care provision. In the 1980’s some large scale health development programmes existed introducing the ‘district health care model’ to Liberia, its counties being the ‘district’. The organisational principles of this ‘county health system’ are still in place, ready to be built upon.

The Ministry of Health and Social Welfare leads the health sector, with a Minister and three deputy ministers, one for social welfare, one for planning and one being the Chief Medical Officer. There is a policy document in place (National Health Policy, 2000), based on the principles of primary health care and decentralisation. However, the policy was never supplemented by a strategic work plan. In addition to the

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6 Acute global malnutrition has been reported at various places to be 5%, with severe wasting being less than 1%. Reported rates of between 20-40% stunting indicate that chronic malnutrition is widespread in Liberia.
transparency problems faced by the Ministry, many informants felt that it had very limited capacity, and that it would have difficulty managing the health sector, and taking forward its stewardship role.

Every County has a County Health Team, headed by a County Health Officer. Each team includes a community health department director, a hospital administrator, a hospital medical director and a nursing director, as shown in the picture below.

![Figure 4: composition of County Health Team](image)

County health facilities typically consist of a basic hospital and 10-20 primary care clinics. All these clinics have prescribed functions and staff patterns, i.e. an officer in charge (e.g. nurse or certified midwife), nurse aid, vaccinator, cleaner, security, trained traditional midwife and a registrar. Most clinics we visited had named lists of people working in these positions. Many of those, however, do not have the qualifications for those posts, with for instance many nurse aides taking up senior positions. Also, most of them are not on the payroll of the government; they are so-called ‘volunteers’. There is a marked difference between clinics that receive support from NGOs, and those who do not. In NGO supported clinics staff receive payment, drugs are supplied and the clinic is rehabilitated and equipped. Patients receive care that is usually (and often very explicitly, see picture) provided for free.

![Figure 5: signpost at a clinic in Grand Bassa](image)

In clinics that are not supported, most staff does not get paid and there is a serious lack of basic equipment and drugs. Staff manage to keep these clinic running, at a very low level,
on incentives they receive from the Expanded Programme for Immunization (EPI) programme (which may run from such clinics) and patient user fees, provided the clinic has some drugs\textsuperscript{7}. Staff may also participate in workshops and polio-campaigns that come with incentives.

During the war, massive looting and destruction of health facilities took place. Prior to 1990, there were 30 hospitals, 130 health centres and 330 health posts and clinics. An assessment done in 1997 showed that 90 percent of the facilities were extensively damaged and vandalized. Most humanitarian agencies involved in health usually incorporate rehabilitation of these health facilities in the programmes for their target groups. There are about 200 clinics running at the moment, supported by NGOs and other agencies. However, these clinics are unevenly spread, with a focus on areas that were worst hit by the war and home to many returnees, i.e. Lofa and Nimba, and around Monrovia. The south-east of the country is reported to be the most deprived of health services at the moment. There are only few functioning hospitals in the country (around 5-8 with at least some secondary health care services) and JFK hospital\textsuperscript{8} in Monrovia and Phebe hospital in central Liberia as the only tertiary hospitals.

Apart from direct imports, drugs can be obtained from the National Drug Service (NDS); paid for in US dollars, its main clients are currently NGOs that purchase drugs for the clinics they support. Clinics that use cost-sharing therefore buy drugs from local pharmacies. The NDS is a non-profit public service-oriented corporation charged with providing quality drugs and medical supplies to Liberia’s health facilities. It was to be financed, at least in part, by the Cost-Sharing Scheme, which was launched in 2001, but is currently suspended.

The war has caused enormous attrition of trained health staff of all cadres. As a stark example, the number of doctors reduced from a pre-war level of 237 to less than 20. Of staff that remain, the majority are not on the government payroll, while those that are on the payroll are irregularly paid, if at all, with bus fares to collect the payment in Monrovia sometimes higher than the low wages\textsuperscript{9}. On the other hand, it was frequently mentioned that the payroll contains many ‘ghost’ workers, i.e. staff that have long ago left the service.

Training of new staff has almost ceased to exist. The main contributor at this stage seems to be the Mother Patern College of Health Sciences, where nurses and laboratory technicians are being trained. Merlin told us of plans to revive the TNIMA (Tubman National Institute of Medical Arts) where nurses and physician assistants could be trained.

\textsuperscript{7} more drugs may soon become available for this purpose at these clinics through the GFATM
\textsuperscript{8} JFK hospital currently has only a fraction of its former capacity as 650 beds teaching hospital with once 170 doctors in the 1980’s; and all services, from cleaner, lab, nursing, to medicine/surgery has to be paid for by patients
\textsuperscript{9} formal salaries for more senior health staff are in the range of 15-20 US$ per month
3.2 Health Financing

Figures on government health spending are difficult to get. The recent WHO Country Strategy Paper mentions an astonishingly low actual disbursement figure of $330,000 US for the year 2002/3. Other sources mention a current government health budget of around $3 million US, which would be around 6% of the total budget. Unreliable as these data seem to be, they all point in the direction of extremely low government spending on health (as for all other sectors).

There is a relatively long tradition of cost-sharing in Liberia’s health system. Before the war, a Fee-for-Service (FFS), and Drug Revolving Fund scheme\textsuperscript{10} contributed less than 3% of the public health sector expenditure. This scheme stopped functioning when the war started, but in June 2001, a modified version was introduced. In June 2003, this scheme was suspended by the MoH for the transition period due to the plight of the impoverished population, and the many displaced. A number of NGOs now make a strong point of adhering to this ruling in the clinics and hospitals they support.

\begin{figure}[h]
\centering
\includegraphics[width=0.5\textwidth]{figure6.jpg}
\caption{Free care in these hospitals}
\end{figure}

The reality in clinics that do not receive support is that cost-sharing is still in use, typically charging $10 L for service plus $25 L for drugs. For these clinics, it is the only way to provide at least some basic services, irregular and minimal though they are.

Clinics and hospitals (like the St Joseph’s Catholic Hospital in Monrovia) run by faith-based organisations usually continue to raise user fees. Also Redemption hospital, the only free general hospital in greater Monrovia will soon start charging user fees, with the exception of mother and child care in its former satellite facility, the Island Clinic.

Apart from humanitarian input into the health sector (see below), the health sector now receives a substantial financial injection from the GFATM (Global Fund to fight AIDS, Tuberculosis and Malaria), amounting to $24 million US for 2 years. This funding started in 2004 and is currently managed by UNDP. So far, emphasis has been on training for the three diseases and procurement of drugs; in particular malaria treatment (ACT) is

\textsuperscript{10} In this scheme patients paid 10L$ fee for service (of which 70% for clinic staff, 20% for CHT and 10% for central level); plus 25L$ for drugs (to be used by clinic to buy drugs, via the CHT, from the NDS)
now expected to become available soon. Plans are also underway to address some of the critiques of the Global Fund, which are that it should and could contribute to rebuilding the health system, and should move beyond its focus on the three diseases. A start has been made by donating vehicles to all county health teams to allow them to make supervisory visits in their counties.

4. **HUMANITARIAN INPUT IN HEALTH**

Throughout the war, humanitarian agencies kept trying to reach those most affected by the conflict. During the transition phase, the main input in health came via these agencies. As areas opened up again after the CPA, agencies did needs assessments in these newly accessible areas, and started activities where they thought needs were greatest. This resulted in a patchwork of activities, initially focusing on areas where there were IDPs and returnees, and which were also the areas most affected by the war. Only recently has more attention been given to some of the most deprived areas of the country in south-east Liberia.

4.1 **NGOS IN THE HEALTH SECTOR**

There are about 20 NGOs presently active in the health sector in Liberia, including 4 national NGOs. They are funded by private donors, some bilateral donors, and in particular by specialised humanitarian funding bodies, like ECHO and OFDA. Their activities have changed over time, depending on access, funding and other considerations. Not to be exhaustive, but just as a way to give some examples what agencies do, the following list is indicative and illustrative:

- MSF France: support to a special war-related emergency hospital
- AHA: support to over 16 clinics in relation to repatriation, for UNHCR
- Africare: support to around 30 clinics in 3 counties, with a longer term, more developmental approach
- SCF-UK: support to IDPs; SGBV work in 5 counties
- MSF Belgium: focus on IDPs around Monrovia plus support to general hospital
- MSF Holland: support to primary health care clinics in 2 counties
- MSF Switzerland: support to field hospital in refugee camp
- MSF Spain: support to MCH hospital
- IMC: support to clinics in Lofa, for returnees, plus surgical hospital activities
- ICRC: support to PHC clinics in 2 counties, and a hospital in another county
- Merlin: support to 27 clinics and 2 hospitals, taking more of a ‘county health care’ approach, with support to the CHTs, in 4 counties in the south-east.

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11 These include: ACF, Africare, AHA, CHAL, Equip, ICRC, IMC, IRC, MDM, Merci, Merlin, MSF (5 sections), SCF/UK, and few others.
4.2 UN AGENCIES

Several UN agencies play a role in the health sector.\textsuperscript{12}

- WHO has been in country throughout most of the past difficult years, adapting its role to the circumstances. Its primary role is and remains ‘to support government’s efforts in achieving priority national health’. A recently published Country Cooperation Strategy specifies a focus on four Strategic Areas of Intervention:\textsuperscript{13}
  - Emergency Preparedness and Humanitarian Response
  - Strengthening Performance of the Health System
  - Disease Prevention and Control
  - Improvement of Maternal and Child Health

Most of its activities during the transition period could also be captured under these headings and entail a variety of activities, some more outspoken than others. In particular WHO’s role regarding the second item, strengthening the health system, has been difficult. More of this will be covered in a later chapter.

- UNHCR, with its primary mandate being to look after refugees and their return, is playing an active role in promoting health rehabilitation in areas of return, in addition to health care provision in remaining refugee camps. It has also taken on an important role in IDP return issues, partly in response to a void in coordination between the various UN agencies and UNMIL.

- UNICEF, in line with its traditional child-focused role in amongst others education and health, plays a country-wide role, primarily stimulating EPI ‘as skeleton to build up the health system’. It has also been instrumental in reactivating many clinics, in particular their refurbishment. As noted above, many un-supported clinics continue to survive and provide a few services thanks to the existence of these EPI activities.

![Figure 7: Store room in Bokay clinic, Grand Bassa](image)

\textsuperscript{12} UNFPA is not specifically mentioned here, but it is relevant to mention that a next Demographic and Health Survey will be undertaken early 2006

\textsuperscript{13} please refer to the Country Cooperation Strategy document for more details
4.3 **HUMANITARIAN DONORS**

The main humanitarian donors during the transition period were OFDA and ECHO.

- **OFDA**, which is the Office for U.S. Foreign Disaster Assistance within USAID, provides substantial funding for humanitarian health activities, contributing $5.5 million US over the past year, or more than half of the total humanitarian health budget. OFDA’s mandate is one of ‘gap-filling’ during crisis, a mandate that usually does not extend very much into transition. Thus, OFDA is likely to phase out its funding in Liberia, despite major concerns over the lack of a strategic direction for the health sector and the great uncertainty over the likelihood of development funding after the elections, such as that provided by other offices within USAID. Several informants commended the workshop USAID/OFDA organised in April 2005 with its implementing partners and several guests on the ‘Liberian health transition’. It was one of the few occasions that allowed for some reflection on the difficulties people face in the health sector, the balance between emergency work and longer term thinking, and what this means for agencies to programme and think about exit strategies during the transition period. Key themes discussed, which are still highly relevant today, were:

  - the balance between providing support to MoH at national level versus direct provision of services
  - the balance between high quality care for smaller number of beneficiaries versus reaching more beneficiaries with a more focused set of approaches
  - should cost-recovery be reintroduced at this time in Liberia.

- **ECHO** is the largest humanitarian donor in health, with around $US 8-9 million per year and currently 14 contracts with different partner agencies. ECHO could potentially focus more on a transition period, among others with the use of its concept of LRRD (Linking Relief, Rehabilitation and Development), but they are unsure how this concept could be applied to Liberia. Again, this is partly due to the lack of an overarching framework in which a ‘real transition’ for the health sector can take place. Some of the difficulties ECHO and its partners face are also reflected in the discussions during the latest sectoral meetings, which ECHO organises bi-annually with its partners. This is a selection from a list of main challenges that agencies identified during this meeting:

  - Several problems in relation to the MoH (perceived lack of commitment, corruption, lack of coordination, poor supervision/support of field activities and CHTs)
  - Problems related to human resources (lack in quantity and quality, payroll and certification issues, lack of training)

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14 an interesting finding presented during this meeting is that annual drug cost for a primary care facility may add up to around $5000US
Liberia Interagency Health Evaluation Report

- Funding (expected decrease of donor funding, without clear alternative, and with anxiety over cost-recovery to fill this gap)
- Policies (no MoH general strategy; minimal support on policy making by WHO; poor implementation of existing technical policies)
- Successes were also identified, in particular: the Polio campaigns, the health network deployment and the NGO coordination on incentive payments to staff

4.4 EXIT PLANNING

Humanitarian agencies are all thinking about the immediate future, in particular the period after the elections and the installation of a new government. Most are adopting a ‘wait and see’ approach, and in particular, are assessing whether the current state of stability will be further enhanced. Assuming this will be the case, most agencies with a more strict humanitarian mandate (e.g. ICRC, MSF) and the humanitarian donors (OFDA, ECHO) are preparing to leave in the course of 2006/early 2007, since ‘the emergency is over’.

The timeframe for agencies that focus on the resettlement of refugees and IDPs will be determined by the speed of their return. There is an expectation that refugees will come back in greater numbers if the new government facilitates continued stability. Finally, there are agencies with a longer term interest in rebuilding an appropriate and equitable health system for Liberia that are willing to stay longer. However they are apprehensive about the predicted, enormous funding gap for the health sector in the next few years, and feel lack of funding may preclude them from staying on in Liberia.

5. FUNDING FOR THE HEALTH SECTOR

No precise figures can be given here, but crude estimates provide a picture of the current situation, and point to a possibly pretty grim outlook for the coming period. Current spending, on an annual basis, may amount to the following:

- the Government spends (probably much) less than $3 million US on health
- the major humanitarian donors (ECHO, OFDA) donate about $14 million US
- UNHCR will bring in a substantial amount for health for returnees from other sources, as will UNICEF
- some agencies are sponsored by bilateral donors, e.g. Merlin receives a substantial amount from DFID
- other agencies, in particular the MSFs, will bring in money from private donations
- the Global Fund budget is $24 million US for two years

A reasonable guesstimate is that currently at least $20 million US comes in as humanitarian input for the health sector, with over $30 million US if the Global Fund
money is included. The magnitude of these sums is in line with the 2005 Humanitarian Appeal ($32 million US for health) and the 2006 CAP ($23 million US).

If humanitarian funding will dry up as is expected to happen as of 2006, there does not seem to be any replacement by other sources of funding. USAID is expected to formulate a ‘post-transition’ health programme, but its scope is unknown yet and the expected amount will be moderate ($3.5 million US was mentioned as preliminary figure). The European Union, who will incorporate Liberia under its planned EDF funding, is not planning to invest in the health sector, apart from limited support to the NDS. Bilateral donors may contribute, but the extent of this support is unknown (they are not present in Liberia at the moment). The World Bank, a frequent investor in health in other post-conflict areas, is not active yet at sector level. Awaiting the arrival of a new, representative government and the implementation of GEMAP, the Bank may be able to lift the current ‘non-accrual status’ for Liberia, which may open access to regular loan mechanisms, which then –in principle- may include health.

With current humanitarian funding of between $20-30 million US, part of the population, including some of the most vulnerable, i.e. IDPs and refugees, is provided with at least some basic health care services. However, a majority of Liberia’s population does not have any access to health care beyond the very basics (some EPI, some irregular supply of drugs). With humanitarian funding dwindling in the course of 2006, without any outlook for substantial replacement from other sources, this situation is likely to get much worse. Undoubtedly, more emphasis will then be put on revival of cost-recovery schemes, this being the only option left. This will ensure survival of some rudimentary health care, but will never yield sufficient resources to provide even a very minimal package addressing the population’s main burden of disease. In addition, many people will not be able to access care at all if user fees are re-introduced.

The results of this evaluation point to a bleak picture for Liberia’s population, which is likely to emerge from 14 years of conflict into a situation that is not much better in terms of health and other social services. The withdrawal of humanitarian aid and the predicted transitional funding gap will mean that Liberia’s people, who are largely impoverished and already in poor health, will have very little, if any access to health and other basic services. That will not only be a humanitarian tragedy, but may have far reaching consequences in terms of continued peace building and economic recovery of the country.

Of course, with a new government in place that is willing and able to exploit the country’s potential wealth for the benefit of all its population, more funds will become available for the health care sector. However, until the economy of Liberia recovers, which is likely to take years based on previous experience in other post-conflict countries, it is unlikely that health care can be funded entirely from Liberia’s coffers. It seems the health sector needs its ‘own’, additional transitional period of at least three to five years. Ways will have to be sought to combine service delivery during that period with full reform and rebuilding of the health care system, and long-term, sustainable health financing mechanisms must be developed.
Interesting in this respect is growing evidence that it may be possible to deliver a basic package of health services that addresses the major burden of diseases in a cost-effective way for as little as around $5 US per person per year\textsuperscript{15}. If this holds true for Liberia, $15-$20 million US per annum would take Liberia a long way towards delivering a basic package of services (based on its population and the cost per person). Global Fund monies are already in the country and could potentially be used to meet part of the cost of such package.

6. \textbf{REFUGEE HEALTH}

One of the evaluators (Dr. Msuya) travelled to Kenema in Sierra Leone by road and Nzerekore in Guinea by air. These are both sites of Liberian refugee camps. Site visits, interviews with care takers and focus group discussions were conducted at these places. These, together with visits to IDP camps in and around Monrovia, and transit camps for returnees from Sierra Leone, provided the basis for the analysis of questions regarding specific cross-border health issues, and refugee perceptions on health services and health risks affecting their decision to return.

6.1 \textbf{REFUGEE HEALTH CARE}

Care provided in refugee camps is public health-oriented and has managed to achieve low mortality rates of acceptable international standards. In the camps of Guinea both under-five and crude mortality rates are below 1/10,000/day, the SPHERE benchmark for transition from emergency to post-emergency phase in displacement.

Paradoxically, refugees consider the health care provided to them in the camps to be of inferior standard when compared to the health care they were used to in Liberia. In the privately operated health care system in Liberia they were used to more liberal access to a multiplicity of drugs, unlike the ‘Paracetamol Clinics’, as some derisively call the refugee facilities.

The refugees may be exposed to higher prevalence rates of HIV/AIDS than Liberia, which may constitute a potential risk on their return, but this has not yet been ascertained. UNHCR and its implementing partners provide a minimum package for HIV/AIDS/STI in IDPs and refugee camps. The situation of sexual and gender based violence is covered in Section 12 of this report.

Safe Motherhood is more or less assured in the camps. All women have access to antenatal care and all deliveries are performed in health facilities, and ambulance referral is available and functional, unlike the situation in Liberia.

In the refugee camps, TB cases are treated under the host countries’ national programmes and high cure rates have been achieved. Patient compliance, follow up in the ‘captive

\textsuperscript{15} see for instance a recent article by Loevinsohn in the \textit{Lancet} 2005 ; 366:676-681
population’, surveillance and passive and active case finding are good. No multi-drug resistance has been reported in any of the refugee programmes visited. Guidelines must, however, be developed on how TB is to be handled during repatriation and beyond, either by stopping enrolment of new cases or retain the diagnosed TB patient in the host country until the treatment course is completed.

In the camps, visited there have been no measles outbreaks because vaccination coverage is very high. In the refugee camps water quality is very good and conforms to the highest minimum standards for refugee situations. Most of the IDP camps have protected wells which are also regularly chlorinated.

6.2 SELECTED SPECIFIC HEALTH ISSUES

Lassa Fever:

Lassa fever outbreaks have been reported in Liberia, Guinea and Sierra Leone and the disease is therefore one that requires stringent surveillance during the population movements that are expected to occur with repatriation and resettlement. In a refugee camp located in Kenema, three suspected cases of lassa fever were reported in 2004 and one in 2005, which indicates that the danger for cross-border transmission is real even though there have not been any reports of this happening so far.

There is a lassa fever ward in Kenema. A referral laboratory for all the countries of the sub-region is jointly being built by WHO, the Ministry of Health and Sanitation of Sierra Leone, the Ministry of Health and Social Welfare, Liberia, the Ministry of Health Guinea and Tulane University. Progress is slow, but appropriate drug supplies are available in case of an outbreak.

A Strategic Plan for the prevention and control of lassa fever has been prepared by WHO and articulates activities to be taken to improve on case management, capacity building, laboratory investigations, surveillance, health promotion, environmental control and prevention of Lassa Fever in the Mano River Union countries of Guinea, Sierra Leone and Liberia.

Lassa fever education, especially during repatriation, is provided but in view of the potential gravity of transmission during repatriation, more effort needs to be applied.

Yellow Fever:

Yellow fever is endemic in the region and to control cross-border transmission anyone above two years old must have a yellow fever vaccine certificate or receive a yellow fever vaccine at border crossing points. The mandatory 10 days required after a yellow fever vaccine has been given is not observed.
There have been six yellow fever outbreaks between 1999 and 2002, and four confirmed cases of yellow fever in 2004, despite mass immunization campaigns against the disease between 1999 and 2001.

**Malaria:**

Malaria is endemic in the region and is the leading cause of morbidity and mortality in the camps as in the general population. Different treatment protocols are used and this may be a cause for differential resistance patterns and treatment failure. For example, in N’zerekore, most agencies use Sulfadoxine-Pyrimethamine (SP) as first-line drug but in the same area, MSF-Swiss uses Artemesinin Combination Therapy (ACT).

Prevention of malaria for pregnant women using chemoprophylaxis by presumptive intermittent treatment is practiced. In refugee camps, every family gets an insecticide treated net, but most families sell their nets to members of the surrounding communities or exchange them for commodities from the local markets. As a result most households do not even have a single net and this perhaps explains why malaria transmission has remained high.

### 6.3 Repatriation:

Repatriation of Liberian refugees is still spontaneous and voluntary but UNHCR plays a facilitating role when this is needed. It is estimated that more than 150,000 refugees have repatriated spontaneously while over 23,000 have returned with UNHCR assistance. With regard to IDPs, 141,000 have been assisted to return to their places of origin while 100,000 have gone home on their own. Towards the end of 2004, six counties were declared safe for return of refugees and IDPs. All other counties have since been declared safe as well.

There are many reasons why many Liberian refugees are not yet convinced that the situation in their home country is safe enough for them to return to. Most have adopted a wait-and-see attitude until at least the elections to assess if stability will remain or if the country will revert back to political wrangling, and possibly armed conflict.

Other reasons relate to the conflict itself. Many refugees know persons who were involved in the conflict and the atrocities they committed. They worry that these people will kill them when they return home so as to destroy evidence should there be trials of perpetrators of the atrocities.

Many Liberians say they have nothing to return to as they lost everything -- family, friends, property -- in the war. For some, returning to Liberia will reopen old wounds which have barely started to heal. During an emotion-filled focus group discussion with Liberian refugees, they said if they returned home they would inevitably relive all the horror-laden experiences they went through during the war and on their way to exile. A very large segment of youth, especially in Guinea, does not want to ever go back to Liberia, but prefers resettlement in developed countries.
Liberian refugees of the Mandingo ethnic group fear alleged discrimination and outright hostility by the other tribes when they return. Mandingos are not considered a bona-fide tribe of Liberia and are therefore not welcomed by the indigenous population.

Most returnees and repatriates from IDP and refugee camps respectively who opt to go back choose their original homes as their final destination. Those who have returned have faced many difficulties including lack of health and educational facilities.

- In many villages, clinics and health posts are not functioning. As a result, returnees in some villages are forced to walk long distances in search of health care. When compared to situations in refugee camps, lack of functional facilities acts as a disincentive for return and repatriation. Presence of working clinics and schools act as a ‘pull’ factor for the displaced populations.
- Most villages that were visited in the course of this evaluation had school buildings but no staff or equipment. Children were therefore not going to school despite the presence of classrooms.
- There are many returnees who have gone back to their former IDP and refugee camps due to the absence of health and educational facilities in their villages of return. Those who go back to IDP camps face greater difficulties because when an IDP camp is declared closed, the buildings that are vacated are looted by persons from nearby villages and care-providing agencies will often scale down services. The displaced persons therefore return to places where there are no toilets, clean water or good health care facilities.

The repatriation/return package that is provided is also seen to be insufficient and/or does not last long enough:

- Refugees receive a package containing food for two months, non-food items, $5 US and a few other things including condoms and sanitary materials. The refugee is usually dropped at his/her nearest township and is expected to use the $5 US for their transport home.
- Most refugees say this package is not sufficient. Although they get another food package to last two months when they reach their final destination, it takes more than four months to attain full food-sufficiency in the village.
- Also the $5 US often runs out long before arrival at the destination. Due to the bad transport infrastructure it is sometimes necessary to take a circuitous route home and this often costs more than the $5 US.

Repatriation of refugees located in Guinea and Sierra Leone has slowed down considerably. Due to less than optimal conditions in Liberia, UNHCR is not promoting repatriation; rather it facilitates the process by providing transport, health care, food and other amenities on the way for refugees who wish to repatriate and also supports the settling in. When the right time arrives, it is hoped that active promotion and reduction of assistance in camps will act as a ‘push’ factor that will accelerate the process of repatriation so that the programme can be closed down. There is already a reduction of
assistance in the various camps. For example in Kouankau camp of N’zerekore, UNHCR is no longer providing secondary education or vocational training. In Kenema, rations, including cereals, corn soya blend (CSB) and oil have been gradually reduced.

In many situations, refugees have been so well-accepted by the local population that much integration between them has taken place. Refugees in Jembe refugee camp in Sierra Leone describe the relationship with their hosts as ‘very cordial’, ‘friendly’ and see no reason for repatriation and would opt to stay here if the international community would extend its support to them for a few more years.

7. COORDINATION AND COLLABORATION IN THE HEALTH SECTOR

7.1 FINDINGS

Several coordination mechanisms exist that are pertinent to the health sector during the transition period.

- Early post-CPA, WHO took on a coordinating role, primarily since there was no minister of health in-country at that time. As from December 2003 this role was taken back by the MoH. Ever since, bi-monthly, now monthly coordination meetings with all stakeholders take place at the MoH with all stakeholders. The effectiveness of this meeting is not highly rated by most informants. It is largely confined to sharing of information; little or no substantive discussion or more strategic coordination is reported to take place. Most NGOs report sharing information with the MoH, but this does not elicit much interaction or feedback.

- Within the RFTF, health was part of Cluster 6 (basic services). The cluster was co-chaired by UNICEF and NTGL, while WHO was excluded. Many informants felt that lumping the basic services together in one cluster, without sector specific coordination, was counter-productive and that the RFTF/CAP moneys were not well coordinated. The RFTF framework, as it worked in practice, did not do much to fulfil its intended role for the health sector.

- Relations between UN agencies and UNMIL have been strained, in particular earlier on, and this has created a number of coordination problems, especially around IDP issues. Also, UNMIL has been less active in health than possibly initially foreseen. The demise of OCHA and the consequent slow build up of the HCS in UNMIL has been another factor detrimental to good coordination. The latter, however, has been improved of late, with for instance the commended HIC activities and the recently completed CAP process being two cases in point.

- The NGOs had their own monthly coordination meeting, for years chaired by SCF-UK. These meetings were largely seen as useful, but they did not (of course) provide an optimal forum to deal with some of the larger, sector-wide issues.

- Also, there have been a series of taskforces and other coordinating mechanisms around more technical health topics. For instance, a National HIV/AIDS Policy has been jointly formulated by the Ministry of Health and Social Welfare and the United Nations Country Theme Group on HIV/AIDS.
• Donors like OFDA and ECHO play a coordinating role to an extent, through fund allocation and the regular discussions they have with their implementing partners, as illustrated by the examples given in a previous chapter. Individual donor representatives have supported numerous, often well appreciated, fora of all sorts. However, this was not their role, nor did it give them the leverage to bring about more strategic coordination in Liberia’s health sector.

• It is this strategic coordination that most actors increasingly feel is a major gap in the current situation. People have looked to WHO to take up this role, but it was felt that WHO could not meet this expectation, for which a number of valid explanations exist.

7.2 RECOMMENDATIONS

• The key recommendation of this report is to urgently work on an overarching framework for the development of Liberia’s health system. What direction should service delivery take? What minimum health care should be made available to all Liberians? What will be the role of government, of the not-for-profit non-state providers, of private providers? How should this be implemented, with what resources? How to deal with the numerous human resource issues, their remuneration and their development? How to build the capacity of the MoH and the CHTs to take up their stewardship role? How to strike a balance between longer-term need for system building and more direct and urgent service delivery?

• All these issues can not be solved at once. However, by bringing all the major stakeholders, including the MoH, key UN agencies, NGO representatives and potential donors together in a strategic planning process, it may very well be possible to choose a strategic route and develop implementation from there.

• Creating such an overarching framework is likely to assist many stakeholders to adjust their activities, design exit or entry strategies, and become part of an overall effort to deliver health services to Liberia’s population while building up a viable health care system.

8. APPROPRIATENESS, SUSTAINABILITY, EFFECTIVENESS OF ‘FREE HEALTH CARE’

8.1 FINDINGS

• The MoH suspended the cost-sharing scheme in place at the time of the CPA for at least the transition period. Some argue that cost-sharing will need to be re-introduced; others strongly feel this should not be the case, not at all or at least not for the time being. Yet others argue a differential system may have to come in place, e.g. based on geography (i.e. for Monrovia, not for rural areas) or health service level (i.e. for secondary care, not for primary care).

• It is known from many other places that user fees are regressive, negatively and disproportionately affecting the poor, while exemption schemes usually do not sufficiently work to counterbalance this effect. This is supported by an increasing
number of studies showing that utilisation rates go down when user fees are introduced, or go up when they are abolished. This is not surprising given the high proportion of people living below the poverty line and the high degree of unemployment in the contexts in which these studies have taken place.

- It should be realised that user fees may at best cover a relatively small portion of total health expenditure, including at primary care level. And they will need to be administered transparently and competently, a condition difficult to fulfil in Liberia under the circumstances, according to many informants.

- However, user fees may have a role provided the bulk of costs is covered from other sources, e.g. to foster community ownership of a health facility, and to provide discretionary income at the clinic level.

- A recent statement from WHO\textsuperscript{16} reads: ‘It is important, particularly for the poorest countries, to move towards prepayment systems from a very early stage and to resist the temptation to rely on user fees’. It argues that it is possible to replace out of pocket payments by alternative forms of pre-payment and pooling.

- If substantial external funds do not become available to finance basic health care, Liberia’s health system has no other option, formal policy or not, other than to revert back to cost-sharing schemes to keep some minimal services functioning. The exclusion of the poor and the risk of catastrophic health expenditure are likely to counter other poverty reduction strategies that come into place.

8.2 RECOMMENDATIONS

- User fees are not a solution to fill the existing and possibly deepening huge finance gap for even the most basic of services for the majority of Liberians. Since the government is not able, even under the best scenarios, to fill this gap in the coming years, the only alternative is an injection of funds from outside Liberia. It is therefore highly recommended:
  \begin{itemize}
    \item to not re-introduce cost-sharing schemes, at least not for the time being
    \item to urgently find a solution to cover the costs of at least a basic package of health services for all Liberians, to be covered by the international community at least for a couple of years
    \item to address long-term sustainable health financing as an integral part of the needed and hopefully upcoming reform of Liberia’s health system
    \item to only discuss possible cost-sharing within this overall framework of longer-term health financing options.
  \end{itemize}

9. EFFECTIVENESS AND EFFICIENCY OF RELIEF TO DEVELOPMENT STRATEGIES

9.1 FINDINGS

• It can be argued that what has been labelled a transition period, has in fact been a political process to stop the fighting, a way to put a legitimate government in place, and a means to establish some highly needed preconditions (i.e. the GEMAP). It is only now that one can start thinking about the transition from humanitarian relief to development as far as basic services, like health care provision, are concerned.

• The RFTF was more promising and optimistic in that basic services were supposed to be addressed within a framework of longer term recovery and rehabilitation. This by and large failed, mostly because of the need to sort out other, higher level fiscal management issues first.

• This has left the humanitarian community in limbo, highlighted by the frustration we encountered in many of the interviews. On the one hand, there is the notion that ‘the crisis is over’ and that it is time for the humanitarians to pack up and go home, the only difficulty being the hand-over mechanism, and whom to hand over to. On the other hand, another crisis is looming, which is an impoverished population that will be left without any basic services when the international humanitarian community withdraws. This crisis is not labelled as a humanitarian crisis, and thus it is argued that humanitarian funding should be brought to an end. This does not feel right. As one of our key informants expressed succinctly: ‘more people are dying now than during the war’.17

• Another difficulty agencies in the health field face is their handing-over strategies. In the post-CPA period there has been emphasis on the physical rehabilitation of health facilities, many of which were damaged during the war. This has mainly occurred in areas where IDPs and refugees are expected to return, and where provision of health care services may be one of the ‘pull factors’ that might promote enhanced return. In a number of cases, there seems to have been too much emphasis on the rehabilitation of facilities and not enough on making them functional. In cases where clinics have been made functional, limited thought has been given to a possible hand-over if the responsible agency is to leave, e.g. after resettlement of the displaced. We often came across a vague notion ‘to hand-over to the government’. But any realistic estimate at the moment shows that the government does not have the resources and capacity to take full responsibility for health services in the coming years. Thus, a handover will likely mean a further rapid deterioration of services.

17 data are lacking to prove this statement but the evaluators agree that this may indeed be the case
• Finally, without an overall health strategy that outlines the number and type of services to be provided in the future health system, it has been difficult for agencies to assess if they are rehabilitating health units at the right places and/or to the right functional level. Data available to us did not allow assessment of this possible flaw, but it would not be surprising to find that errors did occur.

9.2 RECOMMENDATIONS

• For health services, it should be assumed that the transition from relief to development is just starting. A first priority is to have a strategic planning exercise that will outline where the health system is heading towards. Only then will the various agencies be able to make realistic exit and handing-over strategies.
• During the transition, which will likely have at least several years, direct service provision should be combined with longer term reform and capacity building efforts.
• The strategic planning exercise should aim to provide an answer as to the perceived role of non-state actors, including the international NGOs.
• Experiences elsewhere have shown some successes in contracting of basic health services to NGOs, for shorter or longer duration, but clearly aligned with government plans and priorities, using performance-based contracts.
• The recent experiences of Merlin in supporting health services in a number of counties in the south-east may act as an example of the kind of county-wide approach and support this may entail. Merlin’s experience seems to show that it is possible to provide a basic package of health services, accessible to a great majority of people in the county, for a sum of around $5 US per person per year.

10. COHERENCE OF PROVISION IN TERMS OF (INTER)NATIONAL STANDARDS

10.1 FINDINGS

• Health care provision is currently two-pronged. Up to recently, most attention and resources went to the areas most directly affected by the war, and where there was a need to provide services for IDPs, refugees and returnees. Only recently has more attention been paid to other areas, equally deprived of virtually all health care as a result of the prolonged conflict.
• In the given circumstances it is not immediately clear which standards can be applied.
• Assistance to IDPs, refugees and returnees may be gauged using the Sphere Minimum Standards. The evaluation does not allow applying these standards, or at least the health aspects, to any specific site. However, the overall impression the evaluation team got out of the many interviews is that there are no gross shortfalls.
• Which standard should be applied to the fact that the majority of people in Liberia do not have access to basic, affordable health care services? The absence of active fighting and obvious human rights abuses means that this situation is no longer
labeled as ‘humanitarian crisis’, in current classifications. The Sphere standards may
not realistically be appropriate, and would not be met in any case. The attainment of
the health MDGs may provide another frame of reference. Unsurprisingly, Liberia
falls very short of the MDG indicators. More worrying, though, is that there is hardly
anything in place or expected to be in place soon, that will contribute to achieving the
MDG indicators.

10.2 RECOMMENDATIONS

• The international community will urgently have to decide if it wants to combine
immediate forms of service delivery with longer term health system building via a
more accountable and capable government. There seem to be enough compelling
arguments to do so, be it from a humanitarian, political, peace-building, or poverty
reduction perspective.
• Some essential, basic health service delivery components are present in the country
that will allow for immediate service provision. These include the basic structure of
the ‘county health care’ approach, and numerous health care actors, including the
NGOs who have the experience and willingness to assist in the rebuild of Liberia’s
health care system.

11. EFFECTIVENESS OF HEALTH STRATEGY CONCERNING RETURNEES

11.1 FINDINGS

• Many IDPs have returned to their places of origin. However, refugees by and large
seem to want more clarity about the situation in Liberia before a decision to return
can be made. Refugee return so far has been largely spontaneously.
• Health care in most refugee camps is well organised with good health outcomes. This
is one of the factors refugees will take into account when deciding to go home, where
facilities are much more basic, if they exist at all. The same applies to educational
facilities.
• There are however many other reasons why refugees, contrary to IDPs, have so far
not returned in big numbers. These reasons include the yet uncertain political
situation, fear of resumption of the conflict, and fear to be confronted by the
perpetrators of the many atrocities experienced.
• Another factor hampering return is that the repatriation/return package is perceived to
be insufficient and/or does not last long enough.
• The threat of cross border transmission of Lassa fever during the repatriation is real
and should be closely monitored.

11.2 RECOMMENDATIONS

• The decision for most refugees to return or not is largely influenced by political and
personal security considerations. The perceived lack of health and educational
facilities back home may play a secondary role. It will be difficult at the places of
return ‘to compete’ with the health standards refugees got used to in the camps. It makes sense, however, to provide basic services wherever possible.

- Planning of facilities for returnees should be balanced with quantity and quality of services for other Liberians and should ideally be part and parcel of an overall nationwide health plan.
- There is some risk related to expected population movements regarding cross-border transmission. This should be monitored as part of the wider strategies to control Lassa Fever in the region.

12. **APPROPRIATENESS OF SGBV INTERVENTIONS**

12.1 **FINDINGS**

- Sexual violence in Liberia is a phenomenon both seen during the war and in peacetime leading to the inevitable conclusion that like in many societies, gender-based violence is culturally-entrenched and is part of the manifestations of male gender dominance.
- However, during the war, rape became a very common occurrence and was deliberately used as a weapon of war to terrorize the population. During this period, rape was characterized by incredible sadism and extreme cruelty perhaps only comparable to the limb amputations practiced in the Sierra Leone conflict of around the same time. Much more information on the violence that occurred and how humanitarian agencies are responding can be found in Annex 6.
- Management of SGBV is hampered by several factors, including non care-seeking behaviour of survivors and lack of widespread expertise in the clinical, social and legal management of SGBV.

12.2 **RECOMMENDATIONS**

- While the prevalence of SGBV is expected to ‘normalise’ now that peace and security are returning, attention is continued to be needed both to address ‘peacetime SGBV’ as well as to care for the large residual caseload of survivors of SGBV generated during the conflict.
- An Inter-agency Task Force on SGBV has been formed in Liberia, and has been responsible for spearheading SGBV activities among its partners, which deserves full support. Existing guidelines for dealing with SGVB should be adhered to.

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18 a more extensive report putting SGBV in a wider perspective has been added as an annex
Liberia Interagency Health Evaluation Report

- SGBV is an issue which exceeds the health sector and has many ramifications needing the input of societal groups, the judiciary, the police as well as a range of other government institutes, including the Ministry of Gender and Development

13. **APPROPRIATENESS AND RELEVANCE OF HEALTH PRIORITIES**

13.1 **FINDINGS**

- Much has already been said about the RFTF and its inability, due to understandable reasons, to focus on the health sector. It seems that only now the space may be created to work on health sector planning and reform, while typical humanitarian work may come to its end.
- Health priorities are those typical to most tropical, low income countries: childhood diseases, maternal mortality, malaria, tuberculosis, and malnutrition. STIs, HIV/AIDS, SGBV and mental health issues should be addressed as well, next to outbreak control of lassa fever, yellow fever and cholera.

13.2 **RECOMMENDATIONS**

- Most health priorities can be tackled by a properly functioning primary health care system, with community involvement, a network of primary care clinics, and basic secondary care. It is therefore recommended to focus resources and energy in the upcoming rehabilitation and reform activities in Liberia’s health sector on the provision of an essential health package that can be delivered at the primary health care level.
- Within this overall priority, service delivery, human resource training, management and supervision, as well as MoH capacity building, will all have to be addressed.
- Other, daunting tasks, like reform of the hospital sector, may be addressed later.
14. **SELECTED DOCUMENTATION**

3. HCS/HIC Briefing Pack, United Nations Office for the Coordination of Humanitarian Affairs, 2005; with updates at [www.humanitarianinfo.org/liberia](http://www.humanitarianinfo.org/liberia)
5. RFTF revision April 2005.
7. Designing health financing systems to reduce catastrophic health expenditure; WHO, Technical Briefs for Policy Makers, number 2, 2005; WHO/EIP/PB/05.03.
16. Designing health financing systems to reduce catastrophic health expenditure; WHO, Technical Briefs for Policy Makers, number 2, 2005; WHO/EIP/PB/05.03.
Annex 1 – Terms of Reference

Terms of Reference for the Interagency Health Evaluation in Liberia

I. Humanitarian Crisis and Health Sector Background

*= Adjusted from source: WHO report by Dr James Teprey, April 2005

**Country Profile**

Liberia lies at Western coast of Africa flanked to the West by Sierra Leone, to the East by Côte d’Ivoire, to the North by Guinea. Liberia is divided into 5 regions, 15 counties and 88 health districts. There are more than 200 chiefdoms, 200 clans and 3,694 towns and human settlements.

The last population census was conducted in 1984. Projections made from the 1984 census estimates the population at 3.3 million with a population growth rate of 2.5% in 2005. With illiteracy rate as high as 75%, poor water, sanitation and hygiene issues have been compromised.

The Vital statistics of Liberia show that the country is among the least in the world. Life expectancy has reduced from 55 years two decades ago to 47.7 in 2002. The total fertility rate is 6.4 and child bearing is early; three out of every four women aged 20-24 years of age have had a child. About 51.8% of the population is less than 18 years of age and 68% reside in the rural areas (UNICEF, 1999). At present, infant and under-five mortalities stand at 134 per 1000 live births and 194 per 1000 live births respectively. Liberia is therefore far above the Sub-Saharan Africa average of 175 per 1000 live births, and ranks 43 out of 46 countries in the WHO AFRO region. Maternal mortality has increased from 578 per 100,000 prior to the war to 780 per 100,000 by 2002. Malnutrition is widespread with 39% of children under five years of age stunted, 26% underweight and there is widespread micronutrient deficiencies among children and women.

**The Humanitarian Crisis**

Liberia fought two major protracted civil wars between 1990 and 1997 and from 1999 to 2003. This resulted into a very complex emergency situation and a catastrophic humanitarian crisis. There are over 365,000 Liberian refugees residing in the neighbouring countries and another 365,800 Internally displaced persons (IDPs) had been displaced in over 17 official IDP camps and irregular camps located across the country. Most of them are concentrated around Monrovia, Salala and Totota in Bong county and Saclepea in Nimba county. Few Ivorian refugees are also located in camps. Repatriation of the refugees and IDPs have began and over 81,000 of them have been relocated to their places of origin by middle of March 2005. During the period about 17,000 Sierra Leone refugees were also repatriated home.

**The Health Sector**

Total health budget as a proportion of GDP fell significant below the WHO stipulated minimum of 5%. The current expenditure level is less then $1 US per capita. Thus, the low level of government resources allotted and expended on the sector grossly affected the level and quality of health services.

The health sector suffered almost total destruction; almost all physical infrastructures have been damaged, health personnel have been dislocated, massive looting of equipment, drugs and
medical supply inventories. All national programs have also collapsed. The accessibility to health services rate is about 10% and health services are mostly located in the urban areas reducing further the accessibility of the rural population. This in turn accounts for the major causes of the country’s high infant and child mortality rates. Full antigen coverage for children age one and less was 28% in 2002. Projected, these figures are expected to be lower now. International NGOs and the private sector continue to provide the lion share of health care services.

Malaria, cholera and other diarrhoeal diseases, acute respiratory infections, neonatal tetanus, measles, and malnutrition are the major causes of morbidity. The prevalence of communicable diseases such as HIV/AIDS, TB and River Blindness continues to escalate at an alarming rate. In 2002, the prevalence of HIV/AIDS is estimated to affect 8.2% of the population between the ages of 15-49 years in 2002 but due to the current situation it is estimated to be about 20%. The poor knowledge, illiteracy, poverty, and multi-sexual behavioural practices, pose great challenges for the health of young adolescents especially females who have been the main victims of rape and sexual abuse throughout the crisis.

*Human Resources*

Prior to the civil war in 1988, approximately 5,056 people worked in the health sector. The public sector employed 3,526, and the private the rest 1,855. These included 2,782 (55%) trained traditional midwives, 237 physicians (4.7%), 656 nurses and nurse midwives (13%) and 1,381 other supporting personnel (27.3%). Presently less than 30 national physicians remain in the country and whilst other cadres of health workers have also reduced by 60%. Most of the active health personnel in the facilities have been recruited and deployed by NGOs, and UN agencies. The few human resources available at their places of work are demoralized and traumatized.

*Health Organization And Management*

The Ministry of Health and Social Welfare has been managing a three-tier health system: namely strategic (central team MoH), technical (Counties’ health teams) and operational (districts’ health teams). In theory, there is a Health Sector Coordinating Committee (HSCC) meeting weekly, chaired by the Minister of Health and has the secretariat in MoH. Participants include MoH, representatives of the NGOs and the health and nutrition sector of the UN Agencies. This is an information-sharing forum where all sector activities; updates and policy issues are planned to be discussed. At present there is some confusion on its existence. During the escalation of hostilities, WHO performed the coordination role until the peace agreement was signed.

*Recent findings*

From May 15-22 2005 a preparation visit by a WHO/UNHCR consultant resulted in the set-up of a Steering Committee on the IHE. During this visit the majority of the stakeholders in health were consulted; this lead to the following description of the current context:

Liberia in transition phase of relief to development. Many relief oriented agencies have pulled out or plan to withdrawn in the coming year. It is felt that there are insufficient number of more development oriented donors to ensure an adequate transition and funding gaps are envisaged. The RFTF was designed on information based collected more than one year ago. Today health actors wonder whether the objectives are still up to date. Some have criticized the document to be too much agency-mandate oriented with many vertical programmes, lacking cohesion and an integrated approach that is needed today in Liberia.

After the peace agreement many health actors have suffered from diminishing quality and frequency of the health sector coordination. Today stakeholders state that this has lead to many
frustrations and ineffectiveness of the humanitarian response in the health sector. It has caused more insular ways of working, possible duplication of activities and competition within the health sector. Amongst others, the competition in employing the same available health staff being in an environment with only small numbers of qualified staff has lead to various frustrations.

During the war many health actors provided health care for free. More than 20 months after the war ended this is still the case. The sustainability of this approach in a country in transition is now questioned and the audience in health seems to be polarized on yes or no to continue to provide formally free health care.

In Liberia sexual and gender based violence is deeply embedded in the society leading to enormous public health problems that have directly and indirectly implications on reproductive health, mental health, malnutrition amongst children and the spread of AIDS/HIV.

The health actors lack urgently and consistently baseline data on health indicators, baseline information on number of real functional health care facilities, health care personnel and their location. In addition, there is a great need for census data; catchment area for health care facility data, etc. Some actors are trying to fill these gaps (Unicef, HIC).

If the data is at all available, little is consistent, poorly shared, hardly centralized and poorly analysed on macro-level. The lack of baseline information causes a weak context to perform an IHE on impact, effectiveness and coverage of many health programmes in the past.

II. Evaluation Purpose

The main purpose of the inter-agency evaluation of the health sector\textsuperscript{20} in Liberia, through a collaborative process involving all relevant stakeholders in health and nutrition\textsuperscript{21}, is to assist Ministry of Health and Social Welfare (MoH), and other stakeholders in health and nutrition to ensure improvement of the performance in the health sector. The results from the IHE will feed into health sector-wide strategy development and planning and/or revision and adjustment. In particular, it will enable to optimize the planning for the (new) MoH after the elections foreseen in October 2005. In addition, the results will provide up-to-date reliable evidence on which to base resource allocation and for resource mobilisation in general. The IHE results will also create opportunities whereby all stakeholders in health can learn from identified strengths and weaknesses from their performance as a whole.

III. Stakeholder Involvement

Representatives of stakeholders groups will be involved in the IHE through a participatory process. Involvement has begun with the establishment of an IHE Steering Committee, representing MoH, UN and donor agencies and NGOs. Prior to the IHE identification of representatives of affected populations is needed in order to include them as soon as possible in the whole evaluation process. (Some suggestions: community, refugee and IDP representatives).

The coordination for the Steering Committee (SC) will be facilitated and chaired by WHO (jointly with UNHCR). Save the Children UK is the secretary of the SC. Throughout the IHE process, but especially after the results of the actual IHE become available, the SC might find it important to redefine the roles and identify new chairing or supporting agencies.

\textsuperscript{20} Health Sector refers to all health and nutrition programmes, services and initiatives

\textsuperscript{21} MOH, UN agencies, Donor agencies, NGOS, representatives of affected populations
The SC as is stands now is merely a platform for all stakeholders in health who have been involved in establishing the IHE. They include Unicef, ACF, MSF/H-B, Liberian NRCS, UNMIL, IMC, EQUIP, Mother Patern College of Health Sciences, MDM, BPRM, ECHO, Save the Children UK, UNHCR, WHO, Ministry of Health, MERLIN, WFP, Africare, USAID, Merci, UNFPA, UNDP, ICR, AHA (and possibly ICRC).

During the first meeting of the SC on 19 May 2005 a Core IHE Working Group was formed that will be responsible on behalf of and in consultation with all interested health agencies to oversee the finalisation of the ToR and the development of the subsequent workplan for the evaluation, and to provide supervision and delegating responsibilities to different IHE Steering Committee members throughout the process; They are responsible for developing a plan for the dissemination of IHE findings and its follow up.

IV. Evaluation Scope and Key Questions

The LIBERIA IHE encompasses various domains ranging from general health governance, health financing and service delivery to the community, refugees/IDPS, to sexual and gender based violence. The IHE will not limit itself to specific geographic areas, except for those issues concerning specific vulnerable populations such as IDPs, returnees, refugees, etc. For obvious reasons accessibility constraints and ‘no-go’ areas defined by UNSECOORD should be taken into account when IHE team plan the field mission\(^\text{22}\). The IHE will focus on the time period starting from the Peace Agreement in August 2003 until now. The IHE will include a mixture of evaluation and assessment components. Key areas and related questions can be found in Annex 2.

V. Follow up on recommendations and lessons-learned

To be developed by the IHE Core Working Group of Steering Committee in consultation with all SC members.

VI. Work Plan and Schedule

A preliminary workplan is developed but needs more refining, finalising key evaluation tasks, planning of IHE, planning interviews and field visits for information gathering; and needs finalising a detailed time line for the evaluation process, etc.

The IHE process will take place over an eight month period (from May – December 2005). The IHE Core Working Group will follow the Liberia IHE. It will provide guidance and technical support to assist the IHE process and finalise this time planning.

VII. Methodology

The actual evaluation in the field will be done by the IHE team. During the first SC meeting 19 May 2005 it was decided that the team of evaluators themselves propose the methodology. It is likely that it will be a mixture of desk research (review of existing documentation\(^\text{23}\) including reports, studies, surveys and assessments) and interviews (key informants, community, focus group), field visits/direct observation and case studies.

\(^{22}\) As it stands now (21 May 2005) the whole country is accessible security wise.

\(^{23}\) on [www.humanitarianinfo.org/liberia](http://www.humanitarianinfo.org/liberia) many valuable documents are accessible
Liberia Interagency Health Evaluation Report

VIII. Reporting

The report will be prepared and submitted by the evaluation team. An initial review will be done by the IHE Core Working Group to see if the evaluators adhered to the ToRs. The draft report will be circulated to all stakeholders (in particular the Steering Committee) with the request to provide feedback on accuracy and adequacy of conclusions and recommendations. The report should be no more than 30 pages and have an executive summary of no more than 3 pages. The report should include a short background to the humanitarian crisis in and health sector in Liberia, methodology, findings, conclusions, concrete recommendations, lessons learned, and annexes. The report will be made available through websites of participating agencies.

IX. Evaluation support to assist in the facilitation of the IHE

While the Core Working Group in collaboration with the Steering Committee will be responsible for the process, it is foreseen that support will be provided by the IHE-Humanitarian Crises Initiative Core Working Group that was launched in March 2004 in Geneva. This group is composed of representatives from ACF-France/AAH-UK, CDC, Epicentre, London School of Hygiene and Tropical Medicine, Merlin, MSF/H, SCF-UK, UNFPA, UNHCR, UNICEF, WFP, BPRM and WHO and holds monthly teleconferences. The chair and facilitation is provided by WHO and UNHCR in Geneva. How the Core Working Group in Liberia and the IHE-HIC Core Working Group will collaborate should be discussed by both and could be an agenda point for the first upcoming teleconference by IHE-HCI Core Working Group.

The composition of the IHE team: expertise of the evaluators should include health finance, reproductive health, health policy and health systems. In addition, experience with post-conflict context and refugees is required. The impartiality and independency of the team should be guaranteed throughout the IHE process.
Annex 2 – Draft methods and questionnaire for Liberia IHE

The following is an expanded version from the initial Terms of Reference, and was used by the evaluators as a tool to discuss the key questions with stakeholders.

Methodology:

The methodology will be a mixture of desk research (review of existing documentation including reports, studies, surveys and assessments related to the key-issues) and interviews (key informants, community, focus group), and case studies.

Interviews will need to be arranged with the most important stakeholders in the health sector, and those responsible for repatriation: Health authorities at central and county level, UN agencies (UNHCR, WHO, UNICEF, UNFPA, etc), UNMIL Humanitarian Coordinating Section, NGOs, Red cross movement, key humanitarian and development donors, including the World Bank.

Field visits/direct observation:
Visits to refugee camps and meeting with relevant authorities for the repatriation in Guinea and Sierra Leone are foreseen to be part of the mission, depending on feasibility of travel and security.
Visits to counties in Liberia, IDP camps, hospitals and health facilities, direct observation, discussion with representatives of the community/health committees, etc

A selection of evaluation criteria will be used per key-issue to analyse and judge performance
The following questionnaire is meant to guide the evaluators with respect to the issues that were identified during the pre-mission.

A. EFFECTIVENESS of coordination and collaboration in health sector
1. Describe the coordination mechanisms, including specific health related taskforces, etc.
2. Are coordination mechanisms representative/inclusive of all key stakeholders, what is role of national health authorities?
3. What are the current functions of the coordination mechanisms and how well do they perform? (describe what is done within the coordination settings, from info sharing, joint assessments, establishing common protocols, etc, to joint programming
4. What are the constraints and gaps in the performance of the coordination? What could be done to improve?

B. APPROPRIATENESS, SUSTAINABILITY and EFFECTIVENESS of ‘free health care’ in Liberia today

After the peace agreement, why was free health care service introduced to replace cost sharing on such a large scale? Have the circumstances changed for a re-introduction of the cost sharing mechanism? Is it time to gradually shift from formally free health care provision in the public sector to alternative forms such as variations on cost-sharing or even cost-recovery schemes? If so when and what would be the introductory mechanisms? If not, why and how will the current (formally free) health care system remain viable in the coming five years?
1. Describe the current financing mechanisms and budgets of the health and nutrition sector (contribution government, external aid, out of pocket payment, pre-payment schemes, etc) and the relation with access to and quality of services, for primary and referral services.
2. How well does the administration function (Payments of salaries by government, financial management by health authorities at province and health facility level, etc)
3. What are the key lessons learned from financing mechanisms in post conflict settings? What are general best practice policies with regard to health financing in fragile states? What is WHO’s latest policy? What is described in the UNDAF, PRSP, etc.
4. How would lessons learned elsewhere apply to Liberia?
5. What are the estimates for the budget that would be required for the health sector for the coming 5 years,
6. Based on the previous, what would be the most appropriate health financing mechanisms that would ensure universal and equitable access to services?

C. EFFECTIVENESS AND EFFICIENCY of strategies during transition phase from humanitarian relief to development

1. Describe the current plans for transition and the process through which they were developed
2. What is done for alignment and harmonisation of health sector policies?
3. Do transition strategies provide a realistic mix of humanitarian and development objectives?
4. Do transition strategies include plans for the basic components of the health sector: Management, infrastructure rehabilitation, pharmaceuticals, Human resource development, financing (see B), quality of service delivery,
5. Are resources in country adequate to support a smooth transition from relief to more developmental oriented aid? (Are exit and handover strategies of the organisations that scale down or withdraw adequate to sustain basic health care provision and coverage?)
6. What is needed in order to ensure this?
7. What can be the role of non-state actors in the future of health service delivery?

D. COHERENCE of health care provision in terms of (inter)national standards

1. Are the health services that address the most important causes for mortality and morbidity provided currently according to international or nationally appropriate, effective and agreed standards?
2. Are there international and national policy / guidelines available and accessible?
3. If not, why not and what possible adjustments are needed?

E. EFFECTIVENESS of health strategy concerning returnees (refugees and IDPS)

Cross-border population movements and disease transmission
1. What are the health /disease transmission risks and benefits associated with population movements (e.g. Lassa fever transmission, transit point opportunity for health education regarding HIV, distribution of Insecticide Treated Nets at the border accompanied by promotion and education on net use in countries of asylum predeparture, measles vaccination pre-departure)
2. Have there been any adverse events reported (such as Lassa Fever outbreaks, stigmatisation of returning refugees as vectors of infectious diseases such as Lassa Fever or HIV/AIDS, net resale after distribution at the border, unassisted delivery or neonatal/infant deaths en route)
Liberia Interagency Health Evaluation Report

3. How have cross-border health issues been monitored (e.g. incident report forms, anecdotal data)
4. How have cross-border health issues been addressed (e.g. medical screening pre-departure, health education, insecticide treated net distribution etc)
5. What activities should be conducted as part of future population movements to minimise disease transmission and associated adverse events; improve monitoring; and maximise the opportunity for disease prevention during assisted population movements (pre-departure, transit, on arrival);

Refugee perceptions of differentials in health services and risk of ill-health in the decision to return
6. Briefly describe any differentials in access to preventive and curative services and disease risk in countries of asylum (Guinea and Sierra Leone) and country of origin (Liberia)
7. How are health services and disease risks perceived by refugees and returnees?
8. Do these perceived differences influence the decision to repatriate to Liberia or return to country of asylum after initial repatriation (e.g. as has been reported from refugees who returned to Ghana after repatriating to Liberia)
9. If so, what adjustments need to be made in the health programmes and how should this be prioritised compared to other urgent health problems?

F. APPROPRIATENESS of past response of the health actors on sexual and gender based violence (SGBV)
1. Describe the extent and scope of the sexual violence in Liberia, including the current capacity and performance to respond to these problems.
2. What are current plans to assist victims of sexual violence and what is done to prevent SGBV?
3. Were the strategies and interventions that were set after the peace agreement concerning SGBV appropriate for the context? If not what should have been different and are adjustments needed?

G. APPROPRIATENESS and RELEVANCE of health priorities
The two-year RFTF, based on a joint needs assessment finalised in Feb 2004, has been drafted in a time that many counties were still not accessible. It is questioned whether the RFTF is complete and up to date with the new situation in Liberia.
1. What are, with new knowledge from areas now accessible, considered to be the main health needs and risks in Liberia? What are main strengths and constraints in the health system to deliver prioritised health services?
2. What are the 5-7 priorities for the health sector? Are these priorities adequately shared by all stakeholders? Does the RFTF today needs to sharpen its priorities and/or needs adjustment of the objectives?
3. Can it be used as such to prioritise the objectives of the MoH after the elections in October 2005? If not, what priorities should be added to or emphasised in the RFTF version of 2005? How should health care priorities be identified (process) in the future?
4. Were beneficiaries involved in the choice/identification of interventions?
Annex 3 - People met in Liberia

- Dr Peter S. Coleman, Minister of Health, MoH Liberia
- Dr Benson Barh, CMO, MoH Liberia
- K. Karfor Kollie, EPR Director, Ministry of Health and Social Welfare
- Mengesha Kebede UNHCR Representative, UNHCR
- Dr. O. Babu Swai, Senior Public Health Officer, UNHCR, Monrovia
- Dr Emmanuel Obura, medical officer, UNHCR
- Dr Eugene Nyarko, WHO Representative, WHO
- Dr James Teprey, HAC Officer, WHO
- Drs Bolay and Dr Clement and other WHO staff, WHO
- Merylena Chea, Administration/Finance-EPI Acting Logistician
- Dr Musu C. Duworko, WHO, Monrovia
- Louis J. Imbleau, Representative, WFP
- Stella C. Subah, National Nutritionist, WFP
- Dr. Nathaniel Bartee, Deputy Minister of Health and Social Welfare, Liberia
- Ms Dedehe Kwekwe, Focal Person for SGBV, Ministry of Gender and Development
- Keith Wright, Senior Programme Officer, Bjorn Forssen, Project Officer / PHC, UNICEF
- Frank Mwangangi, security officer, UNSECOORD
- Prof Marie-Claire Omanyondo, SGBV specialist, WHO consultant
- Merlin staff: Sophia Craig (Country Director), Aggrey Bategereza (Country Health Director) Jennifer Vallet-Krech (ass MedCo), Alice Vahanian, (Project Coordinator)
- MSF staff: Miles Kemplay (HoM MSF Belgium), Beatrice Opiyo (MedCo MSF Holland), Jonathan Caplan (HoM MSF Swiss/Spain), Didaku Oola Odhiambo (HoM MSF France), Kiara Lepora (MSF France), Sebastian Weber (HoM MSF Holland), Martha Bonnie (MSF-Belgium)
- Paivi Laurilla, Health Coordinator, ICRC
- Sandrine Tureo, MDM
- Dennis Johnson, Chief HCS, HCS-UNMIL
- Eric Pitois, Technical Assistant, ECHO
- Stefanie Sobol, OFDA / USAID
- Africare, Claudette Bailey (Chief of Party), Charles J. Nagbe (HIS Specialist), Africare
- Elizabeth Oduor-Noah, Deputy Resident Representative, Global Fund staff, UNDP
- Leila Bourahla, Judah Morris, Jerry Zangar, SCF-UK
- Al Dominique Dunbar, Technical Assistant, IMC
- Berhann Demeke, Medical Coordinator, AHA
- Rosemary Musumba, Senior Humanitarian Affairs Officers, Imogen Prickett HCS Reporting & Liaison Officer, UNMIL
- Albert Saykpa, acting CHO for Grand Bassa
- Bayron Zahnweah, Acting CHO for River Cess
- Many health staff members of clinics and County health teams in Grand Bassa and River Cess counties
- Dr Golafale Kanda (medical director), Mac Gaye (hospital administrator)
- Dr W Taylor Neal, JFK Hospital
- Sr Barbara, Mother Patern College of Health Sciences
- Simon Taylor, Manager, Humanitarian Information centre, Monrovia
- Staff World Vision Clinic, Perry Town IDP
- Staff IMC Clinic, Wilson
- Staff Transit Centre, Sinje and Zimi
- Marious Buga, Assistant Field Officer, UNHCR Tubmanburg, Officer i/c
Annex 4 - People met during refugee camp visits in Guinea and Sierra Leone

Dr. Diallo, Health Coordinator, UNHCR, N’zerekore, Guinea
Ms Victoria Copa Camara, SGBV worker, N’zerekore
Mr. Salif Kagni, Head of UNHCR Sub-Office, N’zerekore, Guinea
Dr. Bangaly Diane, Medecin Superviseur, International Federation of Red Cross and Red Crescent Societies, N’zerekore, Guinea
Ms Leonie Heine, Supervisor Nurse, MSF, N’zerekore
Mr. Lamime Cisse, Pharmacist, IFRC, Kouankau Refugee Camp
Ms Kadiatou Guisse, Clinician, IFRC, Kouankau Refugee Camp
Ms Jestine N. Kanneh, Supervisor, Community Safety Initiative-SGBV, ARC, Kouankau
Mr. Alphonse Munyangye, UNHCR Repatriation/Protection N’zerekore
Ms Christine Goya, UNHCR Protection, Conakry, Guinea
Ms Nantenin Conde, Repatriation Assistant, Conakry, Guinea
Mr. Ibrahim Coly, Head of Sub-office, UNHCR Kenema Sierra Leone
Dr. Colette Houeto, Health and Nutrition Coordinator, UNHCR, Kenema, Sierra Leone
Mr. Sani Chaibou, UNHCR, Kenema
Ms Rebecca Caporn, MSF France, Kenema
Ms Yuka Sugahara, MSF France, Kenema
Ms Hilleke Thybergtien, MSF, Belgium. Kenema
Dr. Andrew T. Muana, Medical Superintendent, Bo Govt. Hospital, Sierra Leone
Mr. Edward S. Massaou, Sierra Leone Red Cross Society
Mr. Gassimu Mallah, Sierra Leone red Cross Society
Mr. Kakkam Lansana, Camp Manager, Jembe Refugee Camp, Kenema, Sierra Leone
Ms Wendor Jallah, IRC/SGBV Social Worker, Jembe Refugee camp

Focus Group with Committee of Refugees, Kouankau Camp, N’zerekore
Mr. Joseph M. K, Deputy, Grievances
Mr. Varlee M Sannor, Secretary, Grievances
Mr. Abu B. Barlli, Camp Secretary
Mr. Seyea Kromal, SGBV Secretary
Mr. Mamadee V. Talawallay, Chief Investigator
Mr Seleke Kamara, Zone 7 Chairman
Mr Valee Dulleh, Youth Representative
Mr. Layee M. Konneh, Youth representative
Mr Fofee Kanneh, Chairman Zone 1

Jembe Camp Leadership, Focus Group Discussion
Mr Mansaray Mohammed, Field Assistant
Mr. Kakkam Lansana, Camp Manager, Jembe Refugee Camp
Mr. Matthew Koroma, A.C. Manager
Mr. Francis F. E. Tabugboh, Agriculture Community .Secretary
Mr. James Kamansa, NFI Co chairman
Ms Baindu Dahn, Youth
Mr Francis M.S. Jah, Co-chairman
Mr. James S. Fortune, Adviser
Mr. Joseph S. Kamera, Agriculture Chairman
Mr. Jimmy J. Turay, SGRV
Mr. Timothy G. Nyorkor, Camp Chairman
Jembe Camp, Focus Group Discussion for Health workers
Mr. E. Sellu, State Enrolled Community Health Nurse (SECHN)
Mr. Christopher Samu, SECHN
Ms Aminita Karimu, SECHN
Ms Wuyah J. Momo, SECHN
Ms Vakissie I. Konneh, Registrar for weight and Height
Ms Mamie Kamona, Maternal and Child Health Aide (MCHA)
Ms Elifrida Fonnie, MCHA/Dispenser
Mr. Varlee B. Sheriff, Dressing
Mr. John Belay, Registrar
Mr. Joseph T. Musa, Cleaner, Security
Mr. Sheku Konneh, Cleaner/Security
## Annex 5 - Places Visited: Itinerary and Work Schedule

<table>
<thead>
<tr>
<th>Date</th>
<th>Place</th>
<th>Activity</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>03 September, 2005</td>
<td>Dar es Salaam to Addis Ababa</td>
<td>Travel</td>
<td>Dr.Msuya</td>
</tr>
<tr>
<td>04 September, 2005</td>
<td>Brussels to Monrovia</td>
<td>Travel</td>
<td>Dr.Sondorp</td>
</tr>
<tr>
<td></td>
<td>Addis Ababa to Lagos to Monrovia</td>
<td>Travel</td>
<td>Dr.Msuya</td>
</tr>
<tr>
<td>05 September, 2005</td>
<td>Monrovia</td>
<td>Meet Dr.Teprey Review TOR Plan Logistics</td>
<td>Consultants</td>
</tr>
<tr>
<td>06 September, 2005</td>
<td>Monrovia</td>
<td>Monrovia: Develop Work Plan Collect materials</td>
<td></td>
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<tr>
<td>07 September 2005</td>
<td>Monrovia</td>
<td>Meet IHE Steering Group Introductions Presentation on Task and Expectations Work Plan</td>
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</tr>
<tr>
<td>08 – 12 September, 2005</td>
<td>Monrovia to Vondjama</td>
<td>Document Review Meet WR Interview WHO Officer Make Appointments</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monrovia to Buchanan</td>
<td>Visit IDP camps Visit Health facilities</td>
<td></td>
</tr>
<tr>
<td>13 September 2005</td>
<td>Monrovia to Vondjama</td>
<td>Interviews Meetings with returnees</td>
<td>Dr.Msuya</td>
</tr>
<tr>
<td></td>
<td>Monrovia to Buchanan</td>
<td>Visit IDP camps Visit Health facilities</td>
<td>Dr.Sondorp</td>
</tr>
<tr>
<td>14 -15 September 2005</td>
<td>Vondjama</td>
<td>Continue interviews and Observations</td>
<td>Dr.Msuya</td>
</tr>
<tr>
<td></td>
<td>Grand Bassa and River Cess</td>
<td></td>
<td>Dr.Sondorp</td>
</tr>
<tr>
<td>16 -21 September 2005</td>
<td>Monrovia</td>
<td>Interview UN and government officials, NGOs, Visit Monrovia Health Facilities, Training College</td>
<td>Consultants</td>
</tr>
<tr>
<td>22 September 2005</td>
<td>Monrovia to Conakry</td>
<td>Travel</td>
<td>Dr.Msuya</td>
</tr>
<tr>
<td>23 September 2005</td>
<td>Conakry to N'zerekore</td>
<td>Travel</td>
<td>Dr.Msuya</td>
</tr>
<tr>
<td>24 to 25 September 2005</td>
<td>N’zerekore</td>
<td>Interview UNHCR HoSD, Medical Officer and others; Guinean Red Cross, MSF, Refugees, SGBV officers, Camp authorities, MoH</td>
<td>Dr.Msuya</td>
</tr>
<tr>
<td>Date</td>
<td>Location</td>
<td>Activity</td>
<td>Person</td>
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</tr>
<tr>
<td>26 September 2005</td>
<td>N’zerekore to Conakry</td>
<td>Travel</td>
<td>Dr. Msuya</td>
</tr>
<tr>
<td>27 September 2005</td>
<td>Conakry to Monrovia</td>
<td>Travel</td>
<td>Dr. Msuya</td>
</tr>
<tr>
<td>28 September 2005</td>
<td>Monrovia to Kenema</td>
<td>Travel</td>
<td>Dr. Msuya</td>
</tr>
<tr>
<td>29 September 2005</td>
<td>Kenema</td>
<td>Interview UNHCR HoSD, Medical Officer and others; Guinean Red Cross, MSF, Refugees, SGBV officers, Camp authorities, MoH</td>
<td>Dr. Msuya</td>
</tr>
<tr>
<td>30 September 2005</td>
<td>Kenema to Monrovia</td>
<td>Travel</td>
<td>Dr. Msuya</td>
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<td>01 October, 2005</td>
<td>Monrovia</td>
<td>Conclude Data Collection and Analysis</td>
<td>Dr. Msuya</td>
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<tr>
<td>02 October 2005</td>
<td>Monrovia to Lagos</td>
<td>Travel</td>
<td>Dr. Msuya</td>
</tr>
<tr>
<td>03 October 2005</td>
<td>Lagos to Addis Ababa</td>
<td>Travel</td>
<td>Dr. Msuya</td>
</tr>
<tr>
<td>04 October 2005</td>
<td>Addis Ababa to Dar es Salaam</td>
<td>Travel</td>
<td>Dr. Msuya</td>
</tr>
</tbody>
</table>
Annex 6 – Sexual and Gender-based Violence (SGBV)

- It has been stated that gender-based violence is deeply embedded in Liberian society leading to enormous public health problems that have directly and indirectly implications for reproductive and mental health. Based on a few small-scale studies, it is estimated that out of 1.7 million persons targeted for humanitarian assistance, 5000 are SGBV survivors. Most anecdotal reports would consider this, however, a gross underestimation. According to the 1999-2000 Demographic and Health Survey, 36 percent of males and 29 percent of females know at least one person who has been raped. Vulnerable groups are often targeted for sexual violence. The disabled, single parents and unaccompanied minors are often victimized.

- The finding regarding widespread prevalence of the practice is supported by primary data from extensive work by Professor Marie-Claire Omanyondo in the counties of Montserado and Bong. In her study involving 412 young (mean age 30.5 years) women the professor found out that each one of them had suffered one or more of 21 different acts of violence ranging from uninvited groping of sexual parts to intrusion of objects into sexual orifices to gang rape.

- Although many of the incidences and especially the more gross ones took place during the protracted Liberian war, some of the other incidents and reports from workers of other organizations (SCF, AHA) show that sexual violence also occurs very much in peacetime leading to the inevitable conclusion that like in many societies, gender-based violence is culturally-entrenched and is part of the manifestations of male gender dominance.

- The sequelae of sexual abuse transcend the physical into mental health. Besides the widely prevalent risk of sexually transmitted infections (STI) including HIV/AIDS and unwanted pregnancy, survivors experience mental health problems that are frequently severe and debilitating. At the social level, rejection by friends and family often leads to divorce, and social dysfunction which may result in poverty and all its consequences.

- Management of SGBV is hampered by several factors. Due to these factors SGBV survivors typically never seek care or do so too late and therefore suffer gross physical, mental and social complications. Due to the stigma attached to SGBV and particularly to rape, survivors would like to keep the ‘shame’ to themselves for long and if possible forever to avoid the intense emotional suffering that goes with disclosure. Most of the SGBV survivors were incidentally discovered by health and community service personnel in the course of providing services.

- The second factor that hampers care of the survivor is the absence of widespread expertise in the clinical, social and legal management of SGBV. Most health workers to which survivors at the community level would naturally seek help from are ill prepared to give advice that would ensure police and law management of the survivor.
so that they are treated with the sensitivity and confidentiality that would preserve their dignity.

- Thirdly, the necessary management tools for SGBV are not readily available at the typical primary care station to which the rape survivor would need to pay a visit without destroying evidence. Clinical workers with capacity to carry out the required examination, the laboratory support, presumptive treatment for STI, Post-exposure prophylaxis (PEP) for HIV and post-coital contraception are not usually present at this level.

- Lack of money to get to a health facility and the general war situation are other reasons survivors do not seeking medical care after their attack. Most of the survivors resorted to their mothers and religion for assistance.

- SGBV has been occurring in Liberia throughout its history where the socioeconomic disparities between persons of different social classes put native Liberian females at the lowest rung of the social hierarchy and therefore at the mercy of males from higher social classes. The tradition of ‘happy hour’ where native girls were used sexually by the powerful ruling class may be seen in this light. Rape of female workers was common since there was no protection under the law.

- As in other African societies, early marriages, sometimes involving girls as young as 12 years, was practiced without the consent of the girl child. Subsequently a law was enacted which raised the age of consensual marriage for girls and now a new bill is in preparation to disallow marriage of girls before the age of maturity which, for Liberia, is 18 years.

- During the war, rape became a very common occurrence and was deliberately used as a weapon of war to terrorize the population. During this period, rape was characterized by incredible sadism and extreme cruelty perhaps only comparable to the limb amputations practiced in the Sierra Leone conflict. Gang rape, intrusion of foreign objects into the genitalia and rectum, amputation of male sexual organs, forced sexual activity between relatives were common and done on a massive scale.

- After the war, the prevalence of rape is believed to be above its pre-war rate and on the increase. Increasingly younger and younger girls are being victimized. The age group most commonly raped nowadays are girls of an average age of 10 years. Most rapes occur to girls between 4 and 13 years. Rape of infants as young as one year has been reported. According to the Demographic and Health Survey, 1999/2000, in both urban and rural Liberia, the modal age when a girl is most likely to be raped is between 10-14 years. In rural areas, more than half of rape survivors are between 10 and 14 years and a quarter are below 10 years of age. In urban areas, one-third of rape survivors are under 10 years – 7 percent of whom are actually below 5 years. Perpetrators tend to be males in their mid thirties and forties.
Increasingly, many cases of rape end in death from haemorrhaging and severe genito-urinary tract infections. There are also more rape cases involving members of the same family.

There are increasingly reports of males raping other males which was completely unheard of in Liberian Society. A forty year old man was recently accused of raping a 5 year old boy. Homosexual behaviour is believed by Liberians to be imported from “outside” and is perhaps done in the misguided belief that it is safer than heterosexual sex as far as HIV transmission is concerned. Also considered of foreign origin is the escalating practice of use of psychoactive substances which play a role in increasing the incidences of SGBV.

During a Focus Group Discussion with the community elders of Kouankau Refugee camp for Liberians, the issue of rape of women during their passage to Guinea aroused much emotion. The elders reported that there was hardly any woman in the various groups crossing the border together who escaped rape. They felt that their whole community, regardless of gender, has also suffered intensely as a result of the rape that their wives and daughters suffered. This seemed to suggest that they considered themselves to be survivors also and in need of treatment too.

In the Kouankau camp of Guinea, SGVB is declining thanks to a vigorous multi-pronged strategy by the various organizations and the Government of Guinea. But during the refugee influxes between 2002 and 2003, it is believed that rape was a very common occurrence. The Programme Supervisor estimates that during the exodus and in the very early days of settlement almost 70% of women experienced one form or another of SGBV, predominantly rape. That means that the camp houses many SGBV survivors who face enormous social and psychological problems including, for some, complete destruction of their lives and failure to cope. Their prime need is psychological care which is now provided by some of the NGOs, such as Action of Churches Together. Survivors receive occupational therapy and in the process get to learn work skills. Reported cases of rape are now down (1 per month or two). Sex exploitation and sex bartering is also on the decrease; it was rampant in the early days of settlement when local officials, guards and refugee workers took advantage of their positions to demand sex in return for amenities such as food.

Wife-beating has always been practiced in Liberia and has been associated with the practice of paying dowry which conferred upon a wife the status of property that can be used in any way the owner pleases. There have been stories of vicious wife-beatings often ending in scarring, maiming and even death. Domestic violence has been on the rise and it is speculated that the economic situation and the trauma that Liberians suffered during the war may explain this rise. In the Kouankau camp, wife beating continues unabated despite much awareness-raising. The SGBV Supervisor believes the practice is also fuelled by religion which asserts male superiority over females. Indeed even at weddings it is not uncommon for the male to be given a cane and advised to use it liberally to keep the wife in line. Wife-beating in this camp is reported to be the most vicious, with many cases of severe physical injury and
miscarriages reported. Child abuse also occurs, and is an accepted way of child rearing. There have been occasions in the camp when children received serious injuries and in at least one case, a mother beat her own child to death.

- Some success is being reported from the sensitization programme against SGBV. Mosques do not preach violence as much as they used to and Guinean Police are more receptive to cases of SGBV than was the case before. The American Rescue Committee (ARC) runs a Legal Clinic in N’zerekore, Guinea’s second city, where survivors may go for legal assistance.

- Awareness-raising activities have enabled discussion of wife-beating, rape and other forms of domestic violence. Rape awareness activities are carried out in IDP camps and health workers are being trained in the management of SGBV. The Rape kit, which contains all the necessary tools for investigation and treatment of a rape survivor, will be distributed after appropriate training on its use.

- Women NGOs have been active on SGBV participating in ‘Stop SGBV’ campaigns but most work has taken place in Monrovia and its environs only. These awareness campaigns seem to be paying off as the number of survivors seeking care from institutions has been rising. When survivors report to any of the Ministries at the various levels they are referred to an appropriate system that includes clinical care, police intervention and the court.

- Forced marriages in the camp continue and girls as young as 14 or 15 may be forced to marry a man of the parents’ choice. Consensual sex between boys and underage girls and between older males and underage girls is very common and often ends in unwanted pregnancies which have become a very serious problem. Many of these teenage pregnancies end in difficult deliveries that require referral. Abortions and attempted abortions that result in obstetric complications are also common.

- Female Genital Mutilation (FGM) is widely practiced by many tribes in Liberia from most of the counties and especially Lofa, Bong, Cape Mount and Bomi. The ultra-secret practice, also known as ‘sande-bush’ is widely practiced also in neighbouring Guinea, Sierra Leone and Ivory Coast. Apart from the heavy bleeding and infection that FGM survivors contend with, there is nowadays the added risk of HIV transmission from use of the same instrument for several girls and the total absence of sterility and hygiene. Unlike places such as Somalia where the mutilation is more radical, the clitoridectomy practiced here does not result in as much vesico-vaginal fistula (VVF) complication.

- FGM is rarely, if ever, mentioned in open discussions. The practice is carried out by secret societies which are very difficult to penetrate and it is expressly forbidden to talk about the practice outside the inner circles of the societies. Contravention of this rule is believed to result in most severe consequences. Even well-educated men and women are reticent about even mentioning the word.
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- FGM is income-generating for the perpetrators of the practice and there is therefore much resistance from them to abandon the practice. The parents of the FGM victim make payments in cash or kind such as rice and other grain. Among the strategies being adopted to stop FGM is to recruit the mutilators to become TBAs.

- The government and its partners have recognized SGBV as a problem and are taking steps towards its prevention and management. Several Ministries, including the Ministry of Gender and Development which has an elaborate one year plan, have focal points for SGBV. Other institutions involved are the Police, the Ministry of Health and the Judiciary. Laws are being changed so that perpetrators can be taken to court. A new Rape Bill which seeks to impose a sentence of 30 years to life for perpetrators has gone through its first reading. The Bill will replace an old one in which Rape was a bailable offence. The new bill will make rape non-bailable and will include in the definition of rape any unsolicited intrusion of any object into a woman’s genital and other orifices which was not the case before.

- The need for widespread psychosocial support and mental health interventions for SGBV survivors is enormous but there is not near enough capacity to provide this. Persons who have been trained in counselling and other mental health interventions in camps should be retained, retrained and deployed to provide this most essential service. UNHCR/WHO should also explore the potential for use of traditional, ethnic-based mechanisms for dealing with situations of this nature that can promote healing. Many African societies have age-tested methods of reconciling warring parties. An anthropologist could assist in this.

- A WHO Consultant whose work has been used in this report is completing a study on SGBV and it is expected some more light will be shed on this issue. An Inter-agency Task Force on SGBV has been formed and has been responsible for spearheading SGBV activities among its partners.

When security in Liberia is more widespread and assured, some expect that SGBV will decrease, however it is important to monitor the situation, to ensure that awareness raising continues, and that health services are enabled to provide services to women and men who are victims of sexual violence.