

Liberia

Providing assistance and promoting preparedness

The context

The Liberia civil crisis of the 1990s, ending with the devastating war of 2003, was characterized by gross human rights abuses including sexual violence, perpetrated against civilian populations, particularly women and children. The peace agreement signed in August 2003 still holds, with a new government elected in November 2005. Major voluntary and assisted returns have been reported since the end of the conflict.

Prior to the conflict, maternal mortality rates in Liberia were 760 per 100,000 live births - one of the highest rates in the world. Inadequate access to antenatal care, a high proportion of home deliveries (63%), lack of emergency obstetric care and poor nutritional status of pregnant women have all adversely affected maternal care.

Liberia is a malaria endemic country and the disease has been the leading cause of morbidity and mortality, accounting for over 10% of all deaths in health facilities. The proportion of clinic attendance due to malaria increased from 34.6% in 1997 to 50% in 2000. As a result of the considerable resources and work invested in malaria control in the last few years, the attendance was estimated at 40% in 2005.

Acute respiratory infections including pneumonia are a new, growing concern. The prevalence rate among children 0-59 months was 25% in 2005. Prior to the recent war, diarrhoeal diseases were the third major cause of morbidity and accounted for 6.9%. In 2004, weekly surveillance reports indicated that diarrhoeal diseases accounted for 4% and 5% of all inpatient and outpatient consultations. In addition, epidemics of cholera occur during rainy seasons when the water and sanitary situation are deplorable.

Tuberculosis prevalence is currently estimated at 4 per 1000 as a consequence of war and due to the emergence of HIV/AIDS which is estimated to infect 8.2% of the population.

General scope of WHO work in country

The CAP 2006 was formulated in November 2005 while three main issues were outstanding:
a) The election of a new president and formation of a new government and ministry of health



b) The selection of Liberia to pilot the cluster approach c) The departure of NGOs from the country with the end of the crisis and the halt of humanitarian funding.

The roll out of the cluster approach produced new responsibilities and requirements in addition to those identified through the CAP 2006 process. WHO, in its capacity as health cluster lead agency, works with partners to strengthen capacity for risk reduction, preparedness, response and health surveillance systems. WHO and the health cluster will also support capacity building within government authorities to respond to health needs, to support coordinated NGO delivery of health services and to strengthen health assessment and implementation.

Specific health sector strategy

Sustain access to basic health services including referral services, psychosocial and mental health care through health care support, rehabilitation and institutional capacity building activities.

Address the gap created by the departure of major NGOs from the country through a mix of measures such as improved networking, recruitment of human resources from other countries in the region and support to educational institutions.

Improve coordination among health sector stakeholders within the health cluster in order to strengthen the capacity of national and local health infrastructures, support and re-establish the national and county health coordination meetings, and develop a sustainable essential drugs supply system.

Strengthen routine epidemiological surveillance, nutritional surveillance, early warning systems, response mechanisms, and outbreak investigation systems through improving the capacity of national and county-level health teams, in 15 counties, to monitor disease trends.

Reduce the maternal and under-five mortality rate through improving reproductive health services, re-introducing the integrated management of childhood illnesses, reduction of acute malnutrition, and strengthening synchronised national immunization days and expanded programme on immunization.

Ensure nationwide presence of HIV prevention and education programmes including voluntary counselling and testing, information, education, communication and behaviour change communication.

Action Pillars

To negotiate new agreements between partners (including donors) to ensure that the population has uninterrupted access to an essential health package. This will include: supporting the handover of some clinics from departing international NGOs to faith based NGOs, providing support in the form of essential supplies, recruitment of human resources and funds to the Ministry of Health (MOH) during the initial period of transition.

WHO will decentralize its public health presence through the establishment of three offices located in Voinjama (serving Lofa and Gbapolu), Harper (serving Maryland, Grand Kru and River Gee) and Zwedru (serving Grand Gedeh Nimba and Sinoe). WHO also plans to appoint a dedicated emergency health coordinator to support the MOH and the United Nations/NGO systems.

To strengthen county health teams, through provision of logistic, technical support and supplies, to deliver medical assistance and to coordinate the various counties in collaboration with partners like UNICEF and UNHCR.

To fill public health gaps, WHO will strengthen and expand disease surveillance and outbreak response to nine counties. In addition, it will continue activities in the field of sexual and gender

based violence to strengthen prevention, medical, psychosocial and mental health support to rape victims and other vulnerable groups.

WHO will closely work with MOH and UNICEF to increase coverage of routine immunizations in the framework of the Global Alliance for Vaccine and Immunization initiative which may be approached by WHO and MOH for system support during transition. WHO will continue to strengthen the polio eradication efforts, using the polio network to provide services under the county health teams.

WHO, in its capacity as lead agency for the health cluster, will continue to support overall policy-making and strategy formulation within the MOH.

Challenges

- ✓ There is a common feeling that the situation in Liberia may worsen during this period when humanitarian donors are leaving, extending to end of 2007 when developmental partners are expected to come on board. This under-funded period is accompanied by great expectations both by the population and the international community.
- ✓ The human resource problem is of unique dimensions. Out of 300 medical doctors before the war, the number has declined to 24 all working with NGOs, UN agencies and at the leadership of the MOH. A mix of measures is needed to overcome this problem while bridging the additional gap resulting from the departure of NGOs.
- ✓ The MOH is embryonic and needs institutional support that should be provided by partners, especially WHO.

Funding

Item	USD
Funds requested in the CAP 2006	3 706 599
Funds requested to implement the cluster approach and to cover the new gaps resulting from NGOs departure	2 401 080
Funds pledged up to May 2006	0
Unmet needs 2006	6 107 679