Reviving health care in Liberia

Liberia is rebuilding its health system after years of brutal conflict. But providing care for those traumatised by the war presents many challenges. Margaret Harris Cheng reports from Monrovia.

In rich, reassuring tones Benjamin Harris, Liberia’s only resident psychiatrist, calmly describes the mentality of many people in the country after the conflict: “People used to say Liberians are slow to anger [but] now there are many maladaptive and dysfunctional behaviours and a markedly decreased anger threshold. A small incident can spark extreme violence: burning, stoning.”

Walk through the streets of Liberia’s capital, Monrovia, which is more like a beachside suburb than a city, and you do not feel the fear or foreboding that Harris’ words might instill. But you are very aware that most of the people around you are young, and that most of them, although very friendly, do not seem to have much to do to occupy their time.

It is these, the children of the conflict that started in 1989 and officially ended in 2003, whom Harris says constitute a population-wide psychiatric emergency. It has been estimated that one in ten Liberian children were recruited as soldiers. “The war lasted a long time. Most young adults grew up during a disordered period and received little nurturing.”

“The needs are great. A household-based survey found that 43% of the survey participants had symptoms of post-traumatic stress disorder”, says Harris. “The biggest community-based problem is substance abuse. It has permeated the country. Just about anywhere heroin and other drugs can be purchased and used.”

The violence, particularly the gender-based violence prevalent during the war, when abduction, forced labour, beating, rape, and coercive sex became almost a norm, did not end when the hostilities officially did. According to a UN protection monitoring report, there were 2745 reported cases of domestic violence and 302 cases of rape (in a country with a population of just under 3·5 million people) between January and November, 2008.

In 2007, the Liberian Demographic and Health Survey found that almost half of women aged 15-49 years had experienced physical violence, with husbands and partners being the most common perpetrators. 18% had experienced sexual violence and 10% reported that their first sexual intercourse was forced.

“A 9-month pregnant woman had been raped. One woman refused to be raped. They couldn’t overpower her, so the soldiers just took a knife and slashed her vagina...Every one of these women had been raped or violated. We were in tears, listening...we had no idea that these women would come with these stories.”

Such a litany of horror might easily overwhelm those seeking to help and heal. But Pillay says it had the opposite effect. It galvanised her team, making them want to do more than simply listen. “Some of the facilitators said they didn’t want to come back unless they are going to be able to do something for the women. I didn’t want it to be like other post-conflict countries where you pick up the women, clear out their stories, then dump them. We’ve documented the cases who need immediate attention and are identifying service providers and are giving names and addresses of people who need help.”

Here Pillay raises what is possibly Liberia’s biggest current challenge: getting comprehensive medical help to the hundreds of thousands who so desperately need it. Liberia has some of the world’s worst health indices. The UN Development Programme’s...
Panel: Improving women’s health in Liberia

At the Fistula Rehabilitation and Reintegration Center—a UN Population Fund (UNFPA) project deliberately located in one of Monrovia’s poorest satellites, Jacob Town—a “graduation ceremony” was underway for the first 17 women to not only have their obstetric fistulas (many of them both vagino-vesical and vagino-rectal) repaired but also to undergo training in either tailoring, baking, soap-making, or fabric dyeing. The ceremony was a celebration to mark the end of their training and the beginning of a new life. Along with their graduation certificates they were given the materials and money needed to start a business back in their home villages.

In 2006, the UNFPA’s Rose Gakuba started working with John Mulbah, one of Liberia’s few obstetricians (there are three) to set up a fistula repair programme based at Monrovia’s main hospital, the John F Kennedy Memorial Medical Center. “A survey done in 2006 found fistula was of much greater importance in Liberia than anyone realised”, said Mulbah.

A team of five (two surgeons, two nurses, and an anaesthetist) were dispatched to Nigeria to learn fistula repair techniques. Later, another delegation went to Niamey in Niger to observe and learn from their fistula rehabilitation programme. From this trip and from visiting fistula programmes in Ethiopia and Mali and working with surgeons from those countries, they were able to put together an integrated programme involving assessment via outreach teams in rural hospitals, along with surgical management and rehabilitation.

So far, 332 women, most of them aged between 11 and 20 years, have been treated. The 17 graduates are the first to have gone through the entire fistula rehabilitation programme. Hence, the experience of other African nations is now being applied in Liberia to assist the thousands of women living with fistulas.

Now that the country is no longer officially in the post-conflict humanitarian crisis phase, the emergency relief funds are pulling out, along with their medical personnel. This transition, from acute crisis to development, is problematic because the country itself is not yet ready to take over the systems now run by the big relief agencies. 50% of health facilities are run by non-governmental organisations (NGOs).

The ministry of health has recently done an audit of all the facilities, from tertiary hospitals down to unmanned rural medical posts, in the country. The result was somewhat disheartening. Some were not even staffed and many lacked the reliable power supply, water, drugs, and equipment the most basic clinic should have.

Achieving adequate staffing levels is particularly difficult—most skilled health workers left during the war years and those left behind missed out on even a basic education, making it hard to find suitable candidates for fast-track training courses. John Snow International has estimated that the country needs to increase their total health-care workforce by close to 10 000 people, including finding 4223 nurses, 842 doctors, 1143 midwives, 249 medical assistants, and 249 pharmacists; skilled staff that cannot be created overnight.

Despite the challenges, the ministry of health has set about upgrading not only its clinic walls but also the quality of the health services being provided within them. The NGOs have been informed they must all submit performance-based contracts for the facilities they are currently running and prove they are meeting the standards set by the ministry. This move has ruffled quite a few feathers in organisations not used to being asked to prove their worthiness.

But doing things differently is what building a health system out of the rubble of a protracted conflict is all about, says Nestor Ndayimirije, WHO’s representative in Liberia. “Post-conflict countries are very different from other countries...Here in Liberia, some times you have to rebuild or re-engineer what was there.”

Nestor said WHO realised that mental health was too low on the priority list and appointed Harris as a consultant to develop a national mental health policy. Harris has managed to come up with an innovative programme.

“We will use all available resources [and] all available health workers”, said Harris, outlining a 5-tier system relying heavily on psychiatric care in the community. “At the base we use information programmes to inform the community about risks associated with various behaviours. At the next tier we will train and support teachers, traditional healers, and NGO staff to recognise potential problems and make referrals. The third level is the primary health-care level, where staff will be given broad-based training in managing all aspects of health care to equip them to provide care at their level of expertise. The fourth level involves formal mental health care in general hospitals and the fifth level is tertiary facilities, very small units for specialised services dealing with mentally abnormal offenders, those who need custodial care.”

This model is a radical departure from the type of psychiatric care offered in Liberia before the conflict. “There was a functional mental health system but not an effective one”, said Harris.

So rebuilding Liberia’s health system is a huge task but not a hopeless one. And, in asking the impossible of the few people with the skills needed to tackle it, it is a task that is yielding some interesting solutions to daunting problems. As Rozanne Chorlton, UNICEF’s representative in Liberia, puts it: “People like to say that working in Liberia is like flying in a plane while still building it. But I prefer to say its like having the scaffolding around the building while you are working in it.”

Margaret Harris Cheng