Health Interventions in Complex Emergencies
A Case Study of Liberia

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I. Introduction

International interventions in humanitarian crises are increasingly taking place within the specific context of "complex humanitarian emergencies." These emergencies are characterized by a convergence of violent conflict, mass forced migration, destruction of infrastructure, political-economic state collapse, and the breakdown of community-level and national social structures. One of the most significant casualties -- in terms of short- and long-term survival of the affected population -- of such a convergence of events is the health care system of the country in crisis. Complex emergency conditions cause the disruption of drug supply pipelines, facility operation, disease surveillance and prevention mechanisms, health information systems, and medical referral systems. These conditions also prompt the flight of capital as well as human resources in the health sector: the destruction or seizure of health facilities is a common strategic objective in war, and trained health professionals and administrators are frequently pushed out of their service communities by threats to their safety or pulled out of them by the promise of greater economic security elsewhere. These effects on the health system only exacerbate the medical and public health consequences of large-scale displacement, food insecurity, and protracted violent conflict.

Despite multi-million dollar international interventions in this sector and the obvious importance of health in complex emergencies, there is surprisingly little common understanding among the organizations that fund and implement these interventions about the most appropriate and sustainable responses to the health needs and vulnerabilities of affected populations at various stages of complex emergencies. Nor is there a sufficient base of knowledge about how international interventions relate to and support local or indigenous initiatives and capacities in this sector.

To address these gaps, the Refugee Policy Group (RPG) has initiated a project entitled "Health Interventions During and Following Complex Humanitarian Emergencies" (HICE). The goals of this project are to define more clearly for decision-makers what the most effective program options are for reducing morbidity and mortality during the various stages of a complex emergency, and to identify local coping mechanisms in the health sector and methods to facilitate them. The project objectives are:

1. To analyze the nature and evolution of complex emergencies, the types of responses to health problems in them, and the political/social context in which those responses take place;
2. To identify various options that are available to health program planners, implementers, and beneficiaries at different phases of the emergency, and to analyze the basis for program decisions compared with known best practices in the health sector;
3. To identify coping strategies among populations affected by complex emergencies, and to analyze the linkages between these strategies and the overall response to health crises in complex emergencies; and
4. To evaluate the degree to which decisions about health interventions can and do assign priority to the support of local health capacities, the sustainability of health programs, and the transition from relief to development.

In order to achieve the above objectives, RPG has chosen several case study complex emergencies in Africa on which to concentrate its project research and analysis. The Liberian emergency of 1990-1997 was selected as a priority case study for this project for several reasons: first, there has been and remains a dearth of technical as well as policy information about the consequences of the Liberian conflict and the humanitarian response to it; second, several characteristics of the Liberian emergency lend themselves to
illustration and cross-case comparison -- namely, the frequent fluctuation between intense conflict and relative calm during the emergency period, the resultant sporadic presence of international relief agencies in much of the country, and the high degree of infrastructural devastation and population displacement; and third, Liberia has recently entered a period of post-conflict transition, thus giving informants a unique perspective when reflecting on health during the conflict.

The Liberian case study involved background and secondary research from RPG’s Washington, D.C. headquarters, as well as a four-week field mission to collect quantitative and qualitative data and to analyze the linkages between international and local initiatives in health. In order to maximize available time and financial resources in the field, the team decided to focus its inquiry on several key events or decisions made by international actors in the health sector, analyzing the basis on which those decisions were made, the degree to which they adhered to standard best practice guidelines for health, and the impact of those decisions on the short-term and long-term health and health capacities of the affected population. These key events (described in more detail in the following sections of this report) include: the switch from rice to bulgur wheat as the staple commodity in general food distributions; the evacuation and return of international relief agencies following the April 1996 crisis in Monrovia; the international non-governmental organizations’ (INGOs) Joint Policy of Operation; the international intervention in the town of Tubmanburg following a lengthy period of instability and inaccessibility in that area; and the suspension of food assistance to internally displaced persons (IDPs) in Buchanan.

The objectives of the HICE project itself and certain conditions on the ground affected the methodology of the Liberia field mission. First, health care delivery issues in the Liberian conflict are invariably tied to political and military ones, and therefore investigations into this subject may be perceived as being politically inclined. Also, RPG’s examination of local coping mechanisms in the health sector tread closely on the culturally sensitive issues of secret societies, traditional medicine, and magic. Finally, the recent influx of refugees fleeing unrest in Sierra Leone, the ongoing repatriation of Liberian refugees, and the quickly progressing agricultural schedule presently occupy the attention of aid workers and beneficiaries alike, and have produced emergency conditions in some parts of the country. This tenuous situation therefore overshadows studies of a more retrospective nature and increases the affected population’s sensitivity toward any assessment or study that may be perceived as a precursor of emergency assistance.

Recognizing that all of these conditions discouraged the use of standardized and widely-administered surveys, the RPG field team instead conducted conversational interviews and focus groups with community informants and other members of the affected population. In addition to the question of sensitivity, logistical obstacles presented some constraint to the mission. Poor road conditions and time pressures eliminated the possibility of visiting the southeast and extreme northwest regions of the country. Also, the lack of health and program data and institutional memory among the international agencies (due to repeated suspension of activities in the country and the almost complete looting of international resources during the April 1996 crisis) complicated the team’s efforts to compile quantitative indicators of health program effectiveness. Although the team was able to obtain and analyze nutritional data gathered by Action Contre la Faim, the mission findings are based more on qualitative information gathered through interviews, focus groups, and observation than on hard data.

In order to supplement and enhance the information gathered from various headquarters of implementing NGOs and donor governments, the RPG field team spent roughly equal amounts of time visiting communities and health facilities in Liberia’s population centers (Monrovia and Buchanan) and in more remote regions which did not benefit from a
sustained international presence during the conflict. The team also interviewed approximately 100 aid donors and implementers, international and national health practitioners, and members of the affected population about the nature and impact of international interventions and the relationship between these efforts and local health capacities. Findings and conclusions from these site visits, interviews, and data are presented on the following pages.

II. Overview of the Liberian Emergency

Historical Context [1]

The roots of Liberia's civil war reach back to its creation as a state -- an event which, according to some interpretations, was a "gesture to humanity."[2] In the early 1800s emancipated slaves from the United States, along with other Africans who were freed from slave ships in the Atlantic Ocean, arrived on the coast of West Africa and established the settlement of Monrovia, under the sponsorship of the American Colonization Society. In 1847 these settlers declared their independence and founded the state of Liberia. Known as Americo-Liberians, the former American slaves represented about five percent of the total Liberian population.[3] However, they consolidated economic and political control over the country, and indigenous Liberians became increasingly underprivileged, resentful, and in many ways subservient to the elite Americo-Liberian society.

Indigenous Liberians remained economically, politically, and socially disempowered until 1980, when the Americo-Liberian government was overthrown in a violent, televised coup led by an indigenous Liberian and former military officer, Samuel Doe. It was generally expected among the Liberian population that the new government would represent the indigenous majority in a fair and democratic manner. However, Doe elevated his own small ethnic group -- the Krahn -- to the power status previously enjoyed by Americo-Liberians, and embarked on a tyrannical dictatorship in which martial law was imposed for its first six years, certain ethnic groups were targeted, and hundreds of civilians were killed.

Political/Military and Humanitarian Chronology of the Emergency

The Liberian civil war -- championed by initiators as one of liberation from the Doe regime -- began in 1989 with an incursion into Nimba County from neighboring Cote d'Ivoire by the opposition group National Patriotic Front of Liberia (NPFL), under the leadership of Charles Taylor. As popular support to the NPFL grew among the ethnic groups most persecuted under Doe’s rule -- namely the Gio and Mano of central Liberia -- the rebel force made considerable and rapid territorial advances. This also prompted a violent counter-insurgent reaction by Doe's army, in which Gio and Mano civilians were massacred and large portions of the 2.8 million Liberian population were forcibly uprooted. In May, the NPFL captured two economically and politically strategic provincial capitals: Gbarnga, a trade and transportation cross-roads in Bong county, and the port city and railway anchor-town of Buchanan in Grand Bassa county. Within six months, the NPFL controlled the vast majority of Liberia, and an estimated 300,000 people had fled to neighboring countries to escape the violence.[4]
Interventions in the health sector during this period of the complex emergency -- a period which has been called the "First War" -- were sustained largely by local actors. The NPFL created a relief arm, the National Emergency Relief Organizing Committee (NEROC), which commandeered trucks, fuel, and staff from the Port of Buchanan and distributed rice that the NPFL had hijacked from a ship. Though efforts were made to separate the rice into soldier and civilian consignments, international relief workers entering Liberia in July noted that soldiers took rice from civilians at gunpoint and that the distribution schedules were irregular and biased toward active NPFL supporters.[5] The Liberian Agricultural Company (LAC), which operated a rubber plantation in Grand Bassa county, managed shelters on its property and provided food and non-food assistance to affected civilians. LAC’s positive relationship with Taylor and the NPFL also benefited international agencies that arrived on the scene in mid-1990. A local NGO, Christian Health Association of Liberia (CHAL), continued to support several health facilities in NPFL territory through the procurement of drugs and supplies and minor infrastructural rehabilitation by individual CHAL members. The Liberian National Red Cross Society (LNRCS) also continued to provide non-food items and support clinics upcountry during the First War, with support from the International Committee of the Red Cross (ICRC).

As the conflict converged on the Liberian capital of Monrovia in mid-1990, NPFL and government representatives initiated the first of fourteen attempts at a peace settlement. The Freetown Talks were fruitless, and by the time they were adjourned in mid-June, all United Nations personnel had evacuated from Liberia in response to an apparently government-led attack on displaced ethnic Gio and Mano people seeking protection at the UN’s Monrovia compound. Production at both of Liberia’s principal iron ore mines were suspended, nearly all exports of iron and timber stopped, petrol supplies were depleted, no delivery of food to Monrovia was possible by air, land, or sea, and residents were reported to be eating cattle feed to survive.[6] The government, too, was rendered essentially defunct as all but four Ministers (namely the ministers of defense, education, labor, and commerce) fled the country.[7] The battle for Monrovia began in July, and a splinter group of the NPFL -- identifying itself as the Independent National Patriotic Front of Liberia (INPFL) and under the leadership of Prince Yormie Johnson -- took the city from government control and emerged as the civil war’s second rebel faction. Expatriates from the diplomatic, business, and humanitarian communities in Monrovia evacuated and the city served as the venue for a violent and protracted conflict between the NPFL, INPFL, and remaining government forces.

While Monrovia bore the brunt of conflict in mid-1990, international agencies established relief operations in accessible parts of the Liberian interior. Operating out of Buchanan, Catholic Relief Services (CRS) staff imported and managed World Food Programme (WFP) and Food for Peace (FFP) food aid for a seven-county area, including rural Montserrado, Margibi, Bong, Nimba, Lofa, Bomi, and Rivercess. Despite concerns about NEROC, CRS initially adopted the NEROC distribution structure and were obligated to work with the agency in order to secure vehicles, housing, and access to beneficiary populations. Medecins Sans Frontieres-Belgium (MSF-B) provided logistical and administrative support to rehydration and feeding centers and displaced persons shelters in Margibi and rural Montserrado counties. One month before the siege of Monrovia, MSF-B began emergency medical assistance in and around the city. This assistance included the pre-stocking of drugs, food, and supplies in hospitals and clinics, medical and public health services and food distribution to newly opened displaced centers, and an ambulance service. After the city fell to the INPFL, most expatriates evacuated and international relief efforts in Monrovia were suspended, not to resume until October. Local agencies, however, resumed operations more quickly: an indigenous NGO called Special Emergency Life Food (SELF) organized a food distribution system in collaboration with the U.S. Office of Foreign Disaster Assistance (OFDA) Disaster Action Response Team (DART) in September.[8]
The Economic Community of West African States (ECOWAS) brokered the Banjul peace accord in August 1990, which called for a cease-fire, the establishment of an ECOWAS Cease-Fire Monitoring Group (ECOMOG) to restore law and order, and the installation of an Interim Government in Liberia.\[9\] The first contingent of ECOMOG peacekeeping forces, representing five West African countries, arrived in Monrovia shortly thereafter. A shaky cease-fire lasted for a total of 14 days before fighting resumed in Monrovia. Further negotiations between ECOWAS, ECOMOG, and the factions led to the Bamako Agreement and a more stable and prolonged cessation of hostilities in November. By the end of the first year of civil war, Doe had been captured and publicly executed by Prince Johnson’s troops, an estimated 80% of the Liberian population had been displaced, and an estimated 10,000-13,000 Liberians had lost their lives due to war-related causes.\[10\]

Refusing to accept the "Banjul-manufactured" Interim Government under the leadership of Liberian statesman Amos Sawyer, Charles Taylor set up a parallel government in October. The National Patriotic Reconstruction Assembly Government (NPRAG) had its headquarters in Gbarnga, Bong county, and from that position Taylor -- as the self-proclaimed President of the Republic of Liberia -- convened a cabinet of representatives from all 13 counties and established several government ministries, including a Ministry of Health (MOH). For the next two years two separate and non-cooperative governments co-existed in Liberia; thus the local as well as international humanitarian community split their relief operations into Johnson/ECOMOG-side (i.e. Monrovia) and Taylor-side programs. UN and non-governmental agencies operating in Taylor-held territory negotiated with NPRAG and delivered relief supplies overland from Danane, Cote d’Ivoire. Agencies operating in Monrovia negotiated with the Interim Government and delivered supplies by sea. The United Nations Children’s Fund (UNICEF), United Nations Development Programme (UNDP), and World Health Organization (WHO) duplicated coordination meetings in Monrovia and Gbarnga in order to give equal recognition to the two administrations.

The dual-administration of Liberia from 1990-1992 proved advantageous to relief interventions and to health in general in several ways. First, although the Interim Government in Monrovia was internationally recognized as the legitimate government of Liberia, it was only the de facto security and bureaucratic structure provided by NPFL through NPRAG that enabled relief agencies to maintain at least sporadic, if not constant, assistance to needy populations in "Greater Liberia," as the NPFL territory was called. Second, the security situation facilitated the establishment of more international relief agencies in Liberia (see chart on page 16). INGOs providing emergency health services now included three arms of the MSF organization -- MSF-B, Medecins Sans Frontieres-Holland (MSF-H), and Medecins Sans Frontieres-France (MSF-F). The three MSFs worked in different Liberian counties to reactivate clinics, hospitals, rehydration centers, and therapeutic feeding centers, provide drugs and supplies to health facilities, distribute targeted food aid, and operate EPI systems. CRS continued to import emergency Title II food aid from the U.S. government country-wide. Save the Children UK (SCF-UK) rehabilitated and reactivated clinics, distributed food aid donated by the European Union (EU), operated mobile health clinics in five counties, and operated Monrovia’s garbage collection system. Action Contre la Faim (ACF) entered Liberia in 1992 to provide emergency medical, nutritional, and water and sanitation services and also monitored food security around the country. While no compiled data is available on the total costs of the emergency relief effort in Liberia during these years, and only partial data exists from later years of the war, these six INGOs implemented the large majority of health services in Liberia throughout the war.

Third, the stability provided by NPRAG’s firm control over large portions of central and northern Liberia enabled public and private health structures to continue functioning even in the periodic absence of international organizations. As will be explained in subsequent
sections of this report, Liberian health workers throughout the region developed and sustained innovative health care delivery systems during this time. Monrovia, under the control of ECOMOG, also experienced a lull in high-intensity conflict for the better part of these two years. In addition to continued emergency relief activities such as general and targeted food distributions, primary health care, and immunization campaigns, international and local agencies also engaged in a few activities that can be appropriately termed "rehabilitative." For example, INGOs, UNICEF, and WHO renovated and supported the operation of major primary and secondary care facilities in the city, and also reactivated the formerly government-run National Drug Service (NDS) as a non-governmental organization. Although the overall situation in Liberia was still clearly a complex emergency and still precarious for relief efforts, international and Liberian actors alike note that the period 1990-1992 was one of relative peace for much of Liberia, due in part to the stability of the stalemate between ECOMOG and the NPFL.

The exceptions to the relative tranquillity during the dual-administration years occurred in the northwest and southeast sections of the country. While representatives of the NPFL, INPFL, and Liberian interest groups convened the All-Liberia National Conference in April 1991 to develop a plan for national reconstruction and elections, NPFL forces attacked towns in neighboring Sierra Leone, presumably in an effort to spread the conflict beyond Liberia’s borders and therefore undermine the ECOWAS peace process. One year later, the United Liberation Movement for Democracy in Liberia (ULIMO) -- a rebel force composed of ethnic Krahn Liberians currently exiled in Sierra Leone -- had engaged NPFL in northwestern Liberia and warned ECOMOG troops not to interfere. ULIMO’s entry into the Liberian war delayed ECOMOG’s deployment to northwest Liberia and thwarted the disarmament process which had been initiated by the Yamoussoukro accord of 1992. Called the "ULIMO war," this conflict spread from Grand Cape Mount county to Bomi, Lofa, Bong, and Montserrado (Monrovia) counties over the next two years, and represented the first serious Liberian challenge to Charles Taylor in the history of the emergency.

The ULIMO war had a significant effect on the health system in these counties which, until late 1992, had functioned to a considerable extent thanks to both international as well as indigenous efforts. Health facilities and health providers were systematically targeted by the entering faction, which sought to punish the health community for having previously served the enemy rather than preserve the system for its own use. The ULIMO war also impaired local initiatives in community- and county-level drug supply systems and outreach services. While thousands of Liberian refugees repatriated to Nimba county and other stable parts of the country in August 1992, approximately 25,000 people fled the northwestern counties to seek safety among Monrovia’s burgeoning displaced population.

A new faction also emerged in the southeast during this period. The National Democratic Front (NDF), composed of ethnic Krahn from Grand Gedeh county, captured a small portion of Grand Gedeh from the NPFL in mid-1991 and forced the United Nations to suspend even the scant attention paid by the humanitarian community to southeastern Liberia. Though the NDF’s role in the Liberian conflict was minor in the end, it nevertheless carved the conflict into an even more complex shape and served as the forerunner to the Liberian Peace Council, which emerged in force in 1993.

These challenges from ULIMO and NDF during the NPRAG era rocked NPFL’s dominance in Greater Liberia, but it was the growing animosity between NPFL and ECOMOG that marked the next "peak" of conflict in the Liberian emergency. Increasing attacks on aid workers and ECOMOG soldiers by NPFL forces upcountry prompted the international humanitarian community to again withdraw from rural Liberia in September 1992. In October, two months after the latest ECOWAS-sponsored peace talks and call for a cease-fire, NPFL launched a military offensive against ECOMOG in Monrovia. "Operation Octopus" lasted for
a week, killed an estimated 3,000 Monrovia residents, wounded 8,000, and cut parts of Monrovia off from relief activities for several weeks.[12] The Octopus incident also did considerable damage to Monrovia’s health infrastructure, which relief agencies -- especially WHO -- and the Interim government had worked to revitalize during the relative tranquillity of the preceding two years. JFK Hospital -- a tertiary care facility which consumed between 28 and 43 percent of annual Ministry of Health budgets during the 1980s[13] and which MSF-B had partially supported during the war -- was one of numerous health facilities that were abandoned by international relief agencies following Operation Octopus. JFK staff continued to work in the hospital without pay, and often without sufficient drugs and equipment to treat their patients, during the international agencies' absence.

At the start of 1993 relations between NPFL, ECOMOG, and the other factions remained tense. Between 600-700,000 Liberians had fled as refugees to neighboring countries, and the population of Monrovia had doubled since the beginning of the war to a total of 1.2 million. It was further estimated that 150,000 war-related deaths had occurred in Liberia since 1990.[14] The number of functioning hospitals in the country had been reduced from 19 to 13, and the number of functioning clinics -- having increased the previous year -- fell from 133 to 80.[15] ULIMO gained considerable territory from the NPFL in the first half of the year and ECOMOG liberated large portions of Margibi and Grand Bassa counties. ECOMOG also established a "relief corridor" from Buchanan through Taylor-held areas, in an effort to block the suspected smuggling of weapons aboard relief convoys coming from Cote d'Ivoire. While this move was intended to block one of the NPFL’s primary conduits of arms, it also eliminated cross-border delivery of relief to the Liberian interior and made all relief operations inside the country dependent upon the stability and accessibility of Buchanan town. Finally, "hit and run" interventions became a more common tactic among the international community as the security situation became more unpredictable. In mid-1993 the United Nations reached an isolated pocket of Sierra Leonean refugees and displaced Liberians in Lofa county and conducted a food and medicine airlift to the area.

The Geneva Peace Talks and Cotonou Agreement of July 1993 called for a cease-fire, disarmament and demobilization, repatriation, and elections to be completed within seven months. Despite periodic reports of cease-fire violations, the UN and NGOs regained access to parts of upper Lofa that had been cut off since October 1992. The Cotonou Agreement instilled confidence among international actors that a permanent solution to the Liberian crisis had been found. The United Nations, for example, established the UN Observer Mission in Liberia (UNOMIL) and deployed military observers to monitor the various implementations of the Cotonou Agreement. The UN also developed a strategic plan for the rehabilitation and reconstruction of Liberia, which included increased support for local NGOs and greater emphasis on training throughout the country.[16] However, the UN’s plan was never fully realized. In a Consolidated Appeal for the period November 1993 to December 1994, UNICEF and WHO requested US $22,217,100 for health activities in Liberia, of which WHO required over US $16 million to undertake "transitional" activities focusing largely on support to the official MOH, revitalization of community-based Primary Health Care, reintroduction of community health financing schemes, and disease control and preventive health education programs.[17] The international response to the consolidated appeal was minute; less than one-tenth of required funds were contributed to UN agencies in the health sector, and none of those contributions were directed to WHO (see chart at the bottom of this page).

Despite promising reports from Cotonou, by the end of 1993 no fewer than six major factions representing various ethnic groups and alliances were battling each other for ethnic retribution as well as for territorial control. The 1993 arrivals included the Liberian Peace Council (LPC), which fought the NPFL in Grand Gedeh, Sinoe, and Rivercress counties and prompted a large influx of displaced persons into Buchanan and Harbel, and the Lofa
Defense Force (LDF), which attacked ULIMO forces in Lofa county and forced international relief agencies to suspend operations there. The year 1994 was consequently characterized by an even greater diversity of security conditions throughout the country than had existed previously in the Liberian conflict. The year began with the deployment of UNOMIL observers and more ECOMOG peacekeeping troops to liberated areas, and the opening of the Monrovia-Gbarnga highway by NPFL. The disarmament process that had been stipulated in the Cotonou Agreement resumed in central Liberia in March, with an estimated achievement rate of 30 percent. At the same time, however, LPC-NPFL hostilities in the southeast prompted a large-scale influx of displaced persons into Buchanan and into Cote d’Ivoire. Also in early 1994 long-held internal tensions within ULIMO manifest themselves in a violent split by ULIMO into two separate and antagonistic factions -- ULIMO-J, representing Krahs and under the leadership of Roosevelt Johnson, and ULIMO-K, representing Liberia’s Mandingo population and commanded by Al Haji Kromah. Thousands of civilians throughout northwestern Liberia were killed or displaced in the ensuing battle between the two ULIMOs, LDF, and ECOMOG, and the four hospitals and forty clinics that had serviced Lofa, Bomi, and Cape Mount counties in 1993 were destroyed or abandoned.[18] For most of 1994, these counties were cut off from international relief assistance.

In mid-1994 ULIMO forces attacked Taylor’s stronghold of Gbarnga, Bong county. By September -- when one of Liberia’s last remaining hospitals, Phebe (Bong county), was destroyed and hundreds of its staff and displaced persons seeking shelter there were massacred -- UN relief agencies and NGOs had officially suspended almost all operations outside of Monrovia and Buchanan.[19] But while conflict converged on Bong county and the county’s IDP population rose to 200,000, the factions operating in northwestern Liberia settled into an arrangement of relative territorial stability and consequent security. Refugees began to return to upper Lofa from Guinea and to resume limited agricultural and commercial activity in late 1994.[20]

Three of the warring factions signed another cease-fire and disarmament agreement in September 1994. Although the other factions contested the agreement and all segments of Liberian society hotly debated it, a shaky peace was established and was later cemented by the Abuja Peace Accord of August 1995. The Abuja Accord was remarkable in that, for the first time in the Liberian conflict, a peace agreement succeeded in installing a transitional government that was representative of and accepted by all major factions. Consequently, although isolated incidents of cease-fire violation occurred (most notably internecine fighting between the two ULIMOs in Bomi county in December 1995), much of Liberia experienced a sustained period of relative tranquillity throughout 1995. Both ECOMOG and UNOMIL increased their troop strength and deployed to previously rebel-held areas of the country. Humanitarian agencies traveled by ship to Sinoe county and overland from Monrovia to upper Lofa and Grand Gedeh counties for the first time in several years. In a cross border operation from Guinea, MSF-B re-launched its support to health facilities in parts of Lofa county; the agency also established outpatient, emergency medical, and immunization programs in Sinoe county, where residents had been without access to medical services for five years. INGOs that had been in Liberia for several years, including ACF, MSF-F, CRS, and SCF-UK -- as well as new arrivals such as World Vision Relief and Development (WVRD) -- also reached previously inaccessible regions of the southeast and northwest.

Another effect of the Abuja Accord and resultant security situation was that, for the first time since the NPRAG/IGNU era of 1990-92, international and local actors began talking about reconstruction, repatriation, and a transition process from relief to development. An estimated 30,000 Liberian refugees repatriated spontaneously from neighboring countries during the year,[21] and the United Nations High Commissioner for Refugees (UNHCR) developed a Plan of Operation for the organized voluntary return of at least 551,000
refugees in 1996.[22] One relief worker explains that "in 1995 it was possible to plan for the future again." With some regionally-isolated exceptions, Liberia was accessible and comparably secure. As happened during the 1990-1992 lull in the conflict, humanitarian agencies again undertook some rehabilitative activities such as infrastructural rehabilitation and the re-establishment of county health systems.

Representatives of INGOs, LNGOs, and UN agencies in Liberia believe that both the 1990-92 and the 1995 periods offered windows of opportunity to transform their strictly emergency interventions -- which are typically "vertical" programs without sustainability or significant transfer of skills and resources to the beneficiary population -- into transitional or development activities which could have contributed toward the longer-term health security and health capacity of the Liberian population. They suggest that the conditions during these "lulls" were conducive to programs of a development nature, and that such programs were needed on the ground (see the section on Decision-making and Sustainability in this report for elaboration). However, some field staff argue that their ability to effect these changes was limited by restrictions on funding for "non-emergency" activities. As one UN staff member quipped, "if our funders even smell "development" in a proposal for an emergency country, they will not fund it." The sluggish mechanisms of donor policymaking also prevented relief agencies from taking full advantage of the lull in 1995. International response to the UN Consolidated Interagency Appeal for the first half of 1995 attests to this fact, as UNICEF and WHO received only about US $1.3 million of over $7 million required to establish a Health Information Network, laboratory services, and HIV/AIDS/STD and other infectious disease prevention and control programs[23] (see chart at the bottom of this page). These activities, typically considered to be "rehabilitative" or "transitional" rather than "emergency," could have been implemented during the 1995 lull if funding had been forthcoming. As a former INGO staff member with substantial experience in Liberia explained,

"During lulls, especially when it would seem that an evolution could be made from emergency to transitional or development programs, donor interest played an important role, and usually a frustrating one. Fence sitting was the order of the day, and a wait and see attitude made it difficult to get a clear policy line from donors, in turn making it difficult to plan and evolve programs, taking advantage of periods of opportunity. One could also argue that donor hesitancy also negatively affected the momentum of positive change, which could be strongly argued during 1995."

Although 1995 represented a window of opportunity for rehabilitative and development activities, it was, as the phrase suggests, a timeframe of limited duration. Optimism for a permanent resolution of the Liberian emergency collapsed entirely in April 1996, when five factions converged on Monrovia for an intense battle which left an estimated 3000 people dead and forced expatriates as well as residents to flee the capital. The "April '96 crisis" began when the Council of State -- the Abuja-created national ruling body composed of six faction warlords -- attempted to arrest ULIMO-J leader Roosevelt Johnson on murder charges. He took refuge in Barclay Training Center, the former Armed Forces of Liberia (AFL) military barracks in Monrovia. ULIMO-J, LPC, and remnants of the AFL, all largely composed of ethnic Krahn fighters, rallied at the barracks and engaged the combined forces of NPFL and ULIMO-K. For two weeks, fighters from all factions indiscriminately looted nearly all Monrovia businesses, private homes, and the offices and warehouses of relief agencies. 20,000 displaced Monrovia residents -- including national staff of international relief agencies -- sought protection at the U.S. Embassy compound known as Greystone, which had no public water or sanitary facilities to support such a population. U.S. Marines evacuated over 2,300 Americans and third country nationals by helicopter, and humanitarian interventions in Monrovia and outside the city were suspended for up to four months. About 3,000 Liberian refugees escaped Monrovia on ships; one of these vessels, the Bulk Challenge, drifted along the coast for nine days while various West African states refused to
give permission for the vessel to dock (Ghana finally accepted the refugees under pressure from the UN and other countries). Finally, an estimated US$18 million in drugs, supplies, and equipment was looted from international organizations and NGOs in Monrovia during the crisis, and 75 percent of Monrovia homes, schools, churches, hospitals, businesses, government buildings were destroyed.[24]

The April 1996 crisis not only limited the humanitarian community’s logistical and material capacity to respond to the ensuing health emergency throughout the country; it also had a significant impact on the collective will of these agencies to do so. In June twelve international NGOs announced their deliberate intention to restrict their work to only immediate life-saving activities and also to limit their capital assets in the country. The agencies’ Joint Policy of Operation (JPO) represented a realization by field staff that their interventions in Liberia may have done more harm than good, and the original declaration as well as subsequent revisions guided the NGOs’ humanitarian response from mid-1996 forward.

The April 1996 crisis centered on Monrovia, but it had a ripple effect on the security situation in much of Liberia. Following several months of heightened insecurity, warring factions signed what became the fourteenth and final peace accord of the Liberian emergency in August. The "Abuja II" Accord restored the 1995 cease-fire and developed a timetable for disarmament, demobilization, and national elections in 1997. In light of the improved security situation after Abuja II, international and national NGOs expanded their programs into Bong, Margibi, and Grand Bassa counties in August, and the humanitarian community responded in force to reports of widespread and extreme malnutrition in Tubmanburg, Bomi county, in October. ECOMOG established buffer zones between the ULIMO, NPFL, and LPC territories and embarked on a three-month disarmament process, which was declared a success by ECOWAS and the United Nations.

The Liberian civil war lasted for seven years, caused an estimated 150,000 excess deaths, displaced over 80 percent of the population, and destroyed approximately 90 percent of the country’s health infrastructure. Although the country has successfully completed the peace process as outlined in the Abuja II agreement -- including democratic elections, which were won by Charles Taylor and his National Political Party -- Liberia remains in a period of post-conflict transition. The new government is trying to develop and implement its first functional budget since the early 1990s, refugees and IDPs are slowly returning to their communities of origin, and private entrepreneurs and exporters are tentatively revitalizing the country’s tattered economy. Despite the fact that Liberia seems to be finally at peace, citizens and international actors alike remain apprehensive and very much aware that they have been "burned" many times before.
### Accessibility by International Relief Agencies, by County per Quarter*

Solid = no international presence Clear = sporadic or regular presence

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<tr>
<td>Montserrat</td>
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</tbody>
</table>
Evacuation Aid workers Operation Octopus Aid workers April 6 attacked (NPFL attack against attacked battle ECOMOG & civilians)

* Rather than having access to the counties as a whole, relief agencies usually only had access to the principal cities (i.e. Monrovia and Buchanan) and communities along the main roads.
### International Health NGOs in the Liberian Emergency

<table>
<thead>
<tr>
<th>Organization</th>
<th>Dates of Operation in Liberia</th>
<th>Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Key Actors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Action Contre la Faim (ACF)</td>
<td>1992-1998</td>
<td>Provided drugs to health facilities; operated therapeutic feeding programs; conducted food security monitoring; provided water/sanitation services.</td>
</tr>
<tr>
<td>Catholic Relief Services (CRS)</td>
<td>1990-1998</td>
<td>Imported and distributed emergency Title II food aid country-wide</td>
</tr>
<tr>
<td>International Committee of the Red Cross (ICRC)</td>
<td>1990-1998</td>
<td>Provided food to displaced persons; supported Liberian National Red Cross Society.</td>
</tr>
<tr>
<td>Medecins Sans Frontieres-Belgium (MSF-B), Holland (MSF-H), and France (MSF-F)</td>
<td>1990-1996</td>
<td>Re-activated clinics, hospitals, rehydration centers, and therapeutic &amp; supplemental feeding centers; provided drugs and medical supplies to health facilities; distributed targeted food aid to vulnerable groups; operated EPI systems. Divided counties between the 3 organizations.</td>
</tr>
<tr>
<td>Medecins Sans Frontieres International (MSF-I)</td>
<td>1996-1998</td>
<td>Reactivated clinics and hospitals in two counties</td>
</tr>
<tr>
<td>Save the Children/UK (SCF/UK)</td>
<td>1991-1998</td>
<td>Distributed EU/ECHO food aid; reactivated clinics; operated mobile health clinics in five counties; operated Monrovia’s garbage collection system.</td>
</tr>
<tr>
<td><strong>Additional Actors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aide Medicale International/France</td>
<td>1991</td>
<td>Provided drugs to public and private hospitals and clinics</td>
</tr>
<tr>
<td>German Emergency Doctors (GED)</td>
<td>1990</td>
<td>Rehabilitated and operated one hospital in Monrovia</td>
</tr>
<tr>
<td>Organization</td>
<td>Dates of Operation in Liberia</td>
<td>Programs</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medical Assistance Programs (MAP)</td>
<td>1990</td>
<td>Donated medical supplies to MSF-B</td>
</tr>
<tr>
<td>World Vision Relief and Development (WVRD)</td>
<td>1996-1997</td>
<td>Established health posts, clinics, and feeding centers in two counties</td>
</tr>
<tr>
<td>Lutheran World Federation/World Service (LWF/WS)</td>
<td>1990-1998</td>
<td>Emergency food distributions and school feeding in six counties; limited hospital rehabilitation</td>
</tr>
<tr>
<td>Medecins du Monde (MDM)</td>
<td>1997-1998</td>
<td>Mobile health clinics in two counties</td>
</tr>
<tr>
<td>Medical Emergency Relief International (MERLIN)</td>
<td>1997-1998</td>
<td>Reactivation of health clinics in two counties</td>
</tr>
<tr>
<td>Children’s Aid Direct (CAD)</td>
<td>1997-1998</td>
<td>Mobile health clinics and reactivation of health posts and clinics in two counties</td>
</tr>
<tr>
<td>OXFAM</td>
<td>1996-1998</td>
<td>Water/sanitation services in one county</td>
</tr>
</tbody>
</table>
## Summary of Requirements and Contributions for Health Activities*

Compiled by OCHA on the basis of information provided by the respective appealing agencies

<table>
<thead>
<tr>
<th>Implementation Period</th>
<th>UNICEF</th>
<th>WHO</th>
<th>International Rescue Committee</th>
<th>TOTAL</th>
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<tr>
<td>1990-1993</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<tr>
<td>Nov 93 - Dec 94</td>
<td>5,910,000</td>
<td>2,128,139</td>
<td>16,307,100</td>
<td>0</td>
</tr>
<tr>
<td>Jan 95 - Aug 95</td>
<td>2,730,000</td>
<td>935,386</td>
<td>4,400,802</td>
<td>328,618</td>
</tr>
<tr>
<td>Sept 95 - Dec 96</td>
<td>6,215,050</td>
<td>3,447,809</td>
<td>5,799,260</td>
<td>572,758</td>
</tr>
<tr>
<td>Jan 97 - Dec 97</td>
<td>1,804,000</td>
<td>2,667,736</td>
<td>3,227,170</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>16,659,050</td>
<td>9,179,070</td>
<td>29,734,332</td>
<td>901,376</td>
</tr>
</tbody>
</table>

*Does not include food and nutrition activities.*
III. Key Decisions in the Liberian Emergency

1. Commodity Substitution: Bulgur Wheat for Rice

Rice has a special place in the Liberian diet and culture. Besides being a staple food for the population, rice also holds symbolic value in traditional religion, the collective identity of Liberian society, and individual status rankings. For the first four years of the Liberian conflict, rice was the primary cereal distributed to affected Liberians by international relief agencies such as CRS, MSF, SCF, and LWF/WS. In 1995, however, the agencies responsible for the importation and distribution of food aid -- namely WFP and CRS -- substituted bulgur wheat for rice in food distributions. While a commodity substitution of this nature in an emergency is not unusual (the substitution of yellow for white maize in Southern Africa Drought Emergency, DESA, of 1992 is but one example), it had considerable political, economic, and social ramifications in Liberia. The factors influencing this decision and its impact are examined below.

Numerous theories and opinions exist in Liberia today about the reasons behind the decision to substitute bulgur for rice in food distributions. The most common reason voiced by international as well as Liberian respondents was an economic one: the price of rice in the United States (a major donor of food aid to Liberia) as well as in other donor countries increased to nearly double that of bulgur wheat in the mid-1990s, due in part to a surplus of bulgur raised in the U.S. It was therefore less expensive for donors to contribute bulgur to the relief effort in Liberia, and this preference was duly expressed to and accepted by recipient aid agencies.

In addition to the international economic issue, there were other legitimate reasons behind the decision to substitute bulgur. First, relief agencies hoped that by providing a less desirable cereal, Liberian beneficiaries, and IDPs in particular, would be encouraged to grow their own rice, thus promoting agricultural self-sufficiency and strengthening local markets. Taking into account local coping mechanisms regarding food procurement (based on food security assessments and nutritional surveys), relief agencies assumed that the strong Liberian preference for rice would prompt them to use other means to obtain it, namely growing it themselves or trading for it. Second, relief agencies believed that fighters and factional or governmental authorities would be less likely to steal the unappealing bulgur rations from NGO warehouses and from the beneficiaries themselves. Lastly, the change from rice was specifically intended to improve access to food aid by the vulnerable populations, such as women, the elderly and disabled, the extremely impoverished, and the IDPs. Again, international agencies assumed that people who could afford to grow or buy rice in the market would do so, in preference to accepting the bulgur wheat which was being distributed. Thus it was reasoned that personal preference for rice would winnow out numerous opportunists who were never intended to receive a free ration.

As noted above, the major donors, in particular the US Government in conjunction with WFP, were the driving force behind the decision to substitute bulgur for rice. However, the idea generated great controversy when it was presented to the various actors in the field. The Government of Liberia, local NGOs, and community leaders, in particular, opposed the decision and resented their "coerced" endorsement of it. Several international aid representatives counter that while the Government's weakness prevented its taking an active role in the decision-making process at the time, local actors were in fact consulted in the decision and substantially involved in the follow-up sensitization and implementation campaigns. The beneficiary population (which naturally included many Liberian relief
workers, civil servants, and health personnel), however, clearly did not take part in the
decision-making process: they heatedly opposed the idea, universally despised bulgur, and
complained of abdominal pain and diarrhea for months after the substitution occurred.

Once the decision was decided upon, relief agencies conducted sensitization campaigns to
prepare the beneficiary population for the impending substitution. A media campaign,
consisting of radio announcements and newspaper advertisements, informed the people of
the coming change, explained what to expect, and instructed them on how to prepare bulgur.
In certain parts of the country, traveling road shows performed bulgur wheat plays, sang
songs, and handed out T-shirts. Community Health Workers were trained to teach people
how to prepare bulgur wheat. The RPG team’s interviews and focus groups with
beneficiaries and relief workers, however, suggests that the sensitization campaign failed to
target rural, poor and illiterate persons. Radio and print media primarily reached people in
urban areas such as Monrovia, Gbarnga, and Buchanan, who also tended to be literate and
able to locate and afford radios and batteries. Most of people who lived in the rural areas of
Liberia did not have access to radios, newspapers, or CHWs, and thus they did not learn
how to properly prepare and eat bulgur wheat. Misinformation and lack of information about
bulgur due to these logistical and demographic obstacles caused bulgur to be improperly
prepared, which consequently caused gastrointestinal upsets among its consumers.

The decision to substitute bulgur for rice also had local economic impacts. In comparing the
price of rice to bulgur in the market in Monrovia in 1996 and 1997,[25] (see graph below), it
can be seen that the price of rice ranges two to four times higher than bulgur. Although
market price surveys for 1995 are not available, it is assumed that this price pattern began
shortly after the bulgur substitution. The likely causes of this disparity are, first, the fact that
rice, as the preferred grain, was also the most highly demanded, and second, that bulgur, as
the commodity being provided for free to IDPs by relief agencies, was in the highest supply.
IDPs and other food beneficiaries in Liberia, as in other emergency settings, commonly sold
a small percentage of the grain to supplement their diet with oil, greens, chilies, and
condiments. Their supplemental income decreased with the bulgur substitution, which had
an indirect effect of driving down overall market prices for all of these commodities. Thus an
unintended result of the bulgur decision was a decrease in the disposable income and
purchasing power of the food aid beneficiaries. On the other hand, the resultant decrease of
market prices for food commodities ultimately helped the general population (the urban poor
in Gbarnga, Monrovia and Buchanan) to afford these supplemental foods.
Although Liberians seemed to universally despise bulgur wheat and attributed numerous different maladies to its consumption, it is unlikely that the commodity substitution of bulgur for rice affected nutritional status. When bulgur is not prepared properly, it can initially cause gastrointestinal disturbances, specifically abdominal pain and diarrhea. It also takes the body time to adjust to the digestion of bulgur if one is used to consuming only rice. On examination of ACF nutrition surveys in Buchanan (see following subsection on IDPs), by holding constant the other necessary factors in interpreting these surveys it can be concluded that there is no overall difference in malnutrition before and after the substitution. This is a soft conclusion, because bulgur was introduced to the general population and IDPs living in shelters in Buchanan sometime between January 1995 and February 1996 (the mission was unable to document the exact date from past reports/surveys), when the amount distributed constituted only a very small amount of the people’s diet.

Some representatives of WFP, CRS and ACF regretted that the change of commodity occurred at the same time as the termination of the general food distribution in many parts of Liberia in 1995. In retrospect, the two actions probably should not have occurred simultaneously, but no documentation or data on the effects of this decision exist.

The bulgur wheat substitution ultimately became a political issue as well. In the 1997 national Liberian elections, then-President candidate Charles Taylor criticized the imposition of bulgur wheat on the Liberian “rice-loving culture.” He effectively used this criticism against fellow candidate Ellen Johnson Sirleaf, who worked at United Nations Headquarters in New York during the Liberian conflict and was thus held “responsible” for the bulgur wheat decision by the Taylor campaign.

An on-going consequence of the bulgur wheat substitution is the risk of creating dependency among the Liberian population upon bulgur wheat itself. School children (95% of current aid beneficiaries) have consumed bulgur rather than rice as their primary staple for several years and have developed a taste for it. Besides the cultural impact of this development, there may be a macro-economic one as well: bulgur is not grown in Liberia, and as the
country stabilizes over the next several years it may find that bulgur has become a rival staple food in the Liberian diet -- one which is unsustainable in a rice-producing environment.

In conclusion, the decision to substitute bulgur wheat for rice in Liberia was taken by international actors who were responding to international (donor) interests which did not prioritize either the short-term health of the population or the long-term sustainability of relief activities. Overtures to local authorities and beneficiaries in making this decision were mostly cosmetic and interpreted as such by the local actors. While serious and probably costly efforts were made to sensitize the population to the decision, it was effective only for those with the means to access the media campaign. The decision did recognize and seek to complement local coping mechanisms regarding food procurement and according to respondents, it likely played a role in increased agricultural productivity and self-sufficiency by compelling Liberians to grow their own rice and by stimulating rice prices in the markets. While the substitution itself may have been an appropriate temporary measure at this point in the Liberian emergency (when food procurement coping mechanisms were strong, security was relatively high, and agricultural production was possible), the manner in which the decision was made and implemented had unforeseen and potentially negative political, social, and economic effects. Greater coordination with local actors would have likely mitigated many of these impacts.

2. The April 1996 Crisis

April 6, 1996 was a crisis in the very sense of the word. As described in the Overview section, Monrovia underwent the worst looting and fighting that it had seen during the seven year civil war. Nothing was spared -- people, buildings or resources. INGOs were specifically targeted in the anarchy and approximately $18 million dollars worth of relief equipment, supplies, drugs, food, and vehicles were looted. Hundreds of trucks were stolen and used by the soldiers to fight and pillage. All of the international relief agencies, embassies, and most other expatriate residents of Monrovia evacuated Liberia in the ensuing chaos.

The crisis -- and in particular the international community’s response to it (i.e. evacuation) -- had a number of impacts on the health of the Monrovia population. First, all but one hospital in Monrovia were damaged and ceased to function. The remaining hospital -- Swederelef, a facility operated by MSF -- continued to provide emergency and obstetric services during the crisis through its national staff after MSF expatriates evacuated (this is further discussed below). Most other health-related facilities, such as Monrovia’s water treatment plant, were also destroyed. Second, although exact numbers are unavailable, it is estimated that approximately 3,000 people died and 300,000 were displaced by the violence in Monrovia.[26] Third, as mentioned above, the crisis provided the means for a transfer of millions of dollars of relief aid and supplies from the international humanitarian community to the fighting factions, further empowering the fighters and disabling the relief agencies. Finally, the crisis caused the INGOs to question the humanitarian as well as political impact of their actions and programs over the last six years. They concluded that their relief efforts had inadvertently aided the factions, thus prolonging the civil war, and this introspection ultimately resulted in the development and adoption of the Joint Policy of Operation (JPO; see following sub-section).

The above impacts on health and health security were the result of the degree to which the UN and INGOs had predicted and prepared for a catastrophic event such as the April ‘96 crisis in their programmatic planning. The RPG team interviewed individuals from the donor, INGO, LNGO, government, UN, and beneficiary communities who were present before, during and after the crisis. Nearly everyone interviewed remarked that before April, there
were clear signs of an impending confrontation between the factions in Monrovia. These signs included increased tension in the streets, more people in the streets carrying their belongings (presumably leaving the city before violence broke out), a visible increase in the number of men with arms in the city, and increased incidents of gunfire. However, no one foresaw the magnitude of the crisis; nor, in retrospect, could anyone offer suggestions as to how the magnitude of the crisis could have been predicted.

A few international relief agencies had incorporated a degree of sustainability planning and emergency preparation into their programs which proved invaluable during the April ‘96 crisis. For example, MSF’s preparations and contingency plans allowed Swederelief Hospital -- a field hospital in Monrovia which the agency has supported since 1993 -- to continue functioning in the absence of expatriates. These preparations included the stockpiling of food, water, medical supplies, and drugs at the hospital, the appointment of highly qualified Liberian health personnel to senior positions on the hospital management team, and the development and implementation of appropriate treatment protocols, emergency protocols, and communications systems allowing Swederelief to remain in contact with MSF’s Abidjan office throughout the crisis. Swederelief also benefited from its geographic location on Bushrod Island, away from the center of town where the heaviest fighting occurred, and from its function as a safe haven for staff, their families, and other displaced Monrovia residents.

Perhaps the most significant factor contributing to the sustainability of Swederelief during the April crisis was the high number and key role of national health staff at the hospital. In the years prior to 1996 MSF had consciously worked to create management teams combined of both Liberians and expatriates who shared decision-making responsibility for the hospital, and had developed a strong, well-trained cadre of national health staff who could maintain much of the hospital’s services in an emergency situation such as that faced in April 1996. The hospital continued to take emergency and obstetric cases throughout the crisis and reopened its outpatient department one month later, and the staff also maintained admission records and patient charts during the emergency. (These records, along with program reports from ACF, are the only health data from INGOs or the UN in Liberia to have survived the April ‘96 looting).

With the exception of Swederelief, however, the international relief community’s preparation for the April ‘96 crisis was tragically minimal. Most INGOs did not plan for the crisis despite the early warning signs mentioned above; only a few agencies stockpiled supplies, and most did not have emergency management plans in place. Nor did specific training for an emergency, such as mock exercises (mass casualties exercises, or “masscals”) and triage, occur. Finally, local health workers from the UN and nearly all of the INGOs were left to fend for themselves, often not knowing if the expatriates would return or if they would be paid for their continued work. Many current and former national staff of these agencies criticized the agencies’ failure to adequately prepare them to continue relief operations in the event of a crisis such as April 1996. Had such contingency plans and training been implemented, many respondents believe, the relief community as a whole would have been better able to assist the victims of this relatively brief, but exceedingly destructive, crisis in the Liberian emergency.

Beyond the national staff of international relief agencies, the crisis also left the entire local health structure without international resources or support, on which the structure had been dependent for most of the civil war; therefore, the structure was rendered essentially impotent. The April ‘96 crisis thus illustrates one of the main themes of RPG’s findings in the Liberian case: international relief agencies generally failed to support indigenous Liberian health capacities during the emergency, and in the case of the April ‘96 crisis, this failure may have been detrimental to the immediate survival and longer-term health of the affected population.
Throughout most of the war, most donors and INGOs tended to ignore the various Liberian authorities, including the "legitimate" transitional governments as well as the de facto resistance administration run by Charles Taylor for several years. Staff of WHO -- an agency which, in accordance with its mandate to work closely with government entities, did make an effort to coordinate and consult with Liberian authorities during the war -- say that the difficulty they encountered in working with the INGOs who did not recognize these authorities proved detrimental to the overall effectiveness of the humanitarian intervention in Liberia. Staff of LNGOs and the Government of Liberia agree, suggesting that this refusal by many international relief agencies to deal with "existing" government(s) was inappropriate, caused inefficiencies and duplication of efforts, and at times hampered the albeit minimal activities of government-run clinics and hospitals. It is true that the Ministry of Health was essentially non-functional at times during the war and that corruption was often rampant. On the other hand, INGOs frequently set up and operated clinics and hospitals beside existing government facilities, without any cross-fertilization of knowledge, resources, or sustainability. International agencies also supported local clinics but not district hospitals, yet would refer patients to these hospitals. Many national as well as international health workers interviewed by RPG concluded that if INGOs had more communication and cooperation with existing government health facilities, Ministries of Health, local NGOs, church health systems, and LNRCS, then Liberian health capacities might have been stronger and the humanitarian response to the April '96 crisis might have been more effective.

The story of the April '96 crisis and the international response to it reveals several lessons and recommendations relevant to health interventions in complex emergencies. First, relief agencies should develop an emergency preparedness plan for unexpected crises such as the one suffered by Monrovia in April 1996. The following should be included in an emergency preparedness plan:

- A written plan of action;
- Stockpiling of goods, including water, food, medical supplies and drugs;
- Triage training for local staff to prioritize the severity of patients’ illnesses in cases of large-scale emergencies;
- Masscal exercises performed by local health staff without expatriate participation;
- Communications plans to allow contact with expatriate staff in the event of an expatriate evacuation.
- Clear instructions to local health workers regarding their employment status and their payment in the event of an expatriate evacuation.

Second, international relief agencies should work to improve the management and administrative skills of their national staff in addition to technical skills training. National health personnel should be involved at all levels of decision making, including management. Besides empowering the workers, this will enable them to maintain some of the agencies’ relief operations in case of a sudden crisis and international evacuation. Finally, both the UN and INGOs should consciously and strategically communicate and cooperate with the national government(s), LNGOs, and other health actors throughout an emergency, so that local organizations have a role as well as a responsibility in the relief effort. Increased communication and cooperation between international and indigenous structures may help to facilitate positive relationships between the various international and local actors in a complex emergency, improve humanitarian assistance to the affected population through the mutual exchange of knowledge and skills, and sustain relief operations in times of peak crisis and international evacuation.
3. Joint Policy Operation (JPO)

The Joint Policy of Operation (JPO) is a statement of intent that was developed by the INGO community in Liberia in August 1996. It was formed in direct reaction to the April 1996 crisis, in which INGOs and other international organizations were systematically targeted and looted by the different factions in Liberia and forced to evacuate the country. Following that crisis, INGOs went through a process of introspection and evaluation regarding the impact of their programs on the political and well as humanitarian dimensions of the Liberian conflict. They concluded that over the course of the war -- and as had been clearly demonstrated during the April '96 crisis -- their sizable material and financial inputs into the relief effort had "the perverse and involuntary effect of contributing to the war effort of the factions involved in the conflict."[29]  They also determined that the INGOs could have a positive impact at a policy level by adopting a collective and cohesive "commitment to advocacy of human rights and humanitarian principles."[30]  This redefinition of the scope and agenda of INGO interventions in Liberia constitutes one of the most important decisions made by the INGO community during the Liberian emergency, and one which provides several lessons for health interventions in complex emergencies.

The JPO was revised numerous times in 1996 and 1997 as the thinking of the INGOs as well as the situation on the ground changed. The first version of the JPO excluded any activities not falling into a narrowly defined definition of "minimal life-saving activities" and placed considerable emphasis on the idea of minimizing the capital inputs of relief agencies into Liberia. These policies represented a deliberate choice on the part of the INGOs to avoid health education, capacity-building, and other sustainable activities in favor of immediate life-saving ones.

The Abuja II Peace Accord of August 1996 established a framework within which disarmament, demobilization, elections, and national reconstruction could finally take place. As these steps in the peace process unfolded and stability in the country improved, numerous INGOs who had not previously operated in Liberia came onto the scene. The arrival of new actors in the international health community combined with an environment conducive to reconstruction and development, prompted the INGO community to revise the JPO to reflect these changes to the context of relief operations in Liberia. Also, in October 1996, the INGOs hosted a "Smart Aid" workshop in Monrovia, which provided further clarification of the INGOs' impact on the Liberian conflict and their responsibilities toward it. The latter two versions of the JPO therefore gradually expanded the commitment of the INGOs to include more sustainable interventions, such as the "support of local communities to ensure continuity, sustainability, and self-sufficiency."

Chronology of the Evolution of the JPO (see Appendix 3 for text of each JPO)

<table>
<thead>
<tr>
<th>JPO Version</th>
<th>Date of Issue</th>
<th>Key Points</th>
</tr>
</thead>
</table>
| Version 1   | Aug 29, 1996  | -minimum input policy  
|             |               | -maximal impact through targeted and monitored interventions  
|             |               | -advocacy  
<p>|             |               | -maintaining high degree of coordination between INGOs in field |
| Version 2   | Nov 22, 1996  | -to actively support activities designed to promote peace through advocacy |</p>
<table>
<thead>
<tr>
<th>JPO Version</th>
<th>Date of Issue</th>
<th>Key Points</th>
</tr>
</thead>
</table>
|             |              | -to endeavor to do no harm through INGO assistance to program beneficiaries, implementing partners, and program staff  
- to provide only essential capital assets needed to address "agreed to" needs of beneficiaries so that INGO minimize risk of fueling war  
- to support local communities to ensure continuity, sustainability, and self-sufficiency  
- to continue with self-regulating mechanism  
- to identify and support local capacities for peace |
| Version 3   | Sept 1997    | -to identify and support local capacities for peace  
- to support local communities to empower and ensure self-sufficiency  
- to conduct regular monitoring and evaluation of programme activities  
- to promote "Do No Harm" approach in all programmes  
Co-ordination  
- to continue with self regulation and co-ordination mechanisms  
Advocacy  
- to strengthen and improve co-ordination with other parties  
- to actively support humanitarian objectives through advocacy |
| Version 4   | April 1997   | -to actively support activities designed to promote peace through advocacy  
- to promote "Smart Aid" and "Do No Harm" approaches in all programmes  
- to provide only essential capital assets needed to address "agreed to" needs of beneficiaries so NGOs minimize risk of fueling war  
- to support local communities to ensure continuity, sustainability, and self-sufficiency  
- to continue with a self-regulating mechanism  
- to identify and support local capacities for peace |

The key objectives contained in the various manifestations of the JPO are as follows, and each will be discussed below:

- Cooperation and communication among INGOs, including joint assessments and sharing of resources;  
- Cohesion among INGOs and unity in dealings with factions, UN and LNGOs  
- Advocacy, national and international;  
- Minimal inputs with maximal outputs with targeted interventions to the vulnerable;  
- Self-regulation and development of the Monitoring & Steering Group;
To support local capacities for peace;
To support local communities to ensure their empowerment and self-sufficiency.

Cooperation and Communication among INGOs, including joint assessments and sharing of resources:

During the first few months after April 1996, and as the INGOs who had evacuated Liberia during the crisis returned, greater cooperation and communication among INGOs did occur. INGOs conducted joint assessments and shared information with each other to a greater degree than had occurred in the past. They established a Monitoring and Steering Group (MSG), which met weekly and worked to coordinate these joint initiatives and to encourage compliance with the other goals of the JPO. But as the peace process instigated by the Abuja II Accord moved forward and more INGOs new to Liberia arrived, this communication and especially the cooperation fostered by the JPO began to break down. For many of the new INGOs, who did not have the April 1996 perspective to draw upon and who desired to find a niche in the Liberian relief effort, cooperation and communication for purposes of both group security and advocacy were not particularly attractive or useful. A common approach to needs assessments never truly materialized, and the sharing of resources was considered too restrictive in the post-Abuja environment of stability and increased access to rural populations.

Cohesion among INGOs and unity in dealings with factions, UN and LNGOs:

During the war, INGOs had adopted different approaches to dealing with other actors in the Liberian conflict and relief effort, and the orchestrators of the JPO decided that unity in such dealings should be a key facet of the document. The agencies agreed that a staff position should be established to facilitate INGO advocacy and coordination efforts, and the position was filled in the summer of 1997. Among other tasks, the INGO Facilitator chairs MSG meetings, works extensively with the Ministry of Planning (the ministry responsible for liaising with the INGOs) and has helped the Ministry develop import tax guidelines for INGOs, INGO accreditation guidelines, and a memorandum of understanding (MOU) between the INGOs and the government. The MOU did not exist before or during the war, and the other documents may have existed but were not adhered to by INGOs prior to the 1997 elections. The INGOs share the costs of the Facilitator.

Advocacy:

The advocacy campaign never truly took off, for several reasons. Many INGOs did not have experience in advocacy, nor was it part of their institutional mandates. Given the varying programmatic activities, organizational structures, and philosophies of humanitarian service among the agencies, it was difficult for the field and headquarters offices of the different INGOs to agree on a specific advocacy strategy. Also, after the 1997 elections it became difficult to criticize the newly elected government, which had power to grant accreditation and working permits. Lastly, the Taylor government has not established a comprehensive program of reconciliation which would perhaps create an easier atmosphere for advocacy work to take place.

Minimal inputs with maximal outputs with targeted interventions to the vulnerable:

During the first few months after April 1996, this did occur, as the INGOs who had previously worked in Liberia returned. They did not stockpile goods, and attempted to decentralize programs and use local material whenever possible. INGOs claim that instead of importing new field-ready vehicles and other equipment to replace their looted goods, they rented
vehicles from local entrepreneurs and purchased supplies to the extent possible on the local market. They also restricted their operations to those collectively determined to be "minimal life-saving activities," and, by necessity due to the limited supply of vehicles that could travel upcountry, they also confined their activities to Monrovia, Buchanan, and environs. But some representatives of the donor community dispute that the INGOs actually made such dramatic modifications to their operations, and also claim that whatever restrictions had been implemented by the INGOs dissolved after the Tubmanburg crisis of September/October 1996.

There are currently more than 30 INGOs in Liberia -- a greater number than before April 1996. The degree of adherence to the existing JPO now varies widely among the INGOs. Indeed, the April 1997 revision of the JPO states that "levels of resources and staff will be left to the discretion of each organisation." Due to increased stability in the country and a push to reach previously inaccessible populations, many INGOs are bringing vast amounts of resources into Liberia, including trucks, personnel, computers, and relief supplies. But other INGOs continue to operate within the framework of the JPO: for example, one INGO does not use zinc roofing for the schools it is rehabilitating, because zinc has been a popular target for looters throughout the war. INGOs have also been refused funding from donors because they refuse to use materials such as zinc sheeting.

**Self-Regulation and Development of the MSG (Monitoring Steering Group):**

Self regulation effectively ended after the Tubmanburg crisis (see Tubmanburg sub-section). The MSG continues to meet biweekly. It is a place to share information, but self-criticism and philosophical discussions on "do no harm" rarely occur. INGO staff say that is very difficult to self-regulate when various INGOs have different mandates and different pressures from headquarters as well as donors to be visible in the relief effort. The self regulation/MSG was developed in order to increase compliance, but as stated above, was and is not very effective. Similarly, there are no measures for evaluation included in the document, and consequently no rigorous evaluations have occurred from which conclusions on the JPO’s short- and long-term effects can be drawn.

**To support local capacities for peace:**

The inclusion of the objective to support local capacities for peace in the later versions of the JPO is admirable, but only certain INGOs with mandates of peace and reconciliation activities were able to incorporate this objective into their programs, and thus its success is difficult to measure.

**To support local communities to ensure their empowerment and self-sufficiency:**

This objective was emphasized in the latest version of the JPO, and will take years to see the results. In the November 22, 1996 version of the JPO it is declared that "working with local structures" will be emphasized. The point is not further elaborated and the only potential reference to it in the document is the goal of supporting local communities to ensure sustainability. It does not address working with existing government ministries, national red cross or local NGOs. The objective of supporting local communities to ensure empowerment and self-sufficiency was only seriously considered after the peace process was underway -- not during the majority of the Liberian conflict. However, this objective should be a common and unifying goal for all INGOs, including relief organizations who most often concentrate on the immediate crisis situation and forsake long term sustainability issues. As shown in other areas of this report, ignoring such existing capacities, despite all of the inherent problems of working with them, decreases sustainability and lengthens the country’s road to recovery.
While the objectives and stated intentions of the JPO were admirable, it was never comprehensively implemented for several reasons. First, according to relief workers familiar with the JPO, it was always more of an idealistic document than a practical program which could be implemented and then evaluated. None of the versions provide specific guidelines or instructions on how to reduce capital assets, cooperate with other agencies, or implement a self-regulating mechanism. Rather, the JPO served as more of a philosophical framework that the INGOs attempted to follow. It has also been suggested that the JPO was a personality-driven document created by individuals in the field who had considerable knowledge of the Liberian situation and were able to discern both the true impact of INGO relief and the potential role for INGO advocacy. But the overarching themes of the JPO -- advocacy, interagency cohesion, and cooperation -- have yet to be institutionalized within the organizations themselves. Although the JPO may have set a precedent for future relief operations, INGO staff in Liberia express doubt that the ideas of the JPO have been integrated into the emergency units of the signatory organizations. At the most fundamental level, the JPO goes against the grain of the signatory agencies, who are mandated to respond to humanitarian emergencies and are not inherently advocacy- or politically-oriented.

Despite the above drawbacks to the Liberian JPO, INGOs should strategically consider developing a policy of operation using the framework of the Liberian JPO at the outset of future complex emergencies. This strategic consideration should be based upon an immediate and repeated analysis of: 1) the political/military and social context of the emergency; 2) the potentially harmful impacts of humanitarian aid in this context; 3) the relationships between international agencies and between international and local actors; 4) the level of interest and commitment of the INGOs to the concepts of advocacy, cohesion and cooperation, and self-regulation; and 5) the impact of deliberate restrictions on INGO activities upon local capacities and the health of the affected population.

Within these considerations, the signing of a document such as the Liberian JPO by every INGO in the field, at the beginning of an emergency, and with appropriate revisions according to the changing conditions of the situation, may at a minimum encourage cohesion and communication between INGOs in that location. Ideally, such a process might also facilitate programmatic evaluations, joint assessments, greater consensus on the direction of humanitarian assistance, and more consideration of the potential intended and unintended impacts of that intervention.

4. The Intervention at Tubmanburg

Tubmanburg, the county seat of Bomi county, is an access point for rubber production and iron ore extraction in Liberia, and was therefore a strategic objective for three factions as well as ECOMOG. Tubmanburg consequently suffered multiple invasions and heavy damage throughout the war:

- Dec 1989: War starts in Liberia
- July 1990: NPFL invades Tubmanburg
- August 1992: ULIMO invades, takes Tubmanburg from NPFL
- mid-1994: ECOMOG enters Tubmanburg
Before the war began in 1989, Tubmanburg benefited from several Liberian relief and development initiatives. Among the most prominent were the LNRCS -- which concentrated on sanitation, road construction, and limited first aid training -- and the Bomi Community Health Department (CHD), which operated clinics and trained health workers throughout the county under the auspices of the Bomi Government Hospital. With periodic support from international relief agencies such as SCF-UK, ICRC, and WFP, these local organizations continued to provide drugs and health services to Tubmanburg and Bomi-area clinics, feeding centers, and other operations during intermittent lulls in the war. CHD, for example, operated rehydration centers, trained community health workers (CHWs) and traditional birth attendants (TBAs), conducted HIV/AIDS education, and provided basic health education in areas such as nutrition, water/sanitation, and indigenous oral rehydration solution (ORS) preparation. In September 1995, CHD also undertook training of trainers in diarrhea prevention in response to a cholera outbreak. However, CHD staff note that when the war escalated, the trained CHWs were often conscripted as combat medics, killed for supporting the other side, practiced medicine beyond their training and ability (i.e. became "black baggers"), or left Bomi to attempt to gain employment with INGOs in Monrovia.

LNRCS and CHD were also able to function at limited levels during most of the peak conflict periods, due to their well-established presence in the communities, the consequent trust by the population in their neutrality and humanitarian interests, and their ability to procure drugs and supplies from sister organizations in other counties when the Monrovia supply pipeline was cut off. With support from SCF-UK, CHD maintained its therapeutic feeding center during the ULIMO split, and another local NGO, the Concerned Christian Community (CCC) provided food for displaced persons in Tubmanburg. However, outlying clinics throughout Bomi county were not supported by either LNGOs or INGOs during most peak crisis periods, due to insecurity and logistical inaccessibility.

On December 25, 1995 a large battle erupted between ULIMO-J and ECOMOG which lasted three months and resulted in ULIMO-J’s capture of Tubmanburg. The intense fighting caused extensive infrastructural damage and forced tens of thousands of people to flee to Tubmanburg from rural Bomi county. Health facilities throughout the county -- including the Bomi Government Hospital and the CHD -- were destroyed and abandoned during this period. No external support could safely arrive in Tubmanburg, including aid from the LNRCS, other LNGOs or INGOs, for nine months. During this period, which has become known as the "Tubmanburg crisis," there was no food distributed in Tubmanburg. People coped by eating bush food, such as roots, wild eddoes, papaya leaves, and palm cabbage. Although exact numbers are unknown, it is commonly assumed that hunger-related deaths soared during this crisis. Even fighters suffered, forcing civilians to look for food for them.

Local health actors attempted to provide assistance to Tubmanburg residents and IDPs in the absence of international support from December 1995 to September 1996. Seven government and former LNRCS health workers voluntarily came together in early 1996 to set up the only functioning clinic in the county. They pooled money from the remaining LNRCS coffers and from the local population, and they bought looted drugs from soldiers. The clinic provided basic primary health care, and included some health education to patients on an individual basis. Community education and outreach, however, was not possible during the crisis due to insecurity. The staff of the reactivated Red Cross clinic in Tubmanburg consisted of three registered nurses, three first aid workers, and one records person, in addition to some volunteers. Patients generally came to the clinic in the morning to avoid
battles, which were most common in the afternoon. Soldiers, however, were given preferential treatment by the clinic staff so that the clinic would be allowed to continue operating. Even during the crisis, adults paid 10 Liberian dollars and 5 Liberian dollars for children. Those with no money were treated for free.

Tubmanburg residents subsisted on the meager support of the ad-hoc Red Cross clinic until September 1996 when, in the spirit of the JPO’s objective of joint evaluation, ACF and MSF, together with the United Nations Humanitarian Coordinating Office (UN/HACO), went on an exploratory mission to Tubmanburg. The team arrived and found extremely high rates of acute malnutrition. 60% of children under 5 years of age had severe acute malnutrition. ACF subsequently issued a call for assistance from the other NGOs. HACO made a video of this visit, which gained prompt international media and donor attention, and one INGO used parts of it in a fund raising campaign. The exposure of the Tubmanburg situation provided by the video evoked pressure from INGO headquarters and donors to respond, and consequently fueled competition among established INGOs in Liberia. Finally, the data and photographic evidence produced by the joint assessment also provided a window of opportunity for several newly arrived INGOs -- who had not worked in Liberia prior to the April 1996 crisis and felt constrained by the conditions of the JPO -- to establish their niche in the Liberian relief effort.

The above factors -- data showing high malnutrition, pressure from headquarters and donors to respond to the highly publicized crisis, inter-agency competition, chaffing against the constraints of the JPO, and the humanitarian mission of the INGOs -- all contributed to a dramatic rush by the INGO community into Tubmanburg in September and October 1996. The INGO health intervention included the set-up and operation of emergency feeding centers, general food distributions, primary health care, and water and sanitation service. INGOs brought expatriate relief workers into Liberia solely to attend to this emergency; one agency brought in 22 expatriates for the Tubmanburg effort. In less than two months, the nutritional crisis in Tubmanburg had been resolved, but INGOs found themselves with a surplus of materials and personnel and had nowhere to place them.

Although the international community credits itself with saving numerous lives through the emergency intervention in Tubmanburg, the spontaneous and "vertical" nature of it has been criticized by international as well as national health workers on the ground. In retrospect, a number of expatriate staff of the INGOs who responded to the Tubmanburg crisis say that the international response went "way over the top," and that this response was driven much more by the presence of television cameras than by the availability of accurate data showing a need for large-scale intervention. If the relief community had been more systematic in their assessment procedures and less anxious to gain publicity and funds by "beating the rush," according to several relief workers, the agencies would have realized that the situation in Tubmanburg was not dire enough to warrant the intervention of so many agencies and so many resources. Apparently, the situation in Tubmanburg turned out to be more complicated than the initial nutrition cluster survey showed. According to international relief workers in Liberia, a large group of Liberians who had been captured by fighters in the forest had been released (or perhaps had escaped), and they had arrived in Tubmanburg prior to the assessment. These people were severely malnourished and were disproportionately included in the assessment survey, but the results of the biased survey were extrapolated to the general population of Tubmanburg.[27] Therefore, the agencies responding to the crisis found that the extent of malnutrition was much less than had initially been anticipated. Relief workers who participated in the feeding programs at Tubmanburg suggest that feeding could have been handled by one organization instead of the six that were present, with much less waste of human and material resources and in the same period of time.
The Tubmanburg intervention is also criticized by national health actors as deliberately overrunning the existing -- albeit scant -- local relief efforts in the town. Although INGOs apparently consulted with the Red Cross clinic in Tubmanburg when they arrived in September, the clinic did not receive supplies or drugs from the INGOs and was essentially excluded from the collective relief intervention. Nor were the clinic staff or the CHWs who were in the area identified and activated by the INGOs, who instead brought numerous expatriate relief workers as well as Liberians from Monrovia to do the job. Local health workers suggest that the agencies could have utilized the expertise in Bomi county during the intervention and thereby could have contributed to the longer-term health capacities of the county. Also, on several occasions the international agencies failed to heed the advice and requests of the beneficiary population during assessments to surrounding areas in September and October 1996. Following one assessment mission to the town of Sinje in neighboring Cape Mount county, relief agencies sent bulgur wheat for distribution to the town residents. A prompt attack by ULIMO fighters on the food distribution site caused the deaths of an estimated 47 civilians. According to relief workers, Sinje residents had specifically requested the assessment mission’s participants not to send any food aid, because it would attract combatants.

Thus the Tubmanburg intervention, while successful in responding to the immediate health needs of the affected population, proved to be a failure in other respects. As the first real test of the JPO, it began auspiciously with a joint evaluation by MSF and ACF, but then all cooperation, coordination and self regulation broke down in the ensuing rush to bring relief. The intervention incorporated little program sustainability or community development, and it missed opportunities to support local capacities.

5. Suspension of Food Aid to Internally Displaced Persons in Buchanan

The capital city of Monrovia and other principal towns -- including the port city of Buchanan in Grand Bassa county -- swelled in population during the Liberian war, as citizens caught in the conflict sought both protection and employment from the international peacekeeping and humanitarian actors anchored there. As Liberia’s second largest city (with a pre-war population of 50,000) and a key hub of import and domestic trade activities, Buchanan’s population increased dramatically during the war, and often in large waves as military conflagrations elsewhere in the country pushed people into the city’s relative stability. At its height in March 1996, over 100,000 IDPs lived in shelters in Buchanan or within the community itself.

Beginning in late 1994, INGOs responsible for emergency food pipelines and distribution (including CRS and ACF) began to reduce the rations of food distributed to IDPs in the Buchanan shelters until the distributions were finally suspended in late 1997. This reduction and suspension of emergency food aid to a beneficiary population is typical of emergency and post-emergency situations, yet neither the causes or effects of this action have been fully examined in the Liberian context. This sub-section investigates some of the factors influencing the protracted termination of food assistance to Buchanan's IDP population, the outcome in terms of nutrition and self-sufficiency, and the appropriateness of the decision and its timing.

Field and headquarters staff of international relief agencies cite several objectives which were sought through the decision to reduce and ultimately suspend food rations to IDPs. First, relief agencies hoped that by decreasing dependence on food aid, local coping
mechanisms for food procurement would be leveraged and farming and local trade would be encouraged. A second objective was to halt the indirect and unintended channeling of relief food to fighters, who would forcibly take food rations from the IDP recipients. Thirdly, relief agencies suspected that IDP figures in Buchanan were inflated, and they aimed to trim the "phantom beneficiaries" from the ration rolls. Finally, relief agencies felt pressure from the orchestrators of the 1996-97 peace process and, after the elections, from the new national government, to be seen as supportive of and confident in the peace by encouraging IDPs to return to their homes.

The schedule for implementing this decision to reduce food rations was affected by a variety of factors over several years. For example, fluctuations in the security situation both in the Buchanan area as well as country-wide periodically forced INGOs to suspend their humanitarian programs and sometimes forced INGOs to evacuate Liberia altogether. Food distributions were consequently interrupted and the overall strategy of reduction delayed. Furthermore, the negative effects of escalated conflict and INGO absence on the health and nutrition of the Buchanan IDPs and residents also obliged relief agencies to temporarily increase food rations in order to improve the nutritional status of the population. Implementing agencies frequently revised and rejected plans for reducing food rations as the political/military situation on the ground dictated. On the other hand, the pace of voluntary or self-instigated relocation of IDPs out of Buchanan and, presumably, back to their homes had the reverse effect of facilitating the eventual suspension of food aid to shelter-based IDPs. By April 1997, only 3,500 IDPs remained in eight shelters.[28] After undertaking vulnerability studies and malnutrition surveys, ACF recommended closing the shelters, suspending food aid to them, and including the remaining IDPs in the Buchanan community-wide assistance programs.

The impacts of the decision to reduce and suspend food aid to Buchanan IDPs can be seen through an analysis of existing nutrition surveys which were conducted regularly by ACF. ACF was the only INGO not looted during the April 1996 crisis in Monrovia, and thus the only INGO to have maintained a fairly complete record of their work during the Liberian emergency. ACF’s cluster and exhaustive surveys are critical tools in evaluating the quality and appropriateness of international health interventions in Liberia; however, their sampling methodology changed over time, making it difficult to compare malnutrition rates between the surveys. Nutritionists surveyed three groups: 1) the community (in a cluster methodology), 2) IDP shelters (using exhaustive methodology, but choosing different shelters at different times thus confusing the newly-arrived IDP population with the whole IDP population, each of which may have had different malnutrition levels) and, 3) the combined community and shelter population. The drawbacks of this difference in methodologies will be revisited below. However, acknowledging the consequent limitations of these surveys for evaluative purposes, and also noting the inevitable gaps in data and contextual information (see Appendix 4), the following tables in this sub-section have been compiled from surveys and other records of ACF-Liberia and provide some insight on the impact of this INGO decision in the Liberian health intervention.

First, as can be seen in Table 1, food rations were reduced dramatically over the period of about two years. Between at least February 1994 (and probably since December 1993) and June 1996, the kilocalories/per person/per day (kcal/p/d) received by IDPs in Buchanan shelters decreased from 1218 to 160. These quantities are well below the recommended level of 2200 kcal/p/d. However, with the exception of May 1994 and August 1996, moderate malnutrition rates were within acceptable range for the emergency situation at the time. These apparent contradictions suggest two possibilities: that periodic emergency supplemental and therapeutic feeding programs for children at risk of malnutrition were operating successfully, and that the larger IDP community had means of food procurement other than the emergency food distributions of the INGOs. The general food ration consisted
only of basic carbohydrates, protein and fat with a scarcity of micronutrients. Since no outbreaks of micronutrient deficiencies occurred among the IDPs, this is further evidence that the IDPs in the shelters supplemented their diets with vegetables and other commodities. It is clear that coping mechanisms -- such as agricultural production, the harvest of wild produce, or market commerce (see report section on Coping Mechanisms for elaboration) made up for insufficient food rations provided by relief agencies. ACF food availability surveys from this time period acknowledge the presence of these complementary foods in the IDPs diets.

Table 1. Reduction of Food Rations and Corresponding Malnutrition Rates

<table>
<thead>
<tr>
<th>Date</th>
<th>12/93</th>
<th>2/94</th>
<th>5/94</th>
<th>12/94</th>
<th>2/96</th>
<th>6/96</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Rice, beans, oil</td>
<td>Rice beans, oil</td>
<td>Rice, beans, oil</td>
<td>-not known</td>
<td>Bulgur, beans</td>
<td>Bulgur, beans</td>
</tr>
<tr>
<td>Quantity</td>
<td>Unknown quantity but same for community and shelters</td>
<td>1218 kcal/p/d for shelters; not known for comm.</td>
<td>-not known</td>
<td>1200 kcal/p/d for shelters</td>
<td>923 kcal/p/d for shelters</td>
<td>160 kcal/p/d for shelters</td>
</tr>
<tr>
<td>% under-five moderate malnutrition in shelters</td>
<td>9.6</td>
<td>12.9</td>
<td>29.5</td>
<td>6.5</td>
<td>4.7 (both comm. &amp; shelters)</td>
<td>47.6 in 8/96; (both comm. &amp; shelters)</td>
</tr>
</tbody>
</table>

Food rations to the community-based IDP population were suspended earlier than those to shelter inhabitants, although none of the respondents interviewed by the RPG team could agree on an exact date. Available nutrition surveys also reveal the ability of community-based IDPs to supplement their food rations with other commodities. During the 27 month time period shown in Table 2, ten malnutrition surveys provided data on IDPs in shelters, in the community, and in a combination of both. Unfortunately, the methodology employed does not permit a separation of community-based IDPs from the resident Buchanan community; however, assuming that these populations received a similar or slightly lower amount of kcal/p/d in food rations than the shelter-based IDPs, it is apparent that the food quantity seems to have been adequate. The community, as well as the in-shelter IDPs, was thus employing other methods to supplement their diet and not relying heavily upon food aid.

Hence the international agencies’ decision to reduce food rations and the apparent self-sufficiency of the Buchanan IDPs during this time may in fact have a causal relationship, as had been intended by the decision-makers. Of course, it is difficult to conclude whether the deliberate reduction of rations actually bolstered this self-reliance, as had been anticipated by international decision-makers, or whether the programmatic decision was taken because of the strength and profusion of coping mechanisms among the population. Indeed, some INGO staff felt that food distribution to the IDPs should have been reduced earlier. They pointed out that many of the IDPs in Buchanan were essentially self-sufficient in food procurement by 1997 and that many of them actually lived in their villages and only returned to Buchanan on distribution days to pick up their food rations. However, they also suggested that food distribution could not have been terminated before the planting season in 1997 as
the security situation in the country was thought to be too insecure during 1996 for IDPs to return and cultivate their lands.

Table 2. U-5 Malnutrition Rates by Comparable Group[29a]

<table>
<thead>
<tr>
<th>Date</th>
<th>All Shelters (new and old IDPs)</th>
<th>Date</th>
<th>Newly-arrived IDPs in certain shelters</th>
<th>Date</th>
<th>New IDPs and same IDPs 5 mo.s after living in same shelter</th>
<th>Date</th>
<th>Communit y only (i.e. residents and IDPs not in shelters)</th>
<th>Date</th>
<th>Combined community and shelters</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/94</td>
<td>12.9/2.2</td>
<td>12/93</td>
<td>9.6/1.6</td>
<td>7/94</td>
<td>15.2/2.1</td>
<td>5/94</td>
<td>6.3/0.8</td>
<td>7/95</td>
<td>9.2/1.3</td>
</tr>
<tr>
<td>1/95</td>
<td>6.3/0.6</td>
<td>5/94</td>
<td>29.5/9.4</td>
<td>12/94</td>
<td>6.5/1.2</td>
<td>1/95</td>
<td>5.1/0.7</td>
<td>2/96</td>
<td>4.7/1.2</td>
</tr>
<tr>
<td>12/96</td>
<td>6.3/0.1</td>
<td>7/94</td>
<td>15.2/2.1</td>
<td>12/96</td>
<td>14.4/0.5</td>
<td>8/96</td>
<td>47.6/5.6</td>
<td>7/97</td>
<td>7.0/0.7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2/98</td>
<td>7.0/1.5</td>
</tr>
</tbody>
</table>

The above argument leads naturally to a second key objective in the reduction and suspension of food distributions to IDPs. It was thought that this action by the INGOs would act as an incentive for the IDPs to return to their homes. Such a consequence would have political as well as humanitarian value, given the international as well as domestic pressure for a successful and rapid peace process. While the IDP population in Buchanan fluctuated throughout the war in direct reaction to the changing security conditions in the IDPs' home regions, the population began to decline dramatically in mid-1996, with the greatest decrease occurring between April and December of that year (see Table 3).

Table 3. IDP Populations in Buchanan[30a]

<table>
<thead>
<tr>
<th>Location</th>
<th>Displaced</th>
<th>Returned</th>
<th>Still Displaced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buchanan shelters</td>
<td>80,000</td>
<td>61,500</td>
<td>10,500</td>
</tr>
<tr>
<td>Buchanan community</td>
<td>20,000</td>
<td>5,500</td>
<td>2,000</td>
</tr>
<tr>
<td>Total</td>
<td>100,000</td>
<td>67,000</td>
<td>12,500</td>
</tr>
</tbody>
</table>
Several explanations for this decline exist. The most likely instigator of the spontaneous IDP relocation, and consequently of most of the other explanations for it, was the April 1996 crisis that centered on Monrovia. Though Monrovia bore the brunt of inter-factional warfare and suffered the greatest loss of life, the repercussions of April 1996 were felt around the country. First, international relief agencies evacuated Liberia for several weeks and most relief operations were interrupted. ACF, the main distributor of food in Buchanan, evacuated for seven weeks. Perhaps in accordance with the relief agencies’ plan to gradually reduce food rations in Buchanan, but much more likely as a result of the damage inflicted on INGO resources and capacities during the events of April, by June 1996 the quantity of food rations being provided to IDPs in the shelters was at its lowest in at least three years (see Table 1 above). From June 96 onwards, the quantity of food distributed in shelters was so small that food distribution in Buchanan can be considered to have essentially terminated.

At the same time, the April ‘96 crisis in Monrovia also had a serious impact on the Buchanan IDPs’ ability to supplement their meager food rations through agriculture and commerce. Supply lines and transportation routes out of Monrovia were cut off by the fighting in the city, thereby limiting the wares available in rural markets, and the wave of general instability rippling out from Monrovia restricted access to subsistence farms and forests. The August 1996 ACF survey[31] reports that the IDPs in the shelters were only receiving 8-12% of their daily caloric requirements from food distributed. It goes on to mention that while the most common food supply was the local market, followed by small scale farming and food gifts from relatives, nevertheless, one-fifth of the families claimed that they were living solely on food aid. The combination of these above factors may explain the alarming jump in moderate malnutrition levels -- from 4.7 percent of children under age five in February to 47.5 percent in August -- seen in both the Buchanan community and IDP shelters.

Conditions for IDPs in Buchanan in mid-to-late 1996 were thus extremely grim. While the RPG team could not confirm its conclusion with any former IDPs, it is highly probable that IDPs felt the health and nutritional risks of remaining displaced in Buchanan outweighed the security risks of returning home or of temporarily relocating to the bush. It may also be that those IDPs who had already left Buchanan city unbeknown to relief agencies and had been coming into town only on food distribution day -- thereby inflating INGO beneficiary rolls -- chose to forego the minimal rations being offered rather than risk travelling during this period of instability.

Throughout 1997 the IDP population in Buchanan continued to drop dramatically. The favorable progress made on disarmament, preparations for post-conflict elections, and the growing -- albeit cautious -- confidence among the general public in the durability of the peace probably encouraged IDPs in Buchanan to leave for their places of origin. By October 1997 a total of 14,000 IDPs remained in Buchanan --- only 3,500 of them in shelters. While the food distributions had certainly diminished over the past several years, they had not yet been completely suspended by the time of this relatively rapid (April 96 - October 97) exodus from Buchanan. Furthermore, the IDP shelters still existed and IDPs were still treated as a vulnerable group, distinct from the resident population of Buchanan.

This spontaneous return therefore occurred with no direct incentive by the international relief community and at the displaced’s own pace. As of late 1996 and well into 1997, INGOs felt that the security situation in Liberia was too volatile to actively promote repatriation and relocation of displaced persons. And in keeping with their JPO-inspired commitment to “do no harm,” as well as in reaction to the alarming spike in malnutrition observed in August 1996, INGOs appear to have consciously postponed the suspension of food distributions until they had greater assurance of the security situation and clearer understanding of the impact of their actions. The IDPs, however, obviously did not share this perspective. With each drop in the IDP population, INGOs reacted by closing shelters, so that by the time
enumeration occurred in April of 1997 in Buchanan, there were only 8 shelters remaining for 3,500 people. In late 1997, after undertaking vulnerability studies and malnutrition surveys in Buchanan, ACF recommended closing all shelters and stopping food aid. They recommended treating the remainder of the IDPs as though they were part of the community. Ironically, then, while the strategy to reduce food distributions began as intended -- a "push factor" encouraging voluntary return home -- in the end it was the self-directed actions of the IDPs themselves that determined the course and the duration of humanitarian intervention on their behalf.

The decision to gradually reduce and suspend food aid to IDPs in Buchanan, therefore, was made by international relief agencies in response to the population's apparent ability to supplement emergency food rations through agricultural and commercial activities, and in reaction to a variety of external factors such as security and political agendas. INGOs in the food sector deliberately reduced food aid to the population in order to decrease dependency on food aid and fraud in the distribution system, encourage self-sufficiency, and ultimately encourage the IDPs to leave for their homes. It is not clear how much nutritional data influenced these decisions. However, when analyzing available data, it is clear that from December 1993 to June 1996, the IDPs (as well as the community) were able to supplement their diets enough to compensate for the minimal food distributions. This is supported by the malnutrition rates and the absence of any micronutrient deficiency diseases during that time.

ACF's vigilant monitoring of the nutritional status of Buchanan's IDPs during this time and their safeguarding of this data during the April 1996 crisis in Monrovia allow for some retrospective analysis of this food aid decision within the larger context of the Liberian complex emergency. However, a number of surveys from 1993 to the present are missing from ACF's files, some of the sampling techniques used throughout this time period are questionable, and there are gaps in information provided by the available surveys. These problems complicate efforts to evaluate the impact of the humanitarian intervention in this case in both the short and long term. More comprehensive information on security and political situations, migration flows, and food availability and access in the surveys might have helped relief agencies to better predict or respond to the spike in malnutrition which occurred in August 1996, and would also provide considerable value for post-emergency policy and operational analyses. Similarly, the case of food aid in Buchanan suggests that the development of and adherence to uniform surveying and monitoring methodologies by all actors in the health field would have improved the quality and utility of nutritional data from the Liberian emergency.

This case also illustrates the extent to which any type of relief aid can affect peace processes and post-emergency transitions. Relief agencies as well as political actors in post-conflict Liberia recognized that adjustments to food aid, such as the suspension of distributions to IDPs in Buchanan, could both promote the Abuja II schedule and demonstrate support for and trust in the peace process by the international community. These political pressures placed on humanitarian agents in post-conflict peace processes are clearly heavy. Yet in the Liberian case, well-founded caution by INGOs regarding the security situation and living conditions -- especially agricultural opportunity and food supply -- in IDP home localities may have unnecessarily extended the relief effort in Buchanan and dissuaded some IDPs from returning to their homes. While international agencies claimed that security and living conditions in the Liberian interior were not satisfactory to entirely suspend food aid to IDPs in Buchanan in late 1996 and early 1997, the IDP population in that town nevertheless declined dramatically and voluntarily, without overt encouragement by INGOs. Two lessons suggested by this event are that, first, the beneficiary population may have a better sense of when it is safe and feasible to make certain transitions than the international community, and second, the population's ability to recognize these windows of
opportunity and to sustain itself during them merit greater attention, monitoring, and complementing by international humanitarian organizations and their relief interventions.

IV. Coping Mechanisms in the Liberian Emergency

Since at least the mid 1980s, a sizeable body of literature has grown within disaster studies on the role of coping mechanisms -- literally, survival strategies -- among the populations affected by complex humanitarian emergencies. The seven year Liberian conflict, characterized by changing frontlines and intermittent availability of humanitarian programs to the affected population, saw civilians exercise a wide variety of such coping mechanisms in order to ensure their own health, nutrition and immediate survival. This was particularly true in areas where, and during times when, support of the international community, in the form of NGO goods and services, was insufficient, inaccessible, or totally absent. This section examines these strategies, assesses the interaction between the strategies and the interventions of the international community, and identifies suggestions for how the international community might better integrate their interventions with and support the coping mechanisms of the affected population.

Physical survival strategies during peak crises

While early warning signs were not always visible in the various uprisings and offensives during the war, many communities reported that they did have prior intelligence or indications that attacks were imminent. Such signs were apparently present in Monrovia in 1990, 1992 and 1996; in Bong and Nimba in 1992 and 1994; in Lofa in 1993 and 1995; in the Southeast in 1993; and in Bomi County in December 1995, according to the recollections of respondents. These included, for example: heightened tension in the streets of Monrovia; reliable intelligence that a faction was marching toward Rivercess in 1993; skirmishes in and around Tubmanburg in 1995; and periodic massacres in Lofa County. At the time, of course, civilians were not always capable of interpreting or acting upon the early warning signs in an informed or timely manner.

The primary choice faced by civilian populations in these instances was one between flight and accommodation. The fact that seven years of civil war produced approximately 800,000 refugees and another one million internally displaced persons out of a pre-war total Liberian population of 2.5 million indicates that both strategies were valuable and relevant during the war. It is not possible to generalize about the motivations for choosing one or the other strategy. Political affiliation certainly played a large part, as civilians feared reprisals by fighters for having supported (or even endured) the rule of an opposing faction. In a society as ethnically driven as the Liberian one, it stands to reason that the advance of an armed group generally associated with one ethnic group increased the danger to residents of a rival group. This was particularly true in Lofa County where historic tensions between the Loma and Mandingo gave rise to atrocities against civilians. On an individual level, those who had the wherewithal to survive outside their homes (e.g., capital, training, or family members elsewhere) were more likely to flee than those without means.

Of those Liberians who did choose to flee the fighting and/or the collapse of normal social structures, several tactics were adopted. Flight into the dense forest or "bush" surrounding rural towns and villages often constituted the first recourse. This period of refuge lasted from
a few days to as long as several months in some cases. The strategy was practiced on an individual level or by entire communities when sufficient warning time permitted. Civilians in Cestos City, for example, reported that their neighborhood fled to the rural area en masse for three months upon the approach of one faction in 1993. In that instance, they were able to carry a small supply of food with them to forestall hunger during the initial weeks, although such advance provisioning was likely an exception rather than the rule in the Liberian case.

Flight to the capital city of Monrovia or to other large cities often became the second recourse of rural Liberians faced with imminent attack. The population of Monrovia -- 450,000 at the time of the country's last census in 1986 -- had doubled by October 1990[32] and continued to grow and shrink sporadically throughout the war. Buchanan and Gbarnga experienced similar proportions of IDP influx in 1994 and 1995. The rapid and uneven growth of Monrovia, Buchanan, Gbarnga and Voinjama at various times during the war attests to the attraction of cities as a source of protection, food, social services or economic opportunity. The large IDP centers established with support from the international community in Monrovia, Buchanan, and Kakata/Totota proved a magnet to vulnerable civilians. Bart Witteveen, a long-time participant/observer of relief efforts in Liberia, has noted that civilians practiced two opposite coping mechanisms often within the same geographic location: some populations fled to urban areas in hope of relief assistance and security, while others fled from urban areas seeking less densely populated zones where military pressure was less and food might be more plentiful.[33] Neither strategy provided definitive protection or survival: some of the worst fighting took place in major towns like Monrovia, Buchanan and Gbarnga; and once a faction took control of a rural region, all movement became dangerous.

In those Liberian counties adjacent to neighboring countries, civilians typically fled across the border to Cote d'Ivoire, Guinea and Sierra Leone, although this often occurred as an alternative second recourse after initial flight into the bush. Taking asylum required either proximity to the border, physical stamina to reach it, or the financial means to purchase transportation. In the case of those who managed to board the infamous cargo ship *Bulk Challenge* at the Free Port of Monrovia during the crisis of April 1996, all three qualities were required. The odyssey of those on the *Bulk Challenge* is instructive for the flawed reasoning which was manifested by several West African governments in regard to the civilians aboard: "refugee equals rebel."[34] This logic periodically limited access to neighboring countries for all adult males coming from Liberia. Throughout most of the conflict, however, Liberia’s borders remained exceedingly porous, facilitating cross border traffic in both directions. This two-way movement served specific health and nutrition purposes, as explained below.

In a number of cases where flight was not an option or not the preferred option, certain communities made the conscious decision to remain *in situ* and hope for reasonable treatment at the hands of an advancing faction. This strategy produced mixed results. The village of Goyoh Hills in Bomi County, for example, made a deal with the faction which overran it in 1996. The village elders did not wish to flee their homes and see their village destroyed, and managed to convince some 75 per cent of the population to remain in place. The townspeople ended up preserving their houses, but were required to cater to the fighters with food and labor during occupation. A similar phenomenon was reported in towns in lower Lofa County (Kolahun and Vahun) where physical structures were neither burnt nor looted during the war. In another instance, however, the town of Barkiedu in Voinjama District of Lofa experienced heavy damage and large-scale loss of life in 1990, after attempting to adopt a strategy of peaceful accommodation.
The survival strategies of health workers

Rural respondents noted repeatedly that trained health workers were often the first members of their community to flee. There are several explanations for this. First, health workers were often targeted by advancing factions, particularly if they were believed or perceived to have assisted the opposing/retreating faction. Instances of death threats, beatings, killings, forced conscription into the faction’s medical service, and the imposition of hard labor on community health workers were reported. One physician’s assistant (PA) in Grand Bassa County showed scars from his encounter with a faction commander in 1993 and reported that he was obliged to attend to soldiers first before treating residents. Being conscripted as a military medic contained the additional danger of future reprisals from a rival faction when they eventually recovered the lost territory. Fear of becoming a target was very real, and motivated some health workers to flee even before the danger was present in their community.

Second, local health personnel such as CHWs, PAs and registered nurses (RNs) who had received training prior to the conflict found that they could use their skills to earn a living in the towns and cities outside their villages. In time of war, whatever human capital one possesses becomes an advantage for survival. Many health workers accordingly took the opportunity to become medical entrepreneurs -- "black baggers" -- attending the public as private pharmacists or itinerant doctors. As a result of the disrupted health structures in many areas, "black baggers" often provided medical services at a level far beyond their training or their capacity. In some instances, this phenomenon gave rise to quackery, price gouging, abuse of confidence and poor medical practices. One private pharmacist reported that he routinely administered Ringer’s Lactate orally for cases of diarrhea during the war. Vaccines were also available in his drugstore despite the absence of refrigeration. Such practices were undoubtedly common in wartime Liberia, in view of the lack of a cold chain, a regular supply of medical supplies, or any drug monitoring system in such establishments.

It is also likely that some local health workers may have had advanced early warning of imminent military movements, although this was not confirmed by respondents. Some CHWs maintained continuous contact with international and local NGOs in Monrovia as part of their professional responsibilities. When the regular drug supply was cut off, for instance, trained health workers were among the first to know and better positioned than others in their community to take flight. Numerous health workers migrated to Monrovia, to take advantage of the functioning money economy and employment opportunities with relief agencies there. Finally, many health workers employed by the Liberian government left villages and small towns, irrespective of security conditions, in order to seek a higher salary from INGOs.

The drawing of trained personnel from the countryside to the capital constitutes a long-lasting side effect of complex humanitarian emergencies. One County Health Officer complained that the best cadres from his rural district were now working for international NGOs in the capital. The formation of the local NGO MERCI in 1990 was a direct result of the concentration of several qualified physicians in Monrovia who were concerned about the lack of medical services outside of the capital. The refugee "brain-drain" syndrome drew qualified medical personnel out of the country as well: several passengers on the Bulk Challenge were Liberian physicians who had worked at JFK Hospital or Swedelief. No data is available on the number of trained medical personnel who crossed into neighboring countries, but it is likely that many who had the opportunity to leave Liberia did so.

The impact of lost human resources in Liberia is considerable. According to a recent WHO Conference, the number of functioning public health facilities during the Liberian crisis has decreased by more than 60 percent. Throughout the country, only four hospitals, eight health
centers and 56 clinics/health posts remain open. The decrease in numbers of working personnel is reflected in the following table:

<table>
<thead>
<tr>
<th>Personnel</th>
<th>1989</th>
<th>1997</th>
<th>% Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>82</td>
<td>32</td>
<td>39</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>301</td>
<td>185</td>
<td>61</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>185</td>
<td>120</td>
<td>61</td>
</tr>
<tr>
<td>Certified Midwives</td>
<td>209</td>
<td>135</td>
<td>65</td>
</tr>
<tr>
<td>Lab Technicians</td>
<td>84</td>
<td>43</td>
<td>51</td>
</tr>
<tr>
<td>Other Positions</td>
<td>2665</td>
<td>1291</td>
<td>48</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>3526</td>
<td>1806</td>
<td>51</td>
</tr>
</tbody>
</table>

When health institutions were targeted, the response of the trained health personnel was occasionally heroic. In Bomi County, widespread attacks on outlying districts throughout 1995 displaced some 2000 civilians and a large number of Red Cross staff into Tubmanburg, the county seat. Unable to function in the countryside and cut off from Monrovia by road and by radio, the Red Cross chapters pooled their resources and established an emergency health post and first aid clinic, serving the IDP community without any outside support and continuing to do so when the international NGOs finally managed to reach Tubmanburg nine months later.

In Bong County, the fall of the town of Gbarnga in September 1994 led to the closure and looting of Phebe hospital and the massacre of hundreds of displaced persons and staff on the hospital grounds. Most of the staff fled on foot along the road to Monrovia. In Totota, where many from Gbarnga had settled, the remnant staff reconstituted the hospital as a health clinic. Staff bought drugs and food in the local market and provided emergency health services (including Caesarian sections and hernia operations) to the displaced community in the Totota camps.

When Voinjama (Lofa County) fell to one faction in March 1993, most of the trained staff of Tellewoyan Hospital fled into the bush or crossed into Guinea for self-preservation. The conquering faction commandeered the drug supply and converted the hospital into an outpatient clinic, largely for the benefit of the fighters. In 1995, the former Officer-in-Charge returned to Voinjama to put himself at the disposal of the hospital and to serve the community. Despite being recognized as a supporter of the previous political regime in Voinjama, the health official was able to re-open the hospital to admit civilians. (A separate building was designated for the military). In order to procure drugs for the hospital, he was escorted by the faction to the border, where he received a shipment from MSF-Belgium, for whom he had previously worked. In this manner the hospital continued to function, notwithstanding death threats against staff and other personal pressures from the faction.

**Health coping mechanisms in rural areas**

Civilians who fled into the bush to escape the war were usually deprived of what little health services they had enjoyed up to that time. With many of the CHWs displaced in larger towns or in asylum countries, rural villagers were forced to revert to the alternative sources of health information: village elders and traditional healers or Zoes. Their services were typically bought in return for labor or bartered goods. Young women sought information relating to maternal-child health care from older women of the community who were
displaced with them. It has been suggested that female health workers (especially TBAs) tended to remain in their community longer and more frequently than their male counterparts. Though impossible to verify, it seems a reasonable assumption in view of the stronger family ties to children and home. In some cases, however, the TBA disappeared even before the rest of the community.

Traditional remedies, sometimes called "country medicine," thrived in the absence of western practitioners. Respondents told of widespread use of specific herbs, leaves and roots for a variety of ailments, especially malaria, diarrhea, stomach pain and wounds. Some reported the effectiveness of boiling tree bark to produce a hot infusion to combat malaria. Poultices of specific leaves were utilized to sterilize open wounds. Respondents themselves recognized that the treatments were only occasionally effective, and there was widespread death during the conflict years and especially among those hiding in the bush. Medical professionals in Monrovia and Buchanan reported that they spent a good deal of time undoing the damage caused by some inappropriate country medicine cures.

Diarrhea, one of the biggest causes of infant mortality, constituted a serious problem in the bush. While some of the respondents knew about oral rehydration therapy (ORT) and even recalled the instructions for making "home glucose" in the absence of ORS packets, they were often unable to find the necessary ingredients for home glucose, such as sugar, salt or citrus fruit, in the countryside. Near Cestos City, mothers used coconut milk to rehydrate children with diarrhea. In Voinjama and Barkiedu, respondents indicated that it was typical to breastfeed infants from one and a half to three years, which may have served to diminish deaths from diarrhea somewhat.

One of the major problems of survival in the bush and during the war in general, according to villagers interviewed by the mission, was the near total absence of a drug supply. When a faction overran a community, fighters typically looted drugs and other medical supplies from health post, clinic or hospital, for their personal use or sale. Some respondents reported bartering bush-meat and other commodities (coffee, coconuts) for the drugs held by fighters. Where drugs were available, they were often of doubtful reliability, expired or spoiled due to the lack of a cold chain.

Rural villagers, moreover, often did not know how to use drugs properly.

In the early years of the conflict (1990-1992), a drug distribution system remained intact, notwithstanding the divided nature of the country, with the "official" government in Monrovia and the de facto authority of NPRAG controlling "Greater Liberia." Two local NGOs, CHAL and NDS, managed to continue distribution of medicines from Monrovia, while ICRC, MSF-B and UNICEF did some cross-border distributions from Guinea and Cote d'Ivoire.

In Lofa County, communities established their own revolving drug funds, sometimes with the active encouragement of the opposition Ministry of Health in Gbarnga, at least until 1993 when the health system broke down completely. Until that time, community members contributed funds to procure a drug supply across the border in Guinea, based on the local CHW's best assessment of probable needs. Individual health workers even traveled from Monrovia to Lofa during the NPRAG era, crossed into Guinea to procure medical supplies, and distributed them in needy communities. Informants in Barkiedu reported that their revolving drug fund system was stopped by NDS, and that thereafter the community never received a full supply from the regular shipments sent through Voinjama. During and following widespread factional fighting throughout Lofa in 1993, it became more difficult and dangerous to cross the border for drug procurement. Occasional sporadic missions were undertaken by daring individuals, but the supply was neither sufficient nor reliable.
The availability of medical services in areas under factional control varied considerably. In Rivercess and Grand Bassa Counties, families of seriously ill persons had to beg the local commanders for permission to carry patients to Buchanan. When authorization was granted, families still had to pay fees for transportation and gratuities to military guards at checkpoints.[38] Overland travel was at times considered too risky to undertake except in the most urgent cases. Phebe Hospital staff who relocated to Totota in 1994 were fortunate to find that the commander in their area had studied at Cuttington University, near Phebe, and was more sympathetic to their requests for drugs, supplies and logistical support.

In areas adjacent to the border, Liberians were able to use refugee services in Guinea and Cote d’Ivoire, taking advantage of the inexpensive and high-quality facilities set up by the international community. Ironically, in the first months of the war, medical staff of Curran Hospital at Zorzor arranged to send a shipment of drugs from inside Liberia to Macenta in Guinea, in order to provide humanitarian assistance to fellow Liberians who had fled across the border. Less than three years later, the situation was reversed, as Liberians inside the country carried their ill and injured across to the relative security of Macenta for treatment. In the post-election period of 1997, some Liberian refugees from Nzerekore, Guinea, reportedly utilized Phebe Hospital in Gbarnga as the best medical resource in the region, without returning permanently to Liberia or relinquishing their refugee status.[39] The cross-border health connection functioned in another sense as well; some Liberians who had been trained as health workers by international NGOs in the refugee camps of Guinea and Cote d’Ivoire brought back to Liberia the medical protocols and standards they had been using in asylum.

It is common for donor agencies and international relief planners to decry the "magnet effect" of emergency aid provided in border areas, which tends to draw civilians into exile. Food aid, health posts and educational services certainly constitute strong arguments to relocate or to remain across the border. This phenomenon was in fact observed in the responses of Liberian refugees and returnees to surveys on their motives for returning home prior to the 1997 elections.[40] Nevertheless, the international community too often overlooks the valuable transfer of health services which takes place in border areas during emergency conflicts, without necessarily causing people to relocate definitively across the border. During Liberia’s seven-year conflict, the neighboring countries’ tolerance of spontaneous settlement proved a humanitarian boon, permitting a much smoother flow of affected civilians back and forth across the border as security and survival conditions dictated. Many of the border areas, in particular Grand Gedeh County and Upper Lofa, had no health posts of any kind for years after attacks destroyed key installations in the early 1990s. Liberians who, for political or logistical reasons, did not leave their homes were still able to access health facilities in neighboring Cote d’Ivoire and Guinea on a temporary-user basis.

The policy implications of this situation ought to be considered seriously by the international community. Donors would do well to view humanitarian needs regionally, rather than nationally, and recognize that additional resources are required in border areas to attend to the additional demand presented by this coping mechanism. International NGOs ought to plan for the cross-border traffic in their refugee camp programs, laying aside additional stock and facilitating access to those non-refugee civilians whose only recourse is across the border.

**Nutritional coping mechanisms**

In addition to disease, hunger constituted a key problem for Liberians during the complex emergency. In rural areas, "bush-food" became a highly valued commodity. Villagers displaced to the countryside improvised a diet based on eddoes, wild yams and sweet...
potatoes, palm cabbage (heart of palm), papaya leaves, roots and other fruits and vegetables which could be gathered surreptitiously. SCF-UK encountered a sizeable increase in rural cases of adult oedema without marasmus, and speculates that this was due to cassava poisoning, often the result of consuming young cassava without boiling or other preparation. [41] Civilians reported that they feared making a cook-fire, visible by fighters, in the bush, and were prohibited from even basic hunting and gathering activities by the fighters. Wherever possible, displaced persons supplemented their diet with river crayfish and bushmeat. Crop cultivation was often impossible under occupation, except for forced agricultural production on behalf of the faction.

Farmers in communities where the market system had broken down were occasionally obliged to consume their own seed stocks as food, with the consequent negative impact on their productive capacity. In recognition of this fact, international NGOs distributed bulgur wheat along with seed stocks when providing agricultural inputs to targeted communities in order to ensure that at least a portion of the seed was planted. The lower market value of bulgur compared with rice made it more likely that most of the grain would be eaten, preserving the rice seed for subsequent planting (see bulgur wheat discussion in Key Decisions section). Another INGO strategy which meshed with local coping mechanisms was the CRS seed rice exchange program, initiated in 1995, in which CRS swapped milled rice for farmers’ seed rice in order to maintain the stock for next year’s planting. Alternatively, seed rice was purchased from the farmers, to introduce additional cash resources to the household economy. This INGO strategy encouraged the year-round cultivation of swamp rice in neglected fields wherever security permitted.

The community of Sinje, Grand Cape Mount County, found that the presence of food aid acted as a lure to fighters. In the volatile months of late 1996, civilians surveyed requested that the international community not bring relief food, since it would likely lead to attacks. When relief agencies delivered bulgur wheat stocks soon thereafter, fighters attacked the community, causing dozens of casualties. [42]

Some food was available from fighters themselves; Tubmanburg residents bought looted food (as well as medicines) back from ex-combatants during 1996. The village of Barkiedu, Lofa County, bartered its principal crop of palm oil for rice in Voinjama, even though the authorities in the town were faction leaders of a rival ethnic group. It is likely that similar coping mechanisms were employed by civilians throughout the country.

**Coping mechanisms in IDP camps**

The health needs of displaced Liberians in the camps were covered to a great extent by the health posts and clinics established nearby. INGOs conducted periodic screenings of camp populations for communicable diseases and carried out vaccination activities. In Buchanan town, camp residents routinely recurred to the Catholic Hospital for a wide variety of health services, including screening, treatment, vaccination and pre-natal care. At the height of the conflict, when some 200,000 IDPs were in the Buchanan area, the Consolata missionary sisters ran a health clinic in the Catholic Hospital classroom, doing basic health education for IDPs.

Nutritional needs in the camps were closely monitored by Action Contre le Faim, which carried out sophisticated monthly surveys. (ACF’s statistics are virtually the only existing data from the war years, due to the widespread looting of all other Monrovia-based organizations during the April 1996 riots). Camp residents reinforced their diet by selling a small part of the grain and other commodities they received from WFP and CRS for cash,
and purchasing supplementary foods which are staples in the Liberian diet: palm oil, greens, fish, and spices. WFP was aware of the sale and recognized it as both necessary and expected in order to allow the camp population to vary their diet.[43] IDPs obtained additional disposable income by cutting wood for charcoal production, weaving mats for sale and engaging in a variety of small business activities in the camp environment. These are standard coping mechanisms found across Africa in refugee and IDP contexts.

Once the situation outside the IDP camps normalized, the displaced population increasingly engaged in agricultural production. Toward the end of the conflict, many IDPs moved out of Buchanan and Kakata to work their own land, putting in an appearance in the camps only to receive their monthly food ration. As WFP and CRS recognized this phenomenon, they implemented a series of measures to better target the truly needy population:

- Distribution only to IDPs living in shelters and not to the surrounding communities;
- Reduction of the food ration to reflect increased productive capacity; and
- Commodity substitution, through the introduction of bulgur wheat instead of rice.

The monthly surveys of ACF indicate that these three measures did not decrease nutritional levels among IDP shelter populations and the surrounding communities (see discussions on IDPs in Buchanan as well as bulgur wheat in Key Decisions section).

**Dynamic: international interventions versus local coping mechanisms**

The interaction between international community interventions and Liberian coping mechanisms in health and nutrition was less than successful in many cases. To the extent that the international community was aware of health and nutrition conditions among the vulnerable population -- especially outside the capital -- UN agencies and NGOs were somewhat willing and able to take into account the survival strategies of needy Liberians. In other cases, the international community ignored or overrode survival strategies which Liberians had already established. Much of the dysfunction between interventions and coping mechanisms derived from the lack of access to and information about affected civilians up-country. The Tubmanburg intervention and the provision of food to Sinje in 1996 constitute clear examples of this phenomenon.

WFP and CRS, the only two food importers in Liberia, clearly took coping mechanisms into account in their decisions regarding food rations. The motivating factor in both organizations was to avoid creating dependency and encourage agriculture and market commerce in the IDP camps. Thus, the reduction in rations and the switch from rice to bulgur wheat reflected a recognition on the part of the international community that Liberians had access to other sources of food. ACF reports that both WFP and CRS were "generally flexible in terms of changing distribution scales." Where WFP was unable or unwilling to change their ration scale, international NGOs simply increased their own population figures to compensate for what they perceived to be an insufficient food basket.[44] ACF had its own protocol regarding nutritional levels and kilocalories, mandated by headquarters, but attempted to factor into its calculations the predominant coping mechanisms and maternal-child nutritional practices. This was easier to do in a controlled camp environment than in outlying communities during wartime.

There were large portions of the country, however, which were simply ignored, due to insecurity and inaccessibility. As demonstrated by the accessibility chart (page 15), international organizations hardly affected the counties of Grand Gedeh, Grand Kru,
Rivercess, Sinoe and Maryland during large periods of the Liberian emergency. Populations in these areas were basically left to rely upon their own coping mechanisms, assailed by isolation, military occupation, and the virtual disappearance of a market economy. Periodic interventions -- assessment missions up the Robertsport Highway or short visits to Greenville, for instance -- had little impact on the material conditions of these affected populations. In areas where international NGOs had on-going project activities which were interrupted by the sudden outbreak of hostilities, the typical response of international NGOs was to pay off the local staff, withdraw its international staff, and then deploy expatriate assessors a few weeks later to provide salaries and verify what project materials remained in place. The fact that project activities continued to function weeks after hot fighting broke out in Buchanan, Gbarnga and Monrovia is testimony to the effective management capacity of local staff in many organizations. In the absence of an active expatriate presence during hostilities, effective training and promotion of nationals seems to have been the best preparation international NGOs made to capitalize on local coping mechanisms. One example of this was the continued, effective functioning of SwedeRelief hospital in Monrovia during the April 1996 crisis. Unfortunately, such preparation of local staff was far too rare during the Liberian emergency.

The October 1996 interventions in Sinje and Tubmanburg demonstrate how the international community failed to recognize or build upon coping mechanisms. Villagers in Sinje had adopted a reasonably successful strategy of accommodation to the presence of fighters in their community. In Tubmanburg, the LNRC had established a functioning emergency health post in the center of town. The INGOs, out of touch with these communities for months, felt pressured to intervene by the Ministry of Health, NGO headquarters in Europe and the USA, public sentiment, and their own inaction since April 1996. In practice, INGO assistance attracted fighters to Sinje with devastating consequences to that community, and overwhelmed Tubmanburg by opening too many feeding centers for the limited population in need.[45] Had INGOs recognized and supported the local strategies in place, the results would have been less deleterious to the beneficiaries and more efficient in the use of resources.

The fact that numerous rural communities operated their own revolving drug funds, especially in Lofa County, attests to the resilience of local coping structures. The re-opening of clinics by international NGOs did not make sufficient use of this capacity for local cost recovery. Particularly noteworthy was the initiative shown by individuals in Barkiedu town, who collected funds to purchase drugs in Guinea for use in Liberia despite the distance and dangers involved. International NGOs on the Guinean side were wisely hesitant to cross over into faction-held Liberian territory, particularly after one British NGO was looted of all supplies on the Zorzor Road in 1994; however, some form of support to individual border crossers from captive or occupied communities might have been feasible. MSF-B provided such support to the Officer-in-Charge of the main hospital in Voinjama, when he crossed the border for supplies. INGOs working in refugee areas along the border could have recognized the importance of their health resources to the captive populations inside Liberia and increased their stock of medicine and equipment accordingly.

The experience of the displaced health workers from Phebe Hospital shows how international agencies effectively supported local coping mechanisms. When fighting hit the Phebe compound in September 1994, many of the hospital staff walked down the road to Totota and re-established a mini-clinic there. Overland access between Monrovia and Gbarnga was impossible, but the staff managed to notify authorities in the capital that they were operating a medical unit for the displaced camps. CHAL and UNICEF arranged to drop off drugs for the mini-clinic by helicopter, supplying life-saving medicines which were not available on the local market. The intervention is a costly one, and not applicable in most
contexts, but demonstrates an understanding by the international community of the immediate needs of a local structure.

Often overlooked in evaluations of international interventions in complex emergencies is the fact that many communities acted independently from INGOs and were successful. The example of Tubmanburg (mentioned above) is a clear example of community proactiveness and innovativeness in the absence of international relief agencies.

The international community was perhaps too slow in recognizing the productive capacities of displaced persons in IDP camps. Along the Monrovia-Gbarnga axis, IDPs had their food, water, health, housing and other needs taken care of by international and national NGOs, producing a sense of complacency.[46] This phenomenon was noted by the international NGOs in Buchanan as well. Greater attention could have been paid toward the integration of agricultural projects with food distribution in camps, recognizing the fact that many IDPs were able to farm in surrounding areas.

It is not reasonable to expect that donors and INGOs have perfect understanding of the conditions prevailing in communities which have been cut off or occupied for long periods of time. However, some greater degree of interaction is required between the coping mechanisms of affected populations and the international interventions on their behalf. Several approaches are suggested:

- Greater support to and consultation with local NGOs who know the actual conditions on the ground;
- Use of sentinel sites or other surveillance systems to monitor health conditions as well as coping mechanisms employed locally;
- Adoption of community-based approaches wherever possible;
- Working with Community Development Committees or other local structures on emergency activities.

Support to local coping mechanisms pays dividends in a variety of forms. The donor agency avoids duplicating goods and services, saving valuable resources for use elsewhere. The target population sees its own efforts rewarded, empowering beneficiaries to continue their own self-help efforts independent of relief aid. Negative side-effects of poorly-conceived interventions (e.g., Sinje, 1996) can be better avoided, based on a more complete understanding of the situation. Finally, relief interventions are likely to last longer when married to locally developed strategies (e.g., revolving drug funds), increasing the long-term benefit to the community. One clear lesson from the Liberian experience should be the importance and value of recognizing and planning around such local initiatives.

V. Decision-making and Sustainability

One complaint voiced often by Liberian health professionals in regard to relief efforts carried out during the war was the lack of sustainability built into international interventions. Traditionally, emergency work in wartime has been more concerned with humanitarian action than with support for local capacities. Yet the protracted nature of the conflict, combined with the "peaks and valleys" of accessibility, lead to the conclusion that local capacity-building was possible and even necessary in specific locations and time-periods during the war.
Sustainability implies a number of different approaches:

- Support for coordination and cooperation mechanisms;
- Use of existing standards and protocols or development of new, potentially more appropriate ones in conjunction with the local health community;
- Enhancing the capacity of existing local organizations; and
- Training of human resources.

International agencies doing emergency work in Liberia did some local capacity building in each of these areas, but more often missed opportunities to build onto existing resources in the rush to implement urgent, life-saving activities or in order to avoid dealing with existing systems that they felt were corrupt, incompetent, or both. This section assesses the degree to which the international community was able to support local capacities and examines some reasons behind the opportunities that were missed.

Local Coordination Mechanisms

Under normal circumstances, the Ministry of Health would be the locus of control for all policy decisions taken in country. Vital decisions about geographic location of projects, types of interventions, and health protocols to be used should be made by or in cooperation with the Government Ministry. The nature of Liberia as a "collapsed state" during most of the war precluded this to a great extent. During the first two years of the war, there were effectively two ministries of health, based in Monrovia and Gbarnga. There was little cooperation between the two governments, and international agencies interfaced with each Ministry separately regarding actions undertaken in the respective areas it controlled. (The UN held duplicate coordination meetings in both locations during the early years.) The human capacity of the Monrovia Ministry was minimal, however, and was limited to supporting activities in and around the capital. In Greater Liberia, individual NGOs made arrangements with the National Patriotic Reconstruction Assembly Government (NPRAG) in Gbarnga to carry out cross-border supply and support to clinics from Guinea and la Cote d'Ivoire.

From 1993 onwards, the Interim Government of National Unity (IGNU) unified both administrations, but factional fighting made national coordination problematic. Because of the Ministry’s diminished capacity, international NGOs carried out their humanitarian activities without a great deal of participation by Liberian authorities in Monrovia. Other African countries undergoing civil war (e.g. Angola, Mozambique, Sudan, and Uganda), managed to maintain a centralized control of health matters in the capital. Liberia, on the other hand, experienced a de facto political vacuum in Monrovia. Most participants in the Liberian health scene agreed that it would have been extremely difficult for the international community to involve the Ministry of Health more in policy and decision-making, given the lack of capacity and state of disarray which existed during the years 1993-95. The current Deputy Minister of Health recognizes that there were only two staff members working in the Ministry during those years.

Instead of working through the Ministry, the international community chose for the most part to work independently of any central authority, providing moderate support to national NGOs or carrying out themselves those tasks which a ministry would normally coordinate. This strategy permitted the international community to avoid choosing sides during the dual-administration period and also afforded more flexibility of action (i.e., less bureaucracy) during the later IGNU period. It also had the unfortunate side effect of reinforcing a virtually powerless health sector, led by international organizations. As a number of international and
national health workers have indicated, Medecins Sans Frontieres was omnipresent in Liberia up until April 1996, acting virtually as a surrogate ministry of health. In large part, this also produced a parallel system of health services in which INGOs supported basic primary health care structures such as health posts and clinics, relying on government hospitals as referral centers, but without directly supporting the hospitals themselves.

Post-election Liberia now has a minimally functional health ministry, although national coordination is still a slow process. Two structures bring together national and international partners in the sector, the Health Sector Coordinating Committee and the Technical Advisory Committee. The latter includes one international NGO, one local NGO, the EU, USAID and the Ministry of Health. The current decentralization program instituted by the Ministry may facilitate coordination by streamlining the chain of command, partly through the use of County Health Officers. It has only been with the end of the conflict that the international community has supported a national coordination system under the Ministry; it may be difficult to argue that this effort could have taken place any earlier.

Existing Standards and Protocols

Partly as a result of the vacuum at Ministerial level, it often occurred that those individuals making decisions about health treatment and standards during the Liberian emergency were international NGO staff, many of whom were not familiar with traditions and pre-war policies in use throughout the country. Liberian organizations perceived that some internationals presumed no health standards existed and proceeded to impose their own. Such externally-developed and imposed standards included specific drug protocols and the salary structure of staff in health clinics. In fairness to international NGOs, official Ministry of Health guidelines were very difficult to locate in wartime Liberia. Only one of the dozens of health posts and clinics visited by the RPG field team was able to produce a single copy upon request. It is probable that health protocols were used more as an oral tradition rather than a written guide in many parts of the country, even before the war. It is also likely that although the protocols may have existed at one time, they were probably not employed by most health workers.

Certain instances of conflictive or inefficient INGO policy were raised by respondents, however. Instead of striving to equal the salary structure of medical personnel already in place, for example, INGOs tended to overbid government salaries, indirectly facilitating the "brain-drain" which affected rural areas of the country. The salary scale imposed on clinics by the international NGOs funding them created a wide gap between doctors, assistants, and support staff -- as well as between INGO national staff and Liberians working for LINGOs or the government -- and made staffing of health structures unsustainable in the long run. In all fairness, many Liberian workers might have flocked to INGOs even if the agencies had adhered to the established salary scales, since the government could rarely pay its staff at all during the war and the INGOs could guarantee a steadier income.

In similar fashion, one local NGO recalled that the international community sought to train mid-wives from scratch introducing new curriculum, rather than making use of the trained TBAs already on the ground in many communities. Liberian health professionals also expressed concern over the professional qualifications of some incoming international personnel, whose curriculae were not shared with any central government authority. Aside from the lack of trust between local and international NGOs revealed by this issue, it raises the question of transparency in operations. Some degree of tension between local and international NGOs is almost inevitable, in light of the difference in resources and perspective, but it is reasonable to question whether some international NGOs took
advantage of the emergency situation and weak central government to avoid Liberian interference in daily operations and decision-making.

Costs for medical service constitutes another area in which international organizations either failed to recognize or to respect local practice. When the Emergency Drug Program was established in March 1991, international donors, UN agencies and INGOs insisted that all consultations had to be provided free of charge. The humanitarian rationale for this is obvious, but it fails to take into account the tradition already extant of charging for health services in many parts of the country. In Lofa County, for instance, clinics continued to function on a fee-for-service basis well into 1993. During the conflict in Tubmanburg, when no INGOs were present, Liberian health professionals combined to form a Red Cross clinic and charged registration fees to those who could afford it, in order to have money to buy medicines. One local physician argued that the international community’s insistence on universal gratis service reinforced Liberia’s dependence on international agencies.

Numerous INGOs, including AMI, MSF-B, MERC-I and ACF, supported Buchanan’s Government Hospital at various times throughout the war. On several occasions the international community insisted on gratis provision of health care, only to pull out a few months later as insecurity dictated. Upon the withdrawal of the internationals, the hospital generally re-instituted its fee-for-service system and attempted to cover expenses as best it could. The inefficiency and mistrust sown by the constant changes in price-structure, however, did much damage to the institution’s ability to recover costs. It is very possible that some abuses occurred in the absence of the international NGOs, in the form of price gouging and extortion of patients. Nevertheless, the discontinuance of fee-for-service which already existed flies in the face of local practice and opens the way to such abuses.

Local Health Organizations

UN agencies, international NGOs, and donor governments provided a small modicum of support to several national NGOs at different times during the war. With the exception of MSF-B and SCF-UK, however, there was a marked reticence on the part of the INGOs in general to partner with local organizations. NDS, MERC-I and CHAL became three of the more visible local actors implementing health activities in areas where the international community could not reach. Yet in all three cases, the local NGOs were not successful models for capacity-building, but rather instances of the international community creating or supporting relatively weak proxies for their own activities. The sustainability of each organization remains fragile and still essentially dependent upon international support.

The National Drug Service (NDS), a former governmental agency, was reconstituted as an NGO during the war years by international actors in order to provide a non-governmental mechanism for distribution of medicines to health structures throughout the country. The NGO accomplished its purpose, with major support from the European Union and UNICEF, but functioned very much under the influence of international donors. NDS ran into problems over the policy of not charging for drugs. The international funders insisted on this policy in order to avoid corruption, and all recipient institutions -- health posts, clinics, hospitals and other medical NGOs -- were prohibited from charging patients fees for the drugs NDS provided. During emergency or peak crisis periods, most donors require free drug distribution; however, as has been argued previously, the seven year conflict in Liberia not a constant crisis, but rather was marked by long periods of relative calm. Clearly, typical humanitarian responses to peak emergency situations -- such as the fee-for-service and fee-for-drug issues, were not appropriate at all times during the Liberian complex emergency. Mechanisms could have, and should have, been put in place during these lulls which would
enable a greater degree of self-sufficiency and health service sustainability on the part of health facilities such as NDS.

MERCI, another national NGO, was almost an offspring of the international community, maintaining a close relationship with MSF-B from its inception. The Liberian physicians who founded MERCI in 1990 were supported by MSF to provide basic preventive and curative care, set up nutritional feeding centers and the expanded program of immunization, and run clinics in the MSF fashion. Observers in MSF and other organizations recognize that MERCI never enjoyed much autonomy. While technically not a part of MSF, nearly all MERCI’s funding came from the Belgian arm of the organization, which effectively gave MSF tremendous control. Also, MERCI’s Medical Director adamantly pointed out that while no international entity has a responsibility to ensure sustainability for the organization (“That is MERCI’s own job”), donor bias toward international NGOs made it hard for the local institution to survive without the auspices of MSF. Liberians who dealt with MERCI during the early 1990s recalled that MSF failed to support MERCI in the areas in which it most needed training -- namely administration and financial management -- and that these skills might have permitted the organization to develop into a truly viable and sustainable Liberian institution. When MSF stopped funding MERCI and physically separated the two’s offices in 1995, the human capacity of the organization diminished measurably.

The Christian Health Association of Liberia (CHAL) may have the best chance of the three at sustainability, but has been hard hit by the fortunes of war. CHAL existed long before the 1990 conflict broke out, and like many religiously based, pre-war NGOs in Liberia, it got most of its financial support from church groups. With the advent of the conflict CHAL expanded into emergency work with additional funds from major donors. CHAL received funding from USAID (1986-1989) but then lost a US$3.5 million follow-up grant which was de-obligated due to the outbreak of the war. OFDA supported CHAL through CRS in January 1992, but another follow-up grant in October 1992 was interrupted by Operation Octopus. Likewise, funding from a German inter-faith group (EZE) in late 1995 was overtaken by the April 1996 riots in Monrovia. The events of April 1996 devastated the organization; the office in Sinkor was looted, all staff was made redundant and CHAL is still recovering from the losses. Loss of equipment, staff and funding during the volatile war years has made CHAL’s existence exceedingly difficult.

Another local NGO, the Liberian National Red Cross (LNRC), enjoyed some distinct advantages vis-a-vis other institutions in the health sector. The LNRC possesses a volunteer network throughout the country, and claims to have had access to the most inaccessible areas during the war. Because of its special neutral status, the organization managed to work even during the hottest periods of the conflict. It is noteworthy that the Liberian Red Cross acted prominently to clean up Monrovia after April 6 1996, collecting bodies and ensuring the water supply in many areas of town. Notwithstanding this access and delivery capability, LNRC reported that it received insufficient attention from the international NGOs. Its sister organizations, ICRC and IFRC, along with WFP, provided LNRC with food and non-food items for distribution, but the rest of the international community failed to take advantage of this resource. For instance, an LNRC clinic functioned as the sole health care provider in Tubmanburg from the time of the ULIMO-J assault on the town in December 1995, when international resources evacuated, until September 1996, when, as one Liberian NGO administrator said, international NGOs "swarmed in like the California Gold Rush." The Red Cross clinic at Tubmanburg could have benefited enormously from the influx of health supplies, food aid and logistical support from INGOs arriving on the scene in late 1996. Likewise, INGOs could have benefited from consulting, coordinating, and partnering with the Red Cross clinic, which had a keen knowledge of the political, military, and social context of the Tubmanburg population and the crisis. Neither transfer of information or material
resources took place, however, and both the INGOs and the LNRC lost an opportunity to improve the quality and sustainability of their relief intervention at Tubmanburg.

**Human Resource Capacity-Building**

The accepted wisdom of many emergency professionals is that "training people in a period of transience or displacement is a waste of time." Both ECHO and OFDA tend to restrict funding of health training activities and tend to avoid health education in emergencies altogether, although one donor representative suggested that if an NGO was innovative enough to "sneak" education into a broader emergency proposal, it might be funded. Even within INGO headquarters, however, there is sometimes a physical as well as philosophical separation between emergency and development activities: many INGOs establish separate "emergency" and "development" desks, with separate funding rules and standard operating procedures which make traditional development activities like education and training difficult to implement in an emergency context. Most often, the urgent pressure of preventing a human catastrophe in peak emergencies precludes the time consuming process of planning and implementing such a program. The chief arguments against training or education during emergency situations are practical: cost, inaccessibility and/or insecurity.

Certain types of training are obviously less suitable than others in emergencies: for instance, a UNDP-funded education program for the Ministry of Health (1987-1994) sent handpicked government officials overseas for schooling, and saw 85 per cent of them remain abroad rather than returning to Liberia to help rebuild the country. However, notwithstanding the structural obstacles mentioned above, several types of human resource capacity-building took place during the conflict. MSF and ACF both trained CHWs and TBAs at certain times. SCF funded a local NGO, HOPE, to train ORT agents in diarrhea prevention in response to a cholera epidemic. Bomi Hospital’s Community Health Department trained CHWs and TBAs, also with support from SCF, up until the outbreak of hostilities in 1995. Even OFDA, in 1995-1996, funded a private institution in Monrovia, Mother Patton College of Health Sciences, to train CHWs and TBAs. ICRC supported LNRC workshops on STDs and AIDS beginning in 1997.

As seen in the previous section on Coping Mechanisms, however, trained health workers were often among the first members of a community to leave in times of conflict. From that perspective, does health training make sense? A strong argument can be made that it does, for reasons of longevity, appropriateness and empowerment.

In many parts of Liberia, little remains of the international community’s investment in capital equipment and infrastructure. A cursory examination of Curran Hospital, the burned-out NGO offices of Monrovia, or the abandoned towns throughout Grand Gedeh County reveals the magnitude of material resources which were squandered during peak crises between 1989 and 1997. However, investment in human capital has a longer-lasting impact. Even where CHWs and TBAs have fled to the bush, Monrovia, or neighboring countries, the trained resources have generally remained in the region and will likely be used to Liberia’s benefit in the future. The experience of the Voinjama County Health Supervisor is illustrative: the MSF-trained cadre fled to the bush, continued to practice medicine in a small Upper Lofa village in the bush for several months, then returned home to re-open Tellewoyan Hospital and support his community.

It is also appropriate to carry out human resource capacity-building under emergency conditions in light of the needs expressed by the communities most at risk. The village of Goyoh Hills in Bomi County emphasized that its most pressing need was general health
education; specifically, training in general health care and preparedness for the next
emergency. Market women in Cestos City who have recently returned from displacement
express dismay that they do not have the basic information to deal with common illnesses,
diarrhea or fever.

The final justification of training lies in its democratizing power. The underlying causes of
most emergency conditions in Liberia (and the world) are poverty and lack of resources.
Whether the purpose of international interventions is defined as the redistribution of
resources (development) or preventing loss of life (emergency), the best hope for
empowering vulnerable and affected civilians lies in providing them with educational skills to
survive the miserable health conditions which an underdeveloped society has imposed upon
them.

Many rural Liberians felt that general health education, including first aid, mass casualty and
preventive health care, was their key need during the seven-year war. While such education
is impossible during a "hot" conflict, there were numerous periods of calm in entire regions of
the country where community-level health education might have been carried out, perhaps
through a local NGO. Given some basic health education, the population might have been
better able to survive the next period of fighting. As the Officer in Charge of Barkiedu Health
Clinic put it, "Teaching them to remember just one or two things can save them."

SCF-UK supported emergency training of ORT monitors in Bomi County in 1995, during a
relative "lull" in conflict in that region. An alternative mechanism was the revival of the pre-
war institution of Community Development Committees (CDCs), responsible for
disseminating education and information to villagers in a variety of sectors. These village
institutions, it was suggested, might not be perceived as either threat or asset by invading
factions, although it is conceivable that CDC members might be targeted in the same way
that health workers were during the war. Oxfam has been carrying out community-based
development projects since 1997, and recognizes that such initiatives should have and could
have been introduced during the war in the pockets of stability throughout the country.

In conclusion, donors as well as implementing relief agencies need to realize that in a
complex emergency such as Liberia, both relief and development are needed, and they are
not mutually exclusive. The importance of integrating them in modern complex emergencies
is demonstrated by the fact that conditions conducive to either relief or development exist
simultaneously in different parts of the country, and at different times in the same geographic
location. It is clearly not possible to speak of a "relief-to-development continuum" in the
Liberian context. With twenty-twenty hindsight, it can be concluded that the several areas of
sustainable development outlined above -- human resource capacity-building, supporting
local NGOs, and reinforcing existing policies and mechanisms -- were opportunities missed
by the international community. But in the heat of a humanitarian crisis, the pressure to
respond in a timely and humanitarian fashion make such strategies seem like luxuries. A key
lesson to be drawn from the Liberian complex emergency, therefore, is the feasibility and
importance of building sustainability into humanitarian policies in advance of a relief
intervention.
VI. Summary of Conclusions

The Nature of the Liberian Complex Emergency

1. For purposes of analyzing health interventions, the Liberian emergency was characterized by:
   - The absence of any functional national government for much of the conflict, despite several supra-regional attempts to install a transitional administration.
   - Protracted conflict between multiple factions, with little consistent control of any part of Liberia by any particular faction (with the exception of central Liberia for three years).
   - Continuous cycle of "peaks" and "valleys" in conflict intensity. "Peaks" lasted anywhere from two weeks to two years; "valleys" lasted up to three years. Moreover, different parts of the country experienced different levels of conflict intensity at any given point in time. (See graphs on following pages).
   - Massive forced displacement (estimated at 80 percent of the total population, or 2.1 million people), which resulted in a significant shift in population density from rural Liberia to Monrovia, Buchanan, and refugee communities in neighboring countries.
   - Massive infrastructural damage (estimated destruction of 90 percent of all health facilities, as well as destruction of the majority of other public services and private property).
   - Sporadic access by international relief agencies to large segments of Liberia due to insecurity and logistical obstacles.
   - Gradual cohesion and solidarity among international non-governmental relief agencies, in an effort to "do no harm" in their interventions and also to advocate on behalf of peace processes.

INGO Decision-making in the Liberian Emergency

2. One of the most consistent characteristics of the Liberian emergency, and of the health interventions in response to it, is that the programmatic decisions of INGOs were influenced foremost by the political/military situation on the ground. The de facto absence of a functioning national government for much of the war, the presence of multiple factions with fluctuating degrees of territorial control, and the periodic shift in the geographic locus of conflict all combined to jeopardize relief workers’ security and to complicate and often thwart their access to populations in need. Relief operations were also actively used by Liberian actors to advance political or military objectives — a fact demonstrated in discussions of the INGO Joint Policy of Operation in 1996 and the food aid operation for IDPs in Buchanan. Security risks to relief workers and beneficiaries, as well as the threat of attracting violence against either population through a relief operation, prompted frequent evacuations by the relief community, suspension of health and other relief activities, and re-obligation of financial and human resources toward activities considered to be less risky.

3. The second most significant factor influencing INGO decisions on health interventions was the system-level interaction between donor governments and the Liberian political actors, and between donors and implementing agencies. Four of the five key decisions examined by the RPG research team were taken by INGOs based in part upon the need
4. Adherence to the commonly accepted "best practice guidelines" for health in emergencies was not a significant factor affecting the program decisions of INGOs in Liberia. Security on the ground and institutional factors such as donor politics commonly outweighed the policy argument for meeting standardized guidelines in emergency health. However, the Liberian emergency did not always meet the political, social, and logistical conditions needed for these guidelines to have their intended effect in the first place. As opposed to the relatively static and sedentary conditions of a refugee camp environment, the situation inside Liberia during the war changed frequently, and it also varied regionally at any given time. Best practice guidelines in emergency health, which are intended for the former setting, were most often not attainable or applicable for the Liberian context and are difficult to implement in complex emergencies of this nature; modified standards are needed in order to provide more appropriate and effective health care to populations affected by -- and living in -- complex emergencies.

5. Decisions about health interventions were not regularly based upon data analysis. There is very little available health data from the Liberian emergency, especially prior to 1996. This is due, in part, to the low priority given to this task by relief agencies in general, and also to the high losses of material resources and programmatic records sustained during the violence and looting that took place in April 1996. The data which does exist -- mostly in the form of malnutrition surveys by ACF and admission records from random hospitals and clinics -- has limited value for purposes of extrapolation to the broader affected population because of the inconsistent methodology employed and the self-selected nature of the populations that were tracked. Although these nutritional surveys reveal some conclusions about relief interventions in the Buchanan locality, there is limited opportunity to learn broader lessons from the Liberian emergency about the effectiveness of certain interventions or the role of indigenous coping mechanisms in supporting the health of a population in crisis. The Liberian case clearly demonstrates the need for more rigorous surveillance and monitoring of health conditions in a complex emergency, and for greater caution and forethought in maintaining this information in insecure situations.

6. There is very little information available on the financial costs of health interventions during the Liberian emergency. International relief agencies and donors did not track their expenditures in such a way as to allow for comparison and evaluation of programs according to scale or cost-efficiency, either across agencies or across time. UNDHA (now called the UN Office for the Coordination of Humanitarian Activities, or UNOCHA) did not exist in the early 1990s, and no other UN or non-governmental agency had a mandate to fill this role during this time. Even after its establishment, however, UNDHA’s information on financial costs of the Liberian relief effort -- and of the health sector in particular -- remained limited to the agencies participating in the appeal process. Most of the international and local NGOs were not included. This lack of consolidated financial data on health interventions has two important consequences: first, it obliges policy makers to rely on the assertions and fallible memories of field staff rather than on accurate documentation when trying to glean lessons from a relief operation; and second, it permits a lack of accountability on the part of implementing as well as donor organizations.

7. One of the more innovative international responses to the Liberian emergency was the development and implementation of the INGO Joint Policy of Operation (JPO). The actual health impact of this key decision is difficult to measure, due first of all to the lack of health information and data prior to the JPO, as well as to the lack of practical self-
The Role of Liberian Coping Mechanisms

8. With the exception of several months in 1991 and in 1996, at least four and as many as 13 out of 13 Liberian counties were inaccessible by international relief agencies in a given month. Given this frequent absence as well as the magnitude of devastation to the health system in Liberia, the populations in those counties therefore had to rely on their own coping mechanisms to survive.

9. Physical survival strategies implemented by affected populations ranged from active flight into larger Liberian towns, IDP camps, the rural Liberian bush, and neighboring asylum countries, to passive accommodation of military invasion and dominance. Each option carried with it requirements of geographic proximity, physical stamina, financial means, or connections and other assets with which to accommodate warring factions. Different options were employed as the security situation at the time warranted, and every option provided both a safe haven as well as a hazard at different stages of the complex emergency. Those seeking protection in larger cities, IDP facilities, and refugee camps often had the benefit of international humanitarian assistance; those in the remote bush were obliged to fend for themselves.

10. Trained Liberian health professionals played a role in the humanitarian effort by sustaining minimal health services to populations cut off from external assistance. This provision of services took place under the most dire and dangerous of conditions, and also through particularly innovative approaches to drug supply and facility operation. The existence of CHWs, TBAs, P.A.s, R.N.s, and other health professionals in many communities was instrumental to the survival of those populations. However, relief agencies tended to overlook these human resources in their interventions and to channel their relief inputs through non-community sources.

11. The distorted economy produced by the war (and supported by international relief actors) served to pull many trained health workers out of rural communities and into the cities, where opportunities for employment with well-paying international relief agencies were more abundant. This situation has drained trained health resources out of rural Liberia and jeopardizes those areas’ post-conflict reconstruction processes. Migrant health workers also established themselves as “black baggers,” travelling through the country providing health services and dispensing drugs. While these itinerant doctors were often the communities’ only access to western medicine, the providers were often acting in capacities far beyond their qualifications.

12. Contrary to the common assumption that health professionals are granted the same degree of respect and social status as clergy, the Liberian case points out that trained health workers, while clearly vital to the survival of many Liberians affected by the war, were also a liability unto themselves. Health workers in Liberia were targeted by invading or retreating factions who did not intend for their opponents to receive medical
13. Rural and inaccessible populations overwhelmingly resorted to traditional medicine in the absence of western alternatives. This "country medicine" was only occasionally effective and sometimes dangerous; however, it represented a significant source of health care throughout the country and throughout the war. International health agencies interacted very little with this type of medicine and apparently did not factor it into their programmatic decision-making or their intervention strategies.

14. Liberians also resorted to "bush foods" as sources of nutrition when market commodities were not available. Unlike the above issue of country medicine, the international community did in fact recognize and incorporate the Liberians' resourcefulness regarding food supply into international food aid interventions. Agencies responsible for food distributions and food security were aware of and sought to support as well as complement this coping mechanism, with a high degree of success.

15. Liberians living near the border crossed into the asylum countries of Guinea and Cote d'Ivoire quite frequently for food and health care. It is unknown whether, but highly improbable that, relief agencies working in the refugee camps realized the extent to which their efforts were also supporting health and survival inside Liberia for those who could not or chose not to leave. The porous nature of the Liberian border, the generosity of host country immigration and asylum policies, and the stamina of the Liberians themselves all contributed to the somewhat ironic fact that refugee assistance played a very significant role in the health interventions inside Liberia.

16. It is clear that international relief efforts supported (perhaps inadvertently, as in the above point) some indigenous coping mechanisms while neglecting and sometimes even preventing others. More attention needs to be paid by the international community to these practices, and greater effort needs to be given to identifying and complementing them. Such an approach to health interventions may prove more cost-efficient, more culturally appropriate, and more ultimately sustainable.

**Decision-making and Sustainability**

17. The international community did not assign a high priority to the issue of sustainability in their health interventions; consequently, opportunities were missed to strengthen local capacities and to help prepare the affected populations for periods of intense conflict during the war as well as for post-conflict reconstruction and recovery. Conclusions regarding four aspects of sustainability are summarized below:

18. Local coordination mechanisms in the Liberian health sector (i.e. the Ministry of Health) were very weak during the Liberian conflict due to the "collapsed" nature of the Liberian state and the existence of multiple -- and at one point co-existing -- transitional and resistance government administrations in the country. Some international relief agencies attempted to coordinate with these various health authorities; in general, however, the agencies disregarded the Ministry of Health and supplanted its normal functions. The degree of independence afforded to international relief organizations by the essentially defunct Ministry(ies) allowed the former greater flexibility of action in responding to humanitarian needs. On the other hand, the assumption of MOH responsibilities by international relief agencies contributed to the Ministry’s impotence rather than supplementing and strengthening its important role in national health care.

19. The international community tended to develop and impose health standards and protocols without reference to or adherence to indigenous pre-war policies and practices.
20. International relief agencies were generally reluctant to establish partnerships with and support local health organizations during the Liberian conflict, out of mistrust of the local groups’ motives and political allegiances, and out of concern that the required monitoring and supervision of LNGO funding recipients might overwhelm already overburdened international field staff.

21. A few LNGOs were created or supported during the conflict; however, they cannot be considered successful models for capacity-building, but rather mere proxies of the international humanitarian community. While technical training and support to LNGO staff is obviously an important component of capacity-building, perhaps even more important for a local NGO is training in administration and financial management. These skills are critical to the sustainability and viability of any organization, yet they were not transferred by international partners. Nor was coordination and cooperation with functional LNGOs widely practiced during the conflict. As demonstrated by the Tubmanburg incident, the international community missed opportunities to improve the quality and sustainability of their relief efforts by failing to recognize and complement the humanitarian response capacities already present and operational in Liberian communities.

22. The periodic lulls in the Liberian conflict afforded opportunities to strengthen human resource health capacities among the affected population. Some local governmental and non-governmental agencies took advantage of these opportunities to provide training to community health agents and some general health education; however, there was no concerted effort on the part of the humanitarian community as a whole to inject knowledge and skills related to health care into the population. It has been suggested by rural Liberians that education -- especially first aid, preventive health care, and basic care -- was an important but unmet need during the conflict, and it is clear that such skills might have enabled them to better support their own health in periods of intense "peak" conflict when formal health services were unavailable.

Impact and Appropriateness of International Health Interventions

23. When access to affected populations was granted and/or security was assured by the de facto authorities during peak crisis periods, health interventions often took the form of "hit-and-run" operations such as emergency food distributions and airlift of drugs and supplies. Priority was given to meeting the most immediate health and nutritional needs of the population, with the expectation that access would soon be denied again.

24. During longer "lulls" in conflict, such as 1990-92, 1995, and other periods of more localized security, some relief agencies and local groups worked to resurrect the national health system and improve agricultural output. These rehabilitative efforts often took the form of infrastructural renovations, such as physical repairs to health facilities and water/sanitation systems, reactivation of health support centers such as the National Drug Service and the AIDS/STD Testing Facility, and re-establishment of administrative structures such as personnel payroll systems. However, these structural improvements were usually undone in the next peak of conflict, and may have actually caused conflict in the area due to the importation of resources.

25. Health interventions of INGOs and UN agencies in the Liberian emergency were, for the most part, limited to activities commonly thought of as strictly "emergency" or "transitional/rehabilitative." However, due to the vacillation between peaks and lulls in the
26. Conspicuously absent in the international community’s package of health interventions in Liberia were activities traditionally and collectively thought of as "development." These activities include health education, health worker training, and transfer of administrative and technical skills and responsibilities to local health organizations (including NGOs and the Ministry of Health). The basic reason for this neglect is that neither implementing relief agencies in general nor donors have an institutionalized philosophy of developmental relief. Both INGOs and donor governments have management structures which separate "emergency" from "development" operations and impede cross-fertilization between the two. An atmosphere of competition within and between organizations for scarce foreign aid resources reinforces this division in both implementing and donor agencies. In retrospect, had such activities been undertaken during relative lulls in the complex emergency, these skills and knowledge might have added to the set of coping mechanisms used by Liberians to survive in the absence of formal health services during the subsequent waves of conflict. The importance of such activities to the short-term as well as long-term health of the affected population in Liberia therefore support the argument that health education, capacity-building, and other sustainability programming can be considered as much "emergency" needs as development ones.

27. The Liberian case suggests that in a complex emergency situation, where fluctuation in conflict conditions and windows of opportunity is common, and where the affected populations are thus frequently left to their own devices for survival, a distinction between emergency and development programs may be inappropriate. Liberians caught in the civil war lacked basic health knowledge and administrative and technical skills which might have supported their survival during the complex emergency. These "development" activities could have been conducted in tandem with the relief and rehabilitative efforts already occurring during lulls in the conflict, and might have been more sustainable in the Liberian context than were the physical and structural inputs of the relief agencies. But for reasons explained above these needs were not recognized or met by the international community in its health intervention. A significant lesson suggested by the Liberian case is that the humanitarian community needs a new definition of "health interventions in complex emergencies" which adopts a philosophy of developmental relief and instigates a change in policy among implementing agencies, donors, and humanitarian coordinating bodies.
VII. Summary of Recommendations

1. Relief agencies should recognize, and incorporate into their program planning, the likelihood of frequent and dramatic fluctuations in conflict intensity, security, and accessibility over the course of a complex emergency. While these fluctuations can often be predicted by perceptive field staff who are in touch with the community in which they work, the magnitude of peak crises can rarely be foreseen. Therefore, relief agencies should develop emergency preparedness plans for unexpected crises such as the one suffered by Monrovia in April 1996. The following should be included in an emergency preparedness plan:

- A written plan of action;
- Stockpiling of goods, including water, food, medical supplies and drugs;
- Triage training for local staff to prioritize the severity of patients’ illnesses in cases of large-scale emergencies;
- Mass casualty exercises performed by local health staff without expatriate participation;
- Communications plans to allow contact with expatriate staff in the event of an expatriate evacuation.
- Clear instructions to local health workers regarding their employment status and their payment in the event of an expatriate evacuation.

2. Technical skills training for the national staff of relief agencies is clearly important and is acknowledged by most operational organizations. However, INGOs and the UN should also work to improve the management and administrative skills of their national staff. National health personnel should be involved at all levels of decision making, including management, so that the overall quality and competence of the health intervention can be improved and so that some relief operations can be maintained in case of a sudden crisis and international evacuation. In the Liberian emergency, INGOs and INGO-supported facilities with national staff in senior management positions were able to sustain many of their programs and minimize much of the damage done to their operations during peak periods in the conflict. Moreover, the administrative and management skills and responsibilities acquired by national relief workers during the war will benefit those individuals as well as the Liberian health care system during the country’s post-conflict reconstruction and recovery process.

3. INGOs and the UN should consciously and strategically communicate and cooperate with the national government(s), LNGOs, and other health actors throughout an emergency as well as among themselves, so that local organizations have a role as well as a responsibility in the relief effort. Increased communication and cooperation between international and indigenous structures may help to facilitate positive relationships between the various international and local actors in a complex emergency, improve humanitarian assistance to the affected population through the mutual exchange of knowledge and skills, and sustain relief operations in times of peak crisis and international evacuation.

4. INGOs should strategically consider the development of a document similar to the Liberian JPO at the outset of complex emergencies. This consideration should be based upon an immediate and repeated analysis of: 1) the political/military and social context of the emergency; 2) the potentially harmful impacts of humanitarian aid in this context; 3) the relationships between international agencies and between international and local actors; 4) the level of interest and commitment of the INGOs to the concepts of advocacy, cohesion and cooperation, and self-regulation; and 5) the impact of deliberate restrictions on INGO activities upon local capacities and the health of the affected
5. The humanitarian community should modify best practice guidelines for complex emergencies to better apply to the fluctuating security, migratory, and accessibility conditions found in cases such as Liberia. Current best practice guidelines refer primarily to an emergency refugee camp setting where the situation is more stable and access is usually ensured by health care personnel. Research needs to be undertaken to develop modified guidelines which focus on health conditions and needs inside countries in crisis rather than in asylum countries, and which also take into account the great difference in degrees of security, accessibility, and population mobility between the two contexts. Furthermore, best practice guidelines for complex emergencies should adopt as a premise the fact that chronic crises such as Liberia do not tend to follow a linear path from emergency to development conditions, but rather fluctuate periodically and perhaps unpredictably between the two. By adopting this premise and developing best practice guidelines in health accordingly, the humanitarian community will be better prepared to respond appropriately and effectively to future complex emergencies.

6. Greater attention should be paid to recognizing and supporting, in the most culturally appropriate and logistically feasible manner, the indigenous coping mechanisms extant in populations affected by complex emergencies. In so doing, operational relief agencies and other international actors are urged to consult and cooperate with local actors who know the populations, their traditional practices, and the prevailing living conditions on the ground. The international community should also consider using sentinel sites or other surveillance systems to monitor health conditions as well as coping mechanisms employed locally. Finally, international agencies should adopt community-based approaches to their interventions wherever possible, and should identify and work with community development committees or other local structures in order to best take advantage of these coping mechanisms.

7. The humanitarian community should also adopt a policy of sustainability in complex emergency health interventions. This policy should:
   - Promote the inclusion of indigenous governmental/non-governmental structures and standards
   - Present a strategy for such inclusion which seeks to recognize, strengthen, and complement the role of indigenous structures and standards in the country’s health care system
   - Discourage financial and political corruption within these structures while preserving the neutrality and strictly humanitarian nature of the international relief intervention
   - Enable affected populations to support their own short and long-term health care through health education and health worker training.

8. Health organizations working in complex emergencies, along with UNOCHA, should give greater priority to establishing and maintaining uniform health information systems. Data collection methodologies of relief agencies and national health and statistics bureaus should be reconciled, and mechanisms to ensure methodological accuracy, dissemination of data, and the safeguarding of data should be implemented at the beginning of an emergency. A health information system in a complex emergency should:
• Collect data which will enable health professionals to make decisions that will direct their actions and programs;
• Ensure feedback of results of data to workers at all levels of the program;
• Employ qualified personnel to collect and analyze data in the field;
• Employ a consistent, sound, and uniform methodology throughout the country and over time, in order to allow for comparison and evaluation at policy as well as operational levels during and following the complex emergency;

9. The humanitarian community should improve their record keeping of program finances. The lack of consistent and comparable information about program size, program funding, and the specific impact of funding shortfalls upon programs in the Liberian case impairs any evaluation of the humanitarian response during the war and eliminates accountability on the part of operational as well as donor agencies. Program records, including financial data, should be maintained at both headquarters and field locations, and should be kept in such a way as to facilitate programmatic and policy analysis and evaluation. As part of its mandate to coordinate humanitarian activities, UNOCHA should collect such information from all humanitarian actors -- not just those contributing to the UN Consolidated Appeal process -- to the greatest extent possible.

10. The humanitarian community as a whole should re-consider its assumptions about the nature of complex emergencies. The Liberian case suggests that complex emergencies are not static "emergencies," but rather a perpetual flux between periods of peak crisis and periods of greater stability conducive to recovery and reconstruction activities. This cycle necessitates heightened attention and vigilance as well as flexibility by relief agencies to changing conditions on the ground and more prompt responses by funders and implementers to these changes.

11. Relief agencies should re-examine the appropriateness and effectiveness of standard responses to country situations categorized as complex emergencies. Implementing and donor agencies should acknowledge the limitations of traditional "emergency" interventions in terms of supporting long-term health and building local capacities. These agencies should also acknowledge the importance and the feasibility of sustainable health inputs (i.e., support to local coping mechanisms, including health education, to community-level and national-level health capacities, and to preventive health care) in the particular context of complex emergencies, when fluctuations in crisis can both facilitate and restrict access by affected populations to formal health services.

12. In light of the above two recommendations, INGOs, UN agencies, donor agencies, and other actors in humanitarian interventions are urged to adopt a philosophy of "developmental relief" which recognizes the need for and appropriateness of development inputs into a complex emergency. These agencies should support development activities alongside emergency activities as well as facilitate more responsive and flexible programmatic and funding decision-making to take advantage of windows of opportunity throughout a complex emergency.
VIII. ENDNOTES:

1. Primary sources for this section include: U.S. Committee for Refugees, Uprooted Liberians: Casualties of a Brutal War; and Justice and Peace Commission of the Liberian National Catholic Secretariat, The Liberian Crisis.


5. Project Update Number 1, Catholic Relief Services, Buchanan, Liberia.


18. See Appendix #4


24. Sources include UNICEF/Liberia Annual Report, 1996; and UNDHA Situation Reports, April-May 1996;

25. Action Contre La Faim: Market Survey Monrovia 16/04/97


28. ibid.

29. The story of the biased survey is second hand information from several NGOs; we were not able to speak to the actual people who carried out the survey nor examine the survey itself.

30. Summary Information of Food Security Assessment and Monitoring Programme in Buchanan July 1996 - October 1997, ACF. Ogden, K., Hailey, P.

31. a This table presents survey findings by comparable group, date, and the percentage of moderate/severe malnutrition (all using z scores except December 93 which uses the median)

32. a Summary Information of Food Security Assessment and Monitoring Programme in Buchanan July 1996 - October 1997, ACF. Ogden, K., Hailey, P.

33. ACF Buchanan Nutritional Survey, 30 July-3 August 1996.

34. Economist Intelligence Unit Report, Fourth Quarter 1990.


37. Ms. Fatima Tambajan (Health Officer), UNDP. Personal Communication. 5 May 1998.

38. Dr. Nyaquoi Karbgo (Project Medical Coordinator), MERCI. Personal Communication. 22 April 1998. Also, Mr. Doe (Nurse Anesthetist), Buchanan Government Hospital. Personal Communication. 24 April 1998.
43. Una McCaulley and John Hare (SCF/UK). Personal Communication. 21 April 1998.
44. McCaulley and Hare. Personal Communication. 21 April 1998.
47. Una McCaulley and John Hare (SCF). Personal Communication. 21 April 1998.
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