

Changing tracks as situations change: humanitarian and health response along the Liberia–Côte d'Ivoire border

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In recent years, protracted crises and fragile post-conflict settings have challenged the co-existence, and even the linear continuum, of relief and development aid. Forced migration has tested humanitarian and development paradigms where sudden-onset emergencies, violence and displacement arise alongside ongoing development work. Drawing on Médecins Sans Frontières interventions in the region from December 2010 to May 2011, this paper examines aid and healthcare responses to displacement in Côte d'Ivoire and Liberia; it focuses on challenges to the maintenance of preparedness for such foreseeable emergencies and to adaptation in response to changing situations of displacement and insecurity. This 'backsliding' from development to emergency remains a substantial challenge to aid; yet, in exactly such cases, it also presents the opportunity to ensure access to medical care that is much more urgently needed in times of crisis, including the suspension of user fees for medical care.

Keywords: Côte d'Ivoire, emergency, health, humanitarian aid, Liberia, open setting, refugees, stabilisation, post-conflict, user fees

Introduction

In recent years, protracted crises and fragile post-conflict settings have challenged the notion that conflict, the post-conflict phase and stability exist on a linear continuum, just as they have blurred the boundary between relief and development. Much has already been written about the fragility of post-conflict countries, the high potential of return to conflict and the challenges of delivering aid in such rapidly evolving contexts, including in Liberia (Collier, Hoeffler and Söderbom, 2006; Gariba, 2011; Kruk et al., 2010; Rincon, 2010). In such settings, forced migration may test humanitarian and development paradigms as sudden-onset emergencies, violence and displacement arise alongside ongoing development work (Derderian and Schockaert, 2010; Levine, 2011; Van Damme, Van Lerberghe and Boelaert, 2002). Recent developments in Côte d'Ivoire and Liberia are a case in point.¹

The November 2010 run-off elections, the ensuing political crisis and violent clashes in Côte d'Ivoire produced internal displacement as well as successive waves of refugees fleeing to neighbouring countries. One of the epicentres of violence and displacement was in western Côte d'Ivoire, along the border with Liberia, where Médecins Sans Frontières (MSF) had previously documented violence (MSF, 2007b). In 2010–11, an estimated 500,000 people were displaced within Côte d'Ivoire and 188,000 refugees fled to Liberia.

The presence of internally displaced persons (IDPs) and refugees in open settings—in villages or the bush in Côte d'Ivoire and among host communities in Liberia—challenged emergency interventions that centred on camps and towns, even as populations outside these sites became more vulnerable, facing continued violence or declining resources.

Practitioners and researchers have now recognised that the debate around access to health care is inseparable from humanitarian aid responses in countries straddling emergency and recovery. In contexts such as Côte d'Ivoire, vulnerable populations can encounter barriers to accessing health care even during stable periods—with renewed crises affecting health services, exacerbating ongoing needs and, consequently, aggravating the lack of access to medical care. During the recent emergency, the Ivorian government decreed a temporary suspension of user fees for health care, renewing debate about access to health care and user fees, long a concern in this context.

In assessing aid and health care responses to displacement in Côte d'Ivoire and Liberia, this paper draws on MSF interventions in the region from December 2010 to May 2011.² It examines challenges facing aid agencies as they attempt to maintain preparedness for such foreseeable emergencies³ and as they adapt operational and advocacy approaches to respond to changing situations of displacement and insecurity (MSF, 2009a). Humanitarian actors struggle to ensure access to urgently needed health care by providing necessary staff, drugs and materials, while also addressing geographical and financial obstacles. 'Backsliding' from development to emergency remains a substantial challenge to aid; yet, in exactly such cases, this dynamic presents the opportunity to ensure access to medical care that is much more urgently needed in times of crisis, including through the suspension of user fees for medical care.

Liberia and the refugee response

Background

Remote Nimba county in north-eastern Liberia received several influxes of refugees from Côte d'Ivoire. The first eight weeks after the electoral crisis of November 2010 saw nearly 40,000 'pre-emptive' Ivorian arrivals. Larger-scale population movements followed, from February to March 2011, as the northern forces led a military offensive westward, towards Abidjan; the influxes continued beyond incumbent president Laurent Gbagbo's arrest on 10 April 2011.

Many of the refugees told MSF they had suffered violence, often repeated displacement, kidnapping and rape (MSF, 2011). As of the end of May 2011, MSF projects no longer registered any new violent trauma cases. Still, MSF teams continued to see numerous infections and infected wounds on both sides of the border, largely because the displaced lacked access to medical facilities, as few were operational, although some also sought treatment after having resorted to traditional medicine, which occasionally proved fatal. In its mobile medical activities along the border, MSF also observed a high level of consultations for generalised body pain—16% in

April 2011 (732/4,489 consultations)—suggesting not only the difficult living conditions of displaced people sheltered in host families and working their fields, but also suggesting a possible high level of mental health stress in a precarious situation.

The majority of the estimated 93,000 refugees in Nimba county⁴ chose to remain in villages along the border for several reasons:

- kinship relations with local communities and a strong tradition of mutual hosting during wars in each country;
- the desire to stay near their property and homes in Côte d'Ivoire as well as the possibility of farming in locations closer to the border; and
- a reluctance to enter Bahn camp, at a significant distance from the border, itself a scene of violence during prior wars.

The slow-onset arrival of refugees in remote areas initially received little attention, but the presence of often-moving refugees in open settings along the border eventually posed several challenges for all those involved in the refugee response.

At both the national and international levels, outright war in neighbouring Côte d'Ivoire and refugee influxes, along with the possible movement of combatants, were seen as a threat to the ongoing stabilisation efforts of the long-term UN Mission in Liberia and to the country's internal security (HRW, 2012).⁵ Reaching refugees in villages scattered along the border represented a significant logistical challenge; the region's scarce basic services and generally low national health indicators⁶ raised legitimate fears that shared resources could be depleted, affecting both refugee populations and their hosts. Yet immediate emergency responses stalled as they were viewed as 'disrupting' ongoing development work and as politically sensitive in an election year.

When the initial refugee flows arrived in northern and eastern Liberia, the country's health care system was still recovering from massive looting and destruction during the 14-year civil war, which lasted from 1997 to 2003. The war left the overwhelming majority of public health facilities non-functional, with the remaining structures dependent on support from non-governmental organisations (NGOs) and the population still seriously affected by conflict, displacement and extreme poverty (Msuya and Sondorp, 2005). In 2007, the national health plan outlined a basic package of health services to be provided free of charge, with international donors financing 80% of national health spending (Kruk et al., 2010). At the time, the Liberian government noted that 300 of the 389 functional health facilities in the country were supported by NGOs, yet assistance from 40% of the NGOs was slated to end by mid-2008 (Government of Liberia, 2007a). The government also estimated that the country had a health workforce ratio of 0.18/100,000, with health services covering an estimated 41% of the population (CDC, 2008, p. 28).

This precariousness characterised health care in Nimba county as well as throughout much of the rest of Liberia. An informal MSF survey of 50 known health structures in Nimba county in 2007—3 hospitals, 6 health centres and 41 clinics—finds that 30 were operated by NGOs, 9 by faith-based organisations or missions,

6 by the government, 4 by private entities and one by the community. An internal review of 43 of 49 existing health structures in Nimba county in 2008—36 clinics, 3 health centres and 4 hospitals—finds that:

- Residents lived on average 7 km from the nearest health structure, with almost 60% of the population living within a 2-hour walk of a health facility. At the same time, poor roads and a lack of transportation meant that some 70% of women cited geographical distance as a major barrier to accessing health care.
- While all health facilities surveyed had at least one trained health worker—usually a nurse—and 70–86% had some basic infrastructure or equipment, fewer than half of the facilities surveyed had all five of the basic inputs studied, namely staff, electricity, water, stethoscopes and a refrigerator.
- Availability of different health services remained very heterogeneous, with poor child and maternal health evidenced by high rates of infant and under-five mortality, measured at 72/1,000 and 111/1,000, respectively, in 2002–07 (LISGIS, MOH and NACP, 2007). To ensure access to care, availability of services would need to be complemented by factors such as affordability, acceptability, appropriateness and quality of care (Kruk et al., 2010).

As of 2012, much vulnerability remained, with Liberians effectively facing a substantial out-of-pocket burden for health expenses despite the package of free basic services (Downie, 2012).

Still, free health care in Liberia frequently led Ivorians to cross the border to seek affordable care in Nimba county—a trend that only intensified during the emergency and persisted in its aftermath. A local NGO reported to MSF that Ivorians regularly represented 20% of consultations in the Butuuo health centre, even before the crisis, and at least 25–30% of consultations during and after the crisis, up to December 2011.

The refugee response in 2011

As the Ivorian refugees first arrived, national and international programmes in Liberia were promoting a gradual, systematic transition; these efforts confronted a ‘transition gap’ between relief and development as well as multiple challenges linked to the provision of basic services such as health, education and food security (Government of Liberia, 2007b). A state-building approach prevailed, with an emphasis on aligning development aid with government priorities and on taking a whole-of-government approach that would link political, security and development objectives although the continued fragility of the peace was widely recognised (OECD, 2011).

Accordingly, the UN began to draw down its aid agencies in Liberia, including the UN High Commissioner for Refugees (UNHCR).⁷ As a result, little emergency response capacity was available in the country. While a refugee response may take some time to be launched, initial time was lost due to a lack of clarity regarding whether UNHCR would take the lead in what might become a classic refugee situation or whether a UN system-wide approach would coordinate the refugee response through the established cluster mechanism.

In mid-January 2011, UNHCR teamed up with the Liberian government and developed an initial strategy that provided assistance to refugees in Bahn camp and 15 identified host communities at distances of 15 or more kilometres from the border.⁸ Fifteen of these 16 locations, including Bahn refugee camp, were in the Gio and Yacouba tribal areas—in northern Liberia—while only one site was located in a Krahn and Guéré area; this approach left few options for refugees of the Guéré group.

As of March 2011, UNHCR and NGO joint contingency planning foresaw the movement of 70% of the refugee caseload to camps, citing the specific strategic objective of 'swiftly mov[ing] refugees away from the border for security and logistical reasons (as per the principles of the 1969 OAU convention)'—while simultaneously intending the process to meet 'to the greatest extent possible the beneficiaries' expectations and their voluntary choice' (UNHCR, 2011c). Yet between the camp's opening in mid-February 2011 and mid-May 2011, no more than 5,000 of more than 90,000 refugees counted in Nimba ever moved to Bahn camp, while no more than 2,000 sought shelter in relocation villages.

As a result, the majority of the refugees remained along the border area in host communities, where no systematic international assistance was provided. Support from host families, one-off distributions and the presence of some international NGOs was the rule. In addition, UNHCR's policy was repeatedly revised and redrafted throughout the influx—but never finalised. The lack of a clear, finalised policy on UN and NGO assistance for the majority of the refugees in the border areas kept humanitarian actors from launching programmes and providing more extensive assistance there, in addition to the camps.⁹ National and international actors encapsulated the resulting policy with the phrase 'no aid but international protection' in the border areas.

Yet international protection activities remained minimal, with no international UNHCR staff based at the border. In mid-May, the establishment of referral procedures for sexual violence cases in the region had only just begun, while monitoring tools for protection were still in their initial stages. As of May 2011, the sole personnel working on a regular basis at the border were 32 monitors from the Liberian Refugee Repatriation and Resettlement Committee (a government ministry) and 135 national staff hired by an international NGO and posted along the border to inform refugees of their rights.¹⁰ Yet both actors adopted an explicit policy of 'encouraging' refugees to leave the border for the camps or relocation villages or pointing to the greater availability of material assistance in the camp,¹¹ raising questions about the voluntary nature of the choice to move.

As of mid-May 2011, UNHCR was redrafting a policy for assistance at the border, but it was still not finalised as of June 2011, more than six months after the refugee influx had begun.¹² The upshot was a situation in which—after exposure to violence and displacement—Ivorian refugees were again subjected to a difficult choice: they could either stay at the border to share resources with local communities but receive little outside aid or protection, or they could move to a camp or relocation village and receive assistance, but leave family, hosts, fields and a perception of security behind.

Refugees and the provision of health care

Not only did a timely response to the refugee arrivals fail to materialise, but ongoing development work on health care in Liberia also slowed the provision of health services to refugees. The Nimba county health team worked in collaboration with two NGOs—one national, one international—to provide medical care in the region. In January 2011, county-level health authorities, UNHCR and some NGOs expressed a preference for more ‘sustainable’ projects than mobile clinics in border areas hosting refugees; in addition, concern was expressed about the duplication of efforts and the possibility that patients might abandon established health structures in favour of mobile clinics. This debate reflected the messy continuum between primary health care and emergency medical assistance.

While primary health care adopts a long-term, sustainable approach towards optimising health as a condition for development, emergency medical assistance aims for health as an objective in itself, with a short-term and needs-based approach designed to ensure physical survival in urgent situations. Indeed, ‘many real life situations are somewhere in-between’, including refugee influxes that overwhelm pre-existing facilities, while free-of-charge humanitarian services also emerge around refugees (Van Damme, Van Lerberghe and Boelaert, 2002). During the refugee influx, the Liberian Ministry of Health maintained its ongoing work in partnership with NGOs in referral hospitals and health centres serving the local population. Meanwhile, humanitarian actors such as MSF responded to gaps in the country’s health system, which was inaccessible for a significant number of refugees or no longer able to respond fully to increasing demand.

In Nimba county, health structures were overwhelmed soon after the refugee influx, with the two development NGOs already present in the region reporting that refugees accounted for 50% of their consultations by the end of January 2011. Medical staff, drug supplies, surgical capacity and ambulances were scarce and often undependable in the region at the outset of the refugee influx. In late February, the local authorities and international actors agreed that MSF and another NGO could provide mobile health care where no other health facility was available within one hour’s walk—but UNHCR funding would not support any health care outside the camp and the relocation villages. In these locations, health-related activities in the refugee response were still restricted to refugee households and not readily made available to host communities. These included both an emergency ambulance service and—flying in the face of public health logic—spraying for mosquitoes only in refugee houses in shared relocation villages.

Fortunately, no major health or other crisis resulted from the slow response to the refugee arrivals. Yet the experience of 2011 poses questions about the capacity and the will of aid actors and the wider aid system to change tracks to respond to sudden forced displacement—in particular while stabilisation and development work is ongoing. Beyond Liberia, these questions will remain vital ones not only for UNHCR as a mandated refugee organisation, but also for UN missions, donors, humanitarian and development NGOs and national or local authorities, whenever they face sudden-onset emergencies in contexts of stabilisation or development.

Considering the historical volatility of the entire region, a ‘watch and wait’ approach may have predominated among aid actors in the interest of ongoing projects in Liberia as well as in Côte d’Ivoire. Refugee responses may take some time to launch and a situation of refugees or IDPs in open, remote settings with difficult access understandably presents a challenge to aid delivery. Still, international mandates to provide urgently needed humanitarian assistance and to protect refugees are clear and debates on assistance in such settings are long-standing and well known. In the absence of dependable assistance, MSF found that refugees regularly crossed the border back into Côte d’Ivoire—at personal risk—to retrieve food or seeds from their abandoned houses or to search for lost relatives.

A similar absence of emergency response characterised the response on the Côte d’Ivoire side, raising parallel debates about the ability of the aid system to change tracks to meet health and humanitarian needs in view of forced displacement in a context where much has been invested in stabilisation and development.

Côte d’Ivoire and the response in the west

Emergency response in Côte d’Ivoire

Two main waves of internal displacement took place in the Ivorian west, first in response to the offensive of northern forces on the economic capital, Abidjan, in March 2011 and then in mid-April. Most of those fleeing the border area left for Liberia or remained in villages, *campements* (shelters located next to outlying fields) or the bush rather than in camps or major towns in Côte d’Ivoire.

Yet even up to May 2011, UN and NGO activities focused on the major towns of Danané, Duékoué, Guiglo and Man; with the notable exception of Duékoué, where the International Organization for Migration hosted up to 28,000 IDPs, no more than a few thousand IDPs were present in any of these sites. The UN itself estimated in mid-May 2011 that they had registered 137,004 IDPs in the west, some 44,466 in spontaneous sites and 92,538 in host families that would be targeted for assistance and monitoring in these major towns, along with Bin-Houyé and Zouan-Hounien close to the border. Yet ‘as in Abidjan [it was assumed] that the identified IDPs in western Côte d’Ivoire are only a fraction of the actual number of people displaced’ (OCHA, 2011b).

After 11 April, UN personnel was evacuated from Abidjan and other locations to Bouaké, Dakar and Man. UN coordination meetings continued in Man, but UN staff members were unable to travel freely in the west at least until the end of May 2011.¹³ Many NGOs also followed UN security rules, restricting movements closer to the border. While ongoing development approaches in Côte d’Ivoire did not block emergency interventions at a systemic level, two key aid NGOs revealed to MSF that internal tensions between emergency and development wings of their organisations had led to a stalemate, such that no emergency project had been implemented in the zone closer to the border. Similarly, while the UN appeal was still underfunded at 21% at end of June 2011, other available funding remained unused, with one key donor explaining that few NGO implementing partners could be found with the will or capacity to respond to the emergency in this zone.

As in Liberia, no major health or humanitarian catastrophe resulted from the absence of a more intensive humanitarian intervention in the west. However, it must be noted that the region along the border—both the north–south axis between Zouan-Hounien and Toulepleu and the more volatile west–east axis of Toulepleu–Blolequin—saw no permanent UN or NGO presence other than MSF and the International Committee of the Red Cross from week 13 (28 March) until the end of May. Even in the more stable regions, the first inter-agency assessment in the region of Zouan-Hounien took place in week 25—12 weeks after MSF had established permanent international presence in that region and more than half a year after the initial crisis. Meanwhile, Ivorian health staff had returned to work in places where no international actors were yet present, such as Bin-Houyé, where one doctor and two nurses were present by mid-May 2011.

At the time, the west–east axis remained fragile, with 17–25% of patients who came to MSF consultations in this region residing in the bush between weeks 19 and 21. In informal inquiries in ten villages in the health zones around Toulepleu, MSF teams found in July 2011 that 97 people had died of violence at the outset of the crisis, 55 people had died of illness or trauma during displacement, when they had no access to care, and 55 people had died upon return to their villages.¹⁴ This data suggests there were three separate waves of mortality. The first coincided with the peak of violence in March 2011, the second occurred in the weeks and months during which people lived as IDPs with host families, in *campements* or in the bush, and a third wave struck upon return to the villages, as returnees had little to no dependable humanitarian assistance or health care accessible to them.

As of August 2011, returns were not yet complete but the NGO presence was finally growing, more than nine months after the crisis had begun. Since the humanitarian presence from March 2011 onward was so starkly limited, the mortality suffered during these months of displacement was probably avoidable.

Access to health care in the Ivorian crisis

The crisis in Côte d'Ivoire reveals not only the challenge of responding to a sudden-onset emergency in a developed country, but also the way in which crises that are connected to violence and displacement raise questions about access to medical care. During and immediately following emergencies, health services face gaps in staff and medical supplies, while populations rendered vulnerable by crises may confront increased geographical or financial barriers to health care. As governments have done in other recent crises—such as the Haiti earthquake of 2010—the national government of Côte d'Ivoire implemented a countrywide policy of free health care from 16 April to 31 May 2011, based on the exceptional situation that Ivorians experienced in the aftermath of the post-electoral crisis (Government of Côte d'Ivoire, 2012). In June, this policy was extended until further notice, pending evaluations by the relevant actors.

In contrast, Liberia had maintained a blanket free-care policy since 2007, recognising continued vulnerability even after the end of the conflict in 2002; the government

committed to deliver to its citizens, free of charge, a basic package of health services, including communicable disease control, emergency care, maternal and newborn health and mental health care (Downie, 2012). MSF has long documented the positive impact of free health care on access to medical care in Côte d'Ivoire,¹⁵ Liberia and elsewhere (MSF, 2007a; 2008; 2009b; Ponsar et al., 2011).

A number of aid NGOs and donors raised the issue of free care and its implications for the need of concrete support after the recent crisis¹⁶—a development paralleling similar discussions following the earthquake in Haiti.¹⁷ Many key health and aid actors, including donors, have now acknowledged the necessity of maintaining a free health care policy, above all in emergencies and their immediate aftermath, when populations remain highly exposed to disease and generally precarious living conditions, while health structures are fragile (ECHO, 2009; IASC Global Health Cluster, 2010; Pearson, 2004). Accordingly, donors also recognise the long-term impact of conflict and violence, in terms of impoverishment, displacement, increased morbidity and diminished access to health care or other basic services (World Bank, 2011).

The recognition of continued vulnerability in post-conflict and transition contexts, as well as vulnerability within development contexts, has opened a wider debate on free care measures in these settings (Witter, 2009).¹⁸ Based on recent experiences in emergencies, and the increasingly receptive policy environment for free care, this study argues not only that humanitarian actors should reinforce capacities to 'change tracks' so as to ensure adequate emergency responses where they are needed, but also that they should actively raise the issue of access to medical care in such contexts as part of their role as humanitarians. Conflicts with widespread displacement, violence and loss of coping mechanisms—as in Côte d'Ivoire—leave populations facing continued, if not increased vulnerability in the longer term. The result is a greater onus on humanitarian actors to push international and national actors to reconsider paying for health services and to prolong the suspension of user fees, until it can be shown that such a suspension would not risk peoples' lives and health.

Dilemmas and debates

The limited emergency interventions in Liberia and Côte d'Ivoire point to the many obstacles and constraints for humanitarian aid and refugee responses in otherwise stable or 'post-conflict' settings. Emergency responses are particularly difficult to launch in contexts where aid has entered a mode of transition or development. Operationally and politically, going 'backward' to prepare and respond to renewed emergencies remains a challenge. In Liberia and Côte d'Ivoire, as elsewhere, humanitarian agencies may be phasing out or turning to longer-term projects; political sensitivities may surround contingency planning in a context where a high level of investment in state-building is underway; refugees or IDPs may raise security and stability concerns; and health system or other development gains may be perceived as being disturbed by humanitarian presence.

The emergence of emergencies in connection with forced migration in stable settings is not exceptional. Such situations arose recently in the Democratic Republic of the Congo and in South Sudan, and in relation to sub-Saharan African refugees and migrants displaced within and from Libya to neighbouring countries and southern Europe.

Several key dilemmas arise:

- Emergency response can be delayed or blocked by government, donors or development actors that privilege development or stabilisation projects. This is especially the case wherever there are security or other concerns about moving populations and the immediate response to their needs is seen as endangering state stability, aid sustainability or investment in chosen systems, such as the health sector.
- Despite the existence of clear mandates for refugee assistance and protection, timely, effective refugee response faces particular challenges when UNHCR and humanitarian agencies are being drawn down in post-conflict, development or stabilisation contexts.
- Despite a growing body of best practices, there is continued need for debate on strategies to assist refugees and other moving populations in open settings.¹⁹ Aid actors have learned not to discriminate in aid response between refugee and host populations sharing resources, nor to influence decisions of refugees' choice of where to seek shelter, for operational or other convenience. While experience-based standards in refugee assistance are key, in particular distance of camps from international borders, the voluntariness of refugee choices must remain non-negotiable. Today, humanitarian and health activities in response to refugees, IDPs and their host communities in open settings continue to struggle to apply lessons learnt in practice in a meaningful way—and to provide equitable quality and access to assistance and services, including the recognition of the impact of user fees on access.
- Finally, security constraints and institutional tensions between the emergency and development wings of the same NGOs must be acknowledged and better studied in view of the fact that they influence choices in humanitarian action and may lead to a failure to intervene.

Conclusions and the way forward

The year 2011 saw some of the largest refugee outfluxes in a decade (UNHCR, 2011b), as well as the re-emergence of large-scale refugee interventions in new camp-based settings, including in Liberia, Libya, South Sudan and the Sahel. Given how the aid landscape and debates have evolved in the past decade, humanitarian debates around policy and practice must urgently catch up with field realities, in particular for refugee response.

Today's operational environment features influxes of refugees, asylum-seekers and migrants, often in mixed flows, to stable or post-conflict settings (Baouab et al., 2012).

In such contexts, aid faces the challenge of changing tracks to respond to sudden-onset emergencies, even as the humanitarian aid sector encounters ever more prominent stabilisation and state-building activities that may represent a challenge for emergency response. The need for flexibility and responsiveness applies where humanitarian action is left to substitute for political engagement in crises, and where humanitarian action risks being compromised or co-opted in a search for policy coherence, or by competing political and security objectives (Collinson, Elhawary and Muggah, 2010). The concrete impact for refugee (and migration) interventions—in camps, open settings and transit locations—needs to be analysed more closely, and advocated on, as has been the case for contexts of high insecurity and limited access.

In several settings where refugee crises emerged in 2011–12, there was little to no humanitarian presence on the ground (Libya), development approaches predominated (Sahel), a drawdown of humanitarian aid was underway (Liberia) or an overall lack of emergency response capacity was long known to be the case (South Sudan) (MSF, 2009a). The debate on how to respond to unforeseen or sudden-onset refugee crises is long overdue, especially with regard to areas where emergency response capacity is limited and facing competing political and development priorities, challenges now firmly recognised within the field. Moreover, aid actors themselves must also scrutinise their own competing priorities and be vigilant about contexts in which long-term goals risk overriding responsiveness to immediate, urgent needs of newly arriving refugees.

Considering the extensive body of law, policy and operational best practice already gathered through refugee interventions, more attention could be devoted to putting these lessons into practice as well as to updating the approaches to these latest challenges, including open settings and situations where moving populations arrive in stable or stabilisation settings. What leverage can emergency responses for refugees draw from existing mandates, best practices and government commitments that could enable a timelier, more effective response in refugee crises under some of the above-mentioned constraints?

The good news is that while emergency refugee responses must adjust to new environments, aid actors are also presented with new opportunities. Whereas stable, development-oriented settings have thwarted emergency humanitarian responses to violence and displacement in Liberia and Côte d'Ivoire, this case study suggests that humanitarian actors might take on an additional role and responsibility in the aftermath of crises. Indeed, they should take the opportunity to push for recognition of the continued vulnerability of violence-affected populations and to pave the way towards longer-term access to health care through the suspension of user fees.

Acknowledgements

The author acknowledges the substantial input of her colleagues Aurélie Ponthieu and Seco Gerard, as well as MSF teams in Liberia and Côte d'Ivoire. Thanks also go out to Mit Philips, Helga Ritter, Lara Jacquier, Jean-Pierre Amigo and Mano Carton.

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Endnotes

- ¹ As Levine (2011) points out: ‘The humanitarian system is geared to responding to the wrong signals, and is systemically incapable of responding adequately and on time. These problems have been well analysed and there is no excuse for these inadequacies to be revealed yet again. We know that we need longer-term strategies, backed by *programmes with flexible funding that can change track as situations change*’ (emphasis added).
- ² Launched in mid-January and mid-March 2011, respectively, MSF activities along the border between Nimba county in Liberia and Moyon-Cavally in Côte d’Ivoire took similar approaches of adaptable mobile clinics that ‘followed’ the most vulnerable displaced. In Liberia, the clinics stopped in villages with higher concentrations of refugees; in Côte d’Ivoire, they worked along the north–south (Zouan-Hounien–Bin-Houyé–Toulepleu) and west–east (Toulepleu–Blolequin) axes. As of May 2011, 20 mobile clinics in Liberia and 25 in Côte d’Ivoire were operating along the border.
- ³ A comparison can be drawn with the situation in 2009 in Southern Sudan, where donor focus on post-conflict and development approaches to aid led to diminished preparedness and capacity in the face of foreseeable emergencies (MSF, 2009a).
- ⁴ Internal statistics used in the planning of the UN High Commissioner for Refugees (UNHCR) for mid-May 2011. Despite individual and rapid registration, followed by a verification exercise, no official figures were available for the refugees in Nimba county as of late May 2011.
- ⁵ Referring to the aid response to refugees along the border, one UN staff member told MSF in May 2011: ‘We cannot risk the destabilisation of Liberia considering it is still very fragile.’ A similar sentiment was widely expressed in the media and by UNHCR head António Guterres during his visit to the region in March 2011: ‘Guterres and other senior UN officials warned this week in Monrovia that escalating fighting and massive population displacement in neighboring Côte d’Ivoire threatens Liberia’s own fragile eight-year peace’ (UNHCR, 2011d).

Similarly, a UNHCR real-time evaluation mentions issues of security and stabilisation, upcoming elections and political aspects of aid in the region—and how balancing between the need for refugee response and protection had to be weighed against other political concerns: ‘The response was also shaped by the institutional architecture of the UN presence in Liberia, structured around the presence of an integrated peacekeeping mission and a “Delivering as One” model, which aims to draw on the technical capacities of individual agencies in pursuit of common objectives. The refugee emergency was regarded as politically significant, coming in an election year and amid concerns that a major conflict in Côte d’Ivoire might have a destabilising effect in Liberia. [. . .]’

‘This presented particular challenges for UNHCR in determining how to assert and deliver its leadership role in relation to the refugee response, in line with its mandate for international refugee protection, whilst working collaboratively with its partners and drawing effectively on their respective capacities. The fact that the vast majority of refugees were located in host communities, rather than camps, underscored the need for effective collaboration. [. . .]’

‘Managing these coordination challenges drew key resources away from the field-level response at a critical moment in the crisis’ (UNHCR, 2011a, pp. 3–4).

- ⁶ The UN Office for the Coordination of Humanitarian Affairs cites generally poor indicators for health in Liberia, including 100/1,000 infant mortality, 145/1,000 under-five mortality and 1,200/100,000 maternal mortality rates, 24% underweight and 39% stunting among under-fives and 36% of people with no access to improved water sources. At the same time, Liberia is ranked at 162/169 on the Human Development Index and 83.7% of the population lives below the poverty line (OCHA, 2011a, p. iv).
- ⁷ As the internal evaluation of UNHCR's response concedes: 'UNHCR's initial response to the crisis was hesitant. The emergency unfolded in a region where there had been significant progress in resolving the conflict and associated displacement crises of the previous decade, and in common with other humanitarian agencies, UNHCR's field presence had been very significantly reduced. This, combined with the fact that this was a "slow-burning" crisis, the dimensions of which were not immediately evident, contributed (in the case of Liberia) to a delay in identifying and deploying additional resources, especially staff' (UNHCR, 2011a, p. 3).
- ⁸ The Liberian government and UNHCR had reached a consensus that the refugees would have to move to camps or identified host communities at a distance from the border, a policy established in the Liberia Emergency Humanitarian Action Plan: 'A dual strategy will be implemented. It will allow refugees wishing to remain in communities that can absorb them to do so, provided that they are located a reasonable distance from the border. They will benefit from community-based assistance. Other refugees will be transferred to the site recently granted by the Government in Bahn, near the town of Saclepea, and in other camps to be identified should the influx of Ivorian refugees continue' (OCHA, 2011, p. 6).
- This policy reflects regular international practice, as stipulated in UNHCR's *Handbook for Emergencies*: 'to ensure the security and protection of refugees, it is recommended that they be settled at a reasonable distance from international borders as well as other potentially sensitive areas such as military installations' (UNHCR, 2007, ch. 12, para. 35). That distance is usually at least 50 km from the border. Similarly, the Organization of African Unity states that: 'For reasons of security, countries of asylum shall, as far as possible, settle refugees at a reasonable distance from the frontier of their country of origin' (OAU, 1969, para. II.6). As noted in UNHCR (2007), exceptions to this rule should take into account whether the interest of the refugees is better served and whether security and protection allow a presence closer to the border.
- ⁹ Based on an assessment in 14 locations along the border, Save the Children (2011a) shows that refugees chose to remain in border areas although they knew they might be deprived of assistance as a result. The assessment points to the ways in which international disengagement at the border blocked their own ability to assist: '[I]n recent weeks, [Save the Children] has become concerned that, regardless of continuing optimism in some circles that refugees would move from the border to officially designated locations, there has been no indication, despite information campaigns and substantially reduced potential for support and assistance in comparison with refugees in Bahn Refugee Camp, the majority of refugees would agree to move from their first choices of refuge. Such a situation, if prolonged, would mean that Save the Children was responding only to a small percentage of refugee children and would, in effect, exclude those children located in border communities from their rights to education and limit our ability to protect vulnerable minors' (Save the Children, 2011a).
- ¹⁰ As IRIN (2011) reports: '[The] 135 protection monitors [. . .] deliver messages to refugees in villages *encouraging them to move to the Bahn refugee camp*. [. . .] mobile teams of legal advisers [. . .] assist refugees in matters of the law, such as how to get a death certificate, legalize a land claim, or inform them of their rights in other situations' (emphasis added).
- ¹¹ For example, Kaylay village in Nimba county saw the arrival of some 2,500 Ivorian refugees by the end of February. Yet according to refugees and local authorities, no food distribution had reached them despite registration in late May. Information given to the refugees was that no distributions

would be held outside the camp; subsequently, some refugees moved to the camp or to other villages, leaving 1,013 people in mid-September 2011 with no food assistance.

¹² The unfinished policy states: 'In all three counties [of Liberia—Nimba, Grand Gedeh and River Gee] efforts should be made to assist populations where they reside taking into consideration needs, security and accessibility. The assistance provided should cover all sectors (Protection including Child Protection, Food, Health and Nutrition; WASH, Education, Livelihoods) with a specific emphasis on community based services within the framework of national policies and the EHAP [Emergency Humanitarian Action Plan]. Maintaining adequate standards in all locations (over 100) where refugees reside will however be a major challenge in view of the limited access to basic services by local populations prior to the arrival of refugees. Assistance will therefore need to be prioritized' (UNHCR, 2011c).

¹³ In the border areas, UN staff movements were accompanied by armed escorts of the UN Operation in Côte d'Ivoire, which, by mid-May 2011, were patrolling jointly with now-president Alassane Ouattara's Forces Républicaines de la Côte d'Ivoire—one of the belligerents in the zone.

¹⁴ The population of these ten villages—including Bakoubly, Diali, Méo, Nézobly, Péhé and Tiobly—stood at 21,106 before the crisis and at 11,981 as of July 2011, according to local authorities. These mortality numbers are clearly informal and incomplete, as the population has not yet returned, but they are indicative of the impact of the diminished or absent access to health care in the area from March 2011 onward.

¹⁵ Based on a four-year intervention, from 2003 to 2007, in the Centre Hospitalier Régional (CHR) Man in Côte d'Ivoire, MSF teams documented how the suspension of user fees increased the accessibility of health care. The resulting MSF study finds that:

- 67.5% of households in Man displayed some criteria of vulnerability, such as displacement or households headed by women or minors;
- 90% of households lived under the international poverty line of \$1 per person per day, with an average daily income of \$0.27 per person;
- 41.1% of households reported being in debt, with half of these having incurred debt due to medical expenses; and
- hospitalisation would cost the average patient 38 days of income, treatment for severe malaria would cost more than two months' income and a caesarean section would cost about eight months' income.

In contrast to earlier years in which user fees were in place (1999–2000), the number of overall consultations increased constantly from 2003 onward, once user fees were abolished, with a doubling of new cases in 2003–05. Similarly, bed occupancy in CHR Man rose from 51–52% in 1999–2000 to 95% by 2006. About 40% of patients interviewed in June 2007 said they sought care in the CHR Man because the care was free or because of the lack of other affordable options. In June 2008, one year after MSF left the CHR Man and user fees were re-introduced, the impact of the policy change was unmistakable. Overall utilisation of services had dropped by 60%, with 66% fewer outpatient consultations and 75% fewer surgical operations (MSF, 2007a).

¹⁶ International NGOs and the government have discussed this issue; see, for example, AIP (2011) and Save the Children (2011b). Yet they have also debated more widely, with justifiable questions, less about free care itself than about its implementation at the national level (Doumbia, 2011; Connectionivoirienne.net, 2011).

¹⁷ See, for example, MSF (2010; 2013).

¹⁸ See also MSF (2005).

¹⁹ See Koscalova, Lucchi and Kampmüller (2010); Leaning, Spiegel and Crisp (2011); Maystadt and Verwimp (2010); Michael, Pearson and Daliyam (2006); Orach and De Brouwere (2004; 2006); and Van Damme et al. (1998).

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