Médecins Sans Frontières and the Aftermath of War

Jean-Hervé Jézéquel and Camille Perreand

September 2011 - Crash/Fondation Médecins Sans Frontières

IN THE MSF SPEAKING OUT COLLECTION

- Salvadoran Refugee Camps in Honduras (1988), Laurence Binet
  Available in French and English, October 2003 - April 2004
- Genocide of Rwandan Tutsis (1994), Laurence Binet
  Available in French and English, October 2003 - April 2004
- Rwandan refugee camps Zaire and Tanzania (1994-1995), Laurence Binet
  Available in French and English, October 2003 - April 2004
- The violence of the new Rwandan regime (1994-1995), Laurence Binet
  Available in French and English, October 2003 - April 2004
- Hunting and killing of Rwandan Refugee in Zaire-Congo (1996-1997), Laurence Binet
  Available in French and English, October 2003 - April 2004
- Famine and forced relocations in Ethiopia (1984-1986), Laurence Binet
  Available in French and English, January 2005
- Violence against Kosovar Albanians, NATO's intervention (1998- 1999), Laurence Binet
  Available in French and English, September 2006
- MSF and North Korea, 1995-1998, Laurence Binet
  Available in French and English, January 2008
- War Crimes and Politics of terrors in Chechnya, Laurence Binet
  Available in French and English, June 2010

ALSO IN THE CAHIERS DU CRASH COLLECTION

- A critique of MSF France Operation in Darfur (Sudan), Dr Corinne Danet, Sophie Delaunay, Dr Evelyne Depoortere, Fabrice Weissman
  Available in French and English, January 2007
- Humanitarian action in situations of occupation, Xavier Crombé
  Available in French and English, January 2007
- History of MSF's interactions with investigations and judicial proceedings: Legal or humanitarian testimony?, Françoise Bouchet Saulnier, Fabien Dubuet
  Available in French and English, April 2007
- Aid Actors' Handbook
  Available in French and English, November 2007
- De l'Ethiopie à la Tchétchénie, A collection of articles by François Jean,
  Available in French and English, May 2008
- MSF and Protection: pending or closed?, Judith Soussan
  Available in French and English, June 2008
- Food Aid and the Politics of numbers in Ethiopia, (2002-2004), François Enten
  Available in French and English, November 2008
- Child Undernutrition: advantages and limits of a humanitarian medical approach, Jean-Hervé Bradol, Jean-Hervé Jézéquel
  Available in French and English, June 2010

Acknowledgements

I would like to thank all the MSF actors in the field in Katanga who accepted to describe and explain their professional practices.
This work would not have been possible without the precious advice and invaluable support of Marc Le Pape.
I would also like to address my special thanks to the Crash team for the continued encouragement and trust.

Camille Perreand

I would like to thank all the MSF teams who supported me in this project, both on the field and in the different MSF headquarters I visited. I would also like to thank all my colleagues from the CRASH in Paris and the AAU in Brussels for their advice and discussions.
I would particularly like to thank Laurence Binet, Bérengère Cescau, Marc Le Pape and Fabrice Weissman for their invaluable support at the various stages of this study.

Jean-Hervé Jézéquel

Redaction: Jean-Hervé Jézéquel, Camille Perreand - **Assistant**: Bérengère Cescau - **Editing:** Michaël Neuman, Claire Magone, Fabrice Weissman - **Translation:** Philippa Bowe Smith - **Design / Lay out:** Tcgraphite

CONTENT

Introduction: no more certainties

Jean-Hervé Jézéquel

A number of conflicts in areas where Médecins Sans Frontières (MSF) was involved drew to a close during the period from 2000 to 2010 (including Kosovo, Liberia, Sierra Leone, Ivory Coast, Burundi, Congo-Brazzaville, Angola and Uganda). Levels of violence in some of these countries remain high, yet most actors no longer consider them to be situations of open warfare.

As conflicts end, so does the initial reason for intervention by MSF teams. In these situations of relative uncertainty, conflicting feelings of discomfort arise at head office and in the field. On the one hand, some people feel that teams leave too early and that we abandon populations to fend for themselves in situations where they still need a humanitarian presence. Others stress the deployment of a massive aid effort that accompanies the end of conflict, within which MSF struggles to find its place and maintain its autonomy of action. The return of the State and the switch of focus from crisis management to reconstruction and development constitute excellent reasons to call time on MSF missions as soon as a conflict comes to an end. In both cases, post-conflict situations are closely linked – but not subsumable – to the issue of exit strategy policies.
The post-conflict notion is currently much in vogue,[1] but the term is deceptive in its simplicity. We could, for example, offer a seemingly objective definition: the term simply designates the period following the end of an armed conflict, a transition period prior to a return to 'normality'. But this overly simple definition hardly hide the many problems raised by the way actors in the aid and development sectors make use of the post-conflict notion.

1. The idea that post-conflict situations demand the deployment of specific mechanisms and tailored aid policies is commonplace, often a given, in the aid world. It is certainly not a new idea, but recent years have seen endless studies of the topic by academics and other grey literature authors. This interest both reflects and drives major changes in the institutional aid landscape: over the past two decades, many international institutions have set up programmes or departments specialising in treating post-conflict situations.

Who decides that a conflict is over, and based on which criteria? In Kivu, the government and international organisations declared the war over at a time when there remained significant levels of violence on the ground. Is the official reconciliation between Chad and Sudan enough in itself to characterise the situation in eastern Chad as being post-conflict? Conversely, why not describe the violence and crime afflicting the Central African Republic as open warfare? These examples alone suffice to show that the post-conflict notion relates as much to an assessment of levels of violence as it does to a political decision to use the post-conflict paradigm to describe a given situation.

As far as aid organisations are concerned, the notions of post-conflict and conflict do not merely designate periods in time. They also entail a certain perception of the legitimate issues and policies that take them into account. They convey a whole series of representations and messages that define and justify certain types of intervention within a given context.

Since the inception of the "war on terror", the post-conflict notion has provided the ideal context for aligning development policies with international security issues. Nonetheless, it is important not to deduce that all post-conflict policies are informed by the security agenda. It would be more accurate to say that the post-conflict context is a crucible within which converge a whole series of dynamics that impact the aid sector: the increasing convergence between development and security, evidently, as well as the return of international financial institutions (led by the World Bank) to the so-called less efficient countries, international development bodies' revival of interest in engaging with the State, and the movement towards ordering and standardising of aid mechanisms.[2]

MSF cannot escape these dynamics. The two case studies (Liberia and Katanga) presented in this booklet make the case that the representations associated with the end of conflict, whether specific to MSF or common to all actors in the aid sector, influence the content of the operations the organisation puts in place. The representations inform the way in which MSF teams, from head office to the field, envisage the framework for their operations, such as the perception of health risks and relationships to other institutions.

However, these two studies into operational decisions made by MSF highlight two distinctly different sets of phenomena.

The Katanga study examines in detail the way in which the conflict and post-conflict categories are invoked by MSF as justification for its operational choices.

2. For example, the UN's cluster reform was initially introduced into situations of (real or perceived) post-conflict (Liberia, DRC, Sudan, etc.).

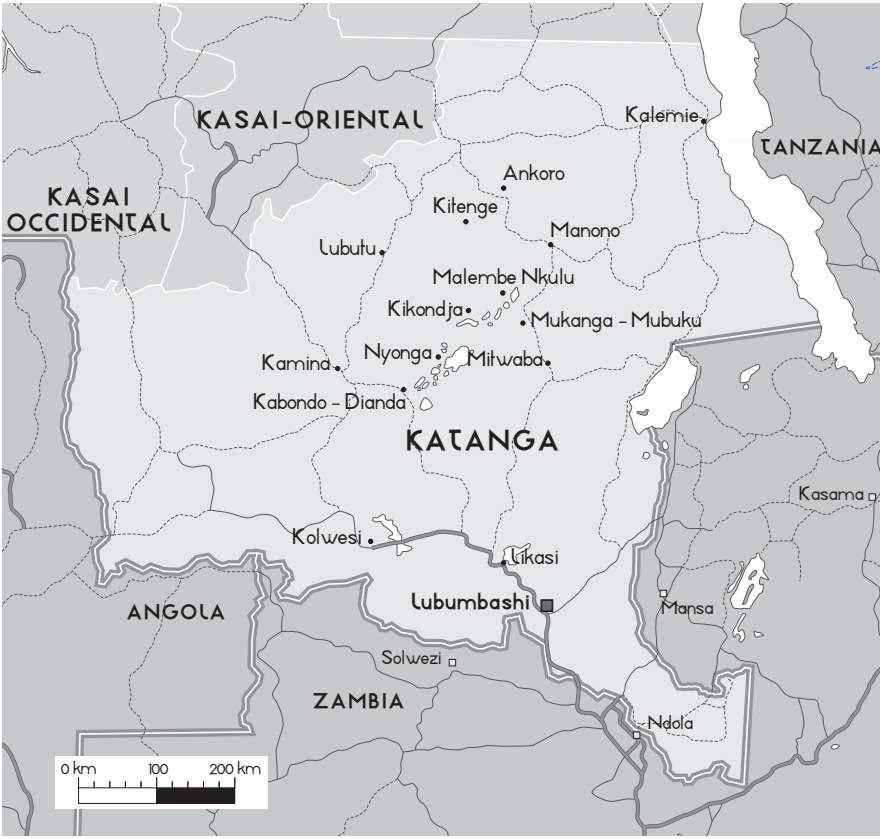
It highlights the fact that MSF has a tendency to think of conflict as a time of exception (exceptional health situation, exceptional supposed absence of State power, etc.) and of post-conflict as being a time when the situation returns to 'normal'. However, the Katanga study demonstrates how hard it is for MSF to adapt to situations that cannot be understood in terms of either conflict or post-conflict; the study calls into question the simplistic way in which the notion of conflict is used as a relevant criteria when characterising a health situation as being either "normal" or "exceptional".

The Liberian study focuses far more on MSF's relationships with other actors in the aid sector. it shows how MSF's operations in post-conflict situations are influenced by interpretations generated by the aid system, even when MSF is not involved in the process. The Liberian example invites us to look anew at the post-war process: by avoiding reducing the post-conflict context to the question of Reconstruction[3] alone, it becomes possible to identify humanitarian issues that the Reconstructors' analysis fails to spot.

The insights that both studies provide highlight the fact that the post-conflict context can never be a standard situation posing the same operational challenges to an organisation like MSF in all locations. Against a background of increasing standardisation in intervention policies and practices, this paper warns of the perils of applying a "manual of good practices" to each and every post-war situation.

3. We have used a capital letter for Reconstruction to designate all policies and practices adopted by the mechanisms for reordering States and societies after armed conflict.

Map of Katanga 2007



Chapter I
MSF in Katanga (2000-2008)

Camille Perreand, Paris, MSF-Crash

This study started out looking at the shift to a post-conflict situation in Katanga; the intention was to describe how MSF's sections negotiated the transition from war to post-war. This raised the question of where to draw the line that distinguishes a conflict from a post-conflict situation. This was no easy task in North Katanga between 2000 and 2006. The situation at the time could be described neither as war nor peace; armed groups were committing widespread atrocities against civilians and this in turn led to extensive internal population displacement and generalised poverty. Our study does not therefore examine a post-conflict situation as such, but an unstable situation that is hard to classify within the dominant descriptions as being conflict/post-conflict, post-war or in transition. Having examined MSF's archives, held interviews and discussions with MSF actors and studied academic papers, I will now attempt to recount the difficulties encountered, and the solutions offered, in Katanga from 2000 to 2008 by the MSF Belgium and MSF France teams.

1. DEMOCRATIC REPUBLIC OF CONGO: THE CHALLENGES OF TRANSITION

This first chapter examines the situation in the DRC during the years 1998 to 2008. The idea is to provide a brief sketch characterising the period: the shift from armed conflict to transition, upsurges of conflict during the transition, successive UN and donor policies, the organisation and state of the Congolese healthcare system, international healthcare cooperation, epidemiological alerts and high mortality rate caused by the conflict as well as the violence inflicted by armed groups. These factors combined to ensure that the DRC constituted

a major international governance challenge during the war and into the transition period, which began in 2002. A number of studies have been produced on international governance in the DRC as well as on the armed groups and rebel movements, Congolese political culture, the electoral process, the pursuit of conflicts in the Kivus and Province Orientale, the pillage of mineral wealth, etc. This is far from being an unknown war. The information presented here is drawn from these studies, but is necessarily only a very small part of the facts and figures they contain.

1.1. A BRIEF HISTORY OF THE TRANSITION

In 1996, in East Zaire, the rebels of the Alliance of Democratic Forces for the Liberation of Congo (AFDL) and Rwandan forces launched what was termed a war of liberation. This war brought about the downfall of Mobutu's regime in May 1997, with AFDL chief Laurent Désiré Kabila and his Rwandan allies taking up the reins of power.

In 1998, Kabila renounced his alliance and Rwandan meddling; war erupted on 2 August. A rebel movement was formed under the direction of former members of Zaire's armed forces and Rwandophone Congolese Tutsis. This movement was backed by Rwanda and Uganda, whose armies were also engaged. In the space of a few days, these forces seized the main towns of the east. Buoyed by this success, the rebels created the Rally for Congolese Democracy (RCD) in August 1998. Kinshasa forged alliances with Zimbabwe and Angola, and the presence of these countries' forces in the field led to a stabilisation of the front-line.

The main aim of the agreement reached during July and August of 1999 in Lusaka, under the guidance of the UN and the OAU, was the progressive establishment of an inter-Congolese dialogue intended to prepare the ground for a new political and institutional framework. The agreement stipulated that foreign troops would withdraw at a later stage, following the establishment of new institutions and the deployment of an international peacekeeping force. However, Laurent Kabila tried to replace the terms of the agreement with a national debate between equals. Initially viewed by the international community as the key obstacle to peace in the region, the DRC gained diplomatic leverage thanks to the outbreak of fighting for control of Kisangani, in August 1999 and again in May and June of 2000, between former allies Uganda and Rwanda. The UN Security Council demanded that Ugandan and Rwandan forces withdraw from

the DRC (resolution 1304, 16 June 2000). It also demanded the creation of an expert panel to examine "the illegal exploitation of natural resources and other forms of wealth of the DRC". The panel was formed in June 2000 and in April 2001 it published its first report, highlighting the "pillage" occurring in the east of the DRC at the hands of Ugandan and Rwandan groups, as well as other military, political and commercial networks.

Laurent Désiré Kabila was assassinated on 16 January 2001. He was immediately replaced by his son, Joseph Kabila, in circumstances that remain shadowy. Joseph Kabila denounced the previous agreement on ending the crisis, making the early departure of foreign troops a condition for continued Congolese acceptance of its undertakings.[4] The international community then undertook to put an end to the "unresolved turmoil", described by some actors as the First African World War.[5] The idea of sending a UN mission, approved in November 1999 under the terms of Security Council resolution 1279, was confirmed with the resumption of talks. Once Joseph Kabila had greenlighted the United Nations Organization Mission in the DRC (MONUC) deployment plan, it was put into effect as of March 2001. The mission's medium-term objective was to obtain the "full and definitive withdrawal of all foreign troops from the DRC" (UN Security Council, resolution 1341, 22 February 2001).

On 17 December 2002, the parties to the inter-Congolese negotiations in Pretoria signed a "global and inclusive agreement" concerning the transition period. Crucially, the agreement heralded the adoption of a power-sharing formula known as 1+4: the head of State was required to work with 4 vice-presidents. The agreement also demanded "the organisation of free and transparent elections". The elections on 6 December 2006 signalled the end of the transition period, and Joseph Kabila was subsequently elected president after the second round of voting, garnering 58% of votes compared to 42% for Jean-Pierre Bemba. There were 25.4 million registered voters, with a turnout of 65.4% for the second round (29 October 2006).

4. G. de Villers, *République démocratique du Congo. De la guerre aux élections. L'ascension de Joseph Kabila et la naissance de la Troisième République (janvier 2001-août 2008)*, Royal Museum for Central Africa (Africa Tervuren), L'Harmattan, 2009, p. 38-41.

5. Term used by Madeleine Albright in her opening remarks to the UN Security Council meeting on the DRC, New York, 24 January 2000, cf. T. Trefon, *Réformes au Congo : attentes et désillusions*, L'Harmattan, 2009, p. 19.

1.2. THE INTERNATIONAL COMMUNITY IN THE DRC

1.2.1. Circumscribed sovereignty and partial trusteeship

Created in November 1999, initially as an observer mission and subsequently entrusted with a peacekeeping mission, MONUC had troops on the ground as of March 2001; it was operating in a country beset by both internal and regional fighting. Following the official withdrawal of Rwandan and Ugandan troops in 2002, stabilisation efforts were concentrated on the east of the country (in particular Kivu, Ituri, Maniema, and the city of Kisangani) and on setting up new political and socio-economic systems. MONUC was granted more extensive prerogatives as the transition progressed. The conditions for the use of force and contingents' rules of engagement were redefined at a time when the mission was tasked with significant new roles covering the reorganisation of the army and police, political structures, the organisation of elections and support to humanitarian actions. In October 2004 (Security Council resolution 1565), its mandate was altered and MONUC became an integrated mission: headed by a Special Representative of the Secretary-General, all its actions were coordinated with those of other specialist UN bodies (UNDP, UNHCR, UNICEF, OCHA, etc.). In this way, the UN played a part in establishing a "regime of partial trusteeship, with limited and controlled sovereignty" [6] in the DRC.

Another component of this regime based on partial trusteeship was the International Committee in Support of the Transition (CIAT), headed by the Special Representative of the Secretary-General and whose members comprised foreign ambassadors, representatives from MONUC, the EU and the OAU. Under the terms of the global and inclusive agreement (Pretoria, December 2002), the CIAT was defined as one of the guarantors of the transition, and it was to "arbitrate and make a decision in any disagreement that may arise between the Parties" to the Pretoria agreement. This power placed the committee at the heart of the political transition mechanism.

1.2.2. "Putting the State back in the driving seat"[7]

Ever since the second to last decade of the Mobutu regime, observers had been vying to outdo each other in their descriptions of the dysfunctional Congolese State. Theodore Trefon takes issue with this view: he maintains that such atti-

6. G. de Villers, *République démocratique du Congo. De la guerre aux élections*, 2009, p. 227.

7. This expression is used by Théodore Trefon as well as in Congolese government documents, such as *Programme minimum de partenariat pour la transition et la relance en DRC*, 17 May 2004.

tudes speak of a lack of understanding of the "journey" taken by the post-colonial State, which does not correspond to the model of the western State ruled by law.[8] It is true that the various reports and institutional papers usually only point to a causal link between the emergence of the conflict and the collapse of the State,[9] or cite the final decades of the Mobutu era in order to describe a journey wherein they recognise the characteristics of a failing State, with the war acting as an "accelerator".[10] This perception, using terms such as chaos, break-up, bankruptcy and collapse, fails to acknowledge that the Congolese State in fact showed a remarkable capacity for resilience. Years of internal conflicts, international wars and foreign occupation of part of the country never called into doubt the existence of a unified and legitimate State.[11]

Timothy Raeymaekers and Koen Vlassenroot[12] believe that the strategy of political power-sharing[13] enabled the emergence of a new State model: during the transition period the State seemed to have lost its Leviathan role for all time, ceding its place to alliances and regulatory systems agreed by economic actors, parties to the conflict, local authorities and public agencies. Yet this seeming displacement of State sovereignty into the private sphere was not a linear process. The emergence of new parallel economic and political terrains within which the State is but one actor amongst others served to weaken the peace process. However, in a context of neither war nor peace, these governable zones made it possible to keep negotiations open between the State and the many other actors present on the ground. Most importantly, they played a part in sustaining the sense of being members of a nation-State within an environment marked by widespread cronyism .[14]

The international community's goal for the DRC consisted, for some, in extricating it from a "conflict trap"[15], whilst others wanted it to break free of a "vicious

8. T. Trefon, *Parcours administratifs dans un Etat en faillite. Récits populaires de Lubumbashi* (DRC), Africa Tervuren, L'Harmattan (coll. Cahiers africains), 2007.
9. K. Ballentine and H. Nitzschke, *Profiting from Peace: Managing the Resource Dimension of Civil War,* Boulder, Lynne Rienner, 2005.
10. European Union, Cooperation Strategy 9th EDF 2003-2007, 2003, p.10.
11. T. Raeymaekers and K. Vlassenroot, *Reshaping Congolese Statehood in the midst of Crisis and Transition*, in U. Engel and P. Nugent (ed.), Respacing Africa, Boston, Leiden, Brill, 2009, p. 137.
12. T. Raeymaekers and K. Vlassenroot, *op. cit.*
13. This strategy governed the quest for a "global and inclusive agreement" embracing all actors in Congolese political life.
14. The authors cite the example of the "coercive governance structure" that emerged during the transition period in the North Kivu's Walikale territory, with adoption of a system of institutionalised political and economic regulations governing exploitation of resources. In this specific governance context, the military, territorial government and economic actors exploited minerals for their own ends and produced a complex governance system by redistributing resources using an institutionalised taxation system.
15. World Bank researcher Paul Collier, specialist in the study of strategies used in post-conflict situations, coined the term "conflict trap". Aid must focus on the real causes of conflict if it is not to break out again.

circle" that maintained the country in a state of chronic conflict and poverty. Political changes and the prospect that they could lead to a way out from the crisis were thought of as being a "window of opportunity"[16] that needed seizing: this is the reason why the political priority for international action at the time was holding "free and transparent" elections, along with maintaining peace and the withdrawal of foreign forces.

1.3. THE CONGOLESE HEALTH SYSTEM: AT THE CROSSROADS BETWEEN WAR AND PEACE

1.3.1. The Congolese health system

Efforts were made to plan and structure a health system in Zaire from the 1960s. The main inspirations behind this effort were the community medicine projects run in the districts of Bwamanda (Equateur), Kisantu (Bas-Congo) and Kasango (Maniema) as well as theoretical work undertaken by Christian networks (protestant and catholic) under the patronage of the Ministry of Health.

These multiple influences played a part in the organisation of a health system based on decentralised territorial entities where private actors and the population at large both contributed to making the system work: health zones.

The Ministry of Health had been setting national health strategies since the late 1980s. The head doctors for each zone, backed by their administrative staff, were in charge of implementing it in each zone. Despite enjoying considerable autonomy, the zone managers were subject to two-tier oversight from the district and provincial medical inspectors.

The zones comprised primary health centres run by professional paramedicals who provided the first level of care via consultations and primary care services. In cases where hospitalisation was required, patients were cared for in local health centres that offered better levels of staffing and equipment. Where there were complications or special requirements, patients were referred to the zone's hospital, which should be able to offer a wider range of treatments.

The presence of health providers at health centres and at the zone, district and provincial levels meant that the state of open warfare (1996-1997, 1998-2002) and internal conflict after 2002 (especially in Katanga) did not lead to a generalised breakdown of care provision. Indeed, the cause of the gradual decline in public health services can be traced to disengagement by the State that began

16. Many of the reports produced by international organisations working in DRC used the notion of a "window of opportunity".

well before the 1996-2002 period. The system of health zones doubtless contributed to preserving a minimum level of provision as it made it easier for external actors to intervene in a context of highly decentralised funding. The health zones are now at the heart of the health strategy adopted by donor bodies and the national government.

Actors involved in the transition determined and implemented a policy for the reconstruction of the health system: the policy was founded on the government's adoption in 2005 of a national strategy for reinforcing the health system, whose implementation was in turn supported by funding support programmes run by the main financial donors. Spending was concentrated on health zones with populations in excess of 100,000, judged to offer good prospects and that retained sufficiently operational infrastructures. The "spillover" policy in these zones focused on supporting health centres that remained functional, with the idea that they served as models for others.

The stated priority of the national strategy was reconstruction of the health system, with the risk of not having any immediate impact on health indicators. The emphasis was on extending coverage and a considerable portion of the funds were spent on setting up a system for coordination at the central and provincial levels. Dovetailing with indicators set by the Millennium Development Goals was not prioritised for the first few years.

As well as rehabilitating structures and supporting their functioning, aid actors undertook to deliver a minimum package of activities (MPA) at health centres and a complementary package of activities (CPA) at hospitals. MPAs comprised curative minor surgery, consultations, care for chronic STDs, preventive activities such as pre- and post-natal consultations and immunisations, as well as programmes to promote good health practices. The package concept aimed over time to make it possible to eliminate vertical approaches that offer funding for specific pathologies (TB, HIV, etc.). Donor contributions resulted in patients paying around 15% less than they otherwise would. The EU sought to establish a fixed price service based on the average income of the population concerned.

Donors active in this governmental policy were involved in healthcare at the provincial level. NGO partners and those qualified to set up projects were responsible for implementing the strategy within health zones.

Support for Katanga, for instance, came from a number of sources: the World Bank's Health Sector Rehabilitation Support Project (HSRSP) and Emergency Multisector Rehabilitation and Reconstruction Project (EMRRP) provide guaranteed support up until 2011. NGOs running HSRSPs have a contract with the Bank and undertake to deliver the minimum health services package in the selected

districts and zones, support malaria-fighting efforts and help build monitoring and management capacity at all levels of the health system. Katanga province was also a USAID priority up until 2009. As part of its AXxes (Integrated Health Services Project) programme, USAID contracts partner NGOs and asks them to establish elements pre-selected as part of the World Bank project within a given zone.

1.3.2. Public health and the international community

Public health was already a major component of international policies in the 1990s, well before the return of international community cooperation in 2002. When aid ceased being provided to the Mobuto regime, the European Commission made public health the core component of its decentralised cooperation during the 1992-2002 period. A transition support programme (PATS 1 and PATS 2) worth €54 million was designed to provide financial and material support to health zones.[17] The return of major donors to the country announced significant new expenditure: the World Bank became involved in 2002 with a 44 million dollar payment made via its EMRRP programme.[18] This funding was supplemented in 1995 by a HSRSP project worth a further 150 million dollars. This sector is also one of the three focal sectors for European Commission development funding covering the transition and post-transition periods.[19]

Published literature on post-conflict management describes the political aims of investment in the health sector: these reflect donors' desire to coordinate emergency actions with development measures. The move from crisis to reconstruction also offers the assurance of making the benefits of the interventions rapidly visible, thanks to the Quick Impact Projects (QIP) funding mechanism. The effect, and thus the value, of health sector funding is to consolidate the autonomy of the State in the medium term and, in the short term, to enhance its popular legitimacy by delivering immediately available services. Furthermore, donors view health as being a neutral public good that plays a role in bringing peace to communities previously in conflict: according to an ECHO representative in the DRC,

17. The support programme was, however, subject to repeated interruptions linked to the war and changes in geographic coverage. Cf. European Commission, *Cooperation Strategy 9th EDF*, 2003-2007.

18. The Emergency Multisector Rehabilitation and Reconstruction Project (EMRRP), set up in 2002 by the World Bank, covered a number of sectors. Its primary objectives were infrastructure rehabilitation (74%), support for social services (23%) and fostering "community development". The project's stated aims were to provide health services, rebuild infrastructure and support sub-projects aiming to "strengthen the capacity of local communities". The programme was wound up in March 2010, having provided project funding equivalent to €700 million from an initial target of €1.7 billion. AS far as health services were concerned, the HSRSP and EMRPP programmes focused their efforts on administrative and logistical reorganisation and rehabilitation of the health zones and intermediary decision centres (provincial administration).

19. The focal sectors are the areas prioritised for the Commission's rehabilitation, reconstruction and development programme.

even if these programmes did not improve the population's health indicators during the war, they did make it possible to get into the war zones and, by kick-starting collective structures, played a part in bringing fighting to an end.[20]
The technical justifications proffered in post-conflict literature regularly mention the motives that lead international actors to invest in public health. According to Béatrice Pouligny, beyond the move from war to peace or increased security, what is at stake is redefining a social contract. Spending on social programmes is a way of resolving the political contradictions inherent in modern State-building policies. Whilst playing a role in importing a "turnkey State model", UN leaders also attempt to use specific policies (especially the holding of elections) to manufacture a popular legitimacy and to "encourage a measure of renewed commitment to living together."[21]

1.3.3. The "humanitarian crisis": mortality and conflict

At the end of the 1990s, faced with a lack of quantified data and difficulties in measuring the extent of the "humanitarian crisis", a number of bodies conducted retrospective mortality surveys in various provinces of the DRC. In 2000, International Rescue Committee (IRC), an NGO operating public health missions in South Kivu since 1996, carried out epidemiological surveys of five sites: Kisangani (Orientale), Moba (Katanga) and three sites in South Kivu. Based on these surveys, and assuming them to be representative of the 5 provinces in eastern Congo (South Kivu, North Kivu, Maniema, Katanga, and Orientale), IRC estimated that mortality caused by the conflict in these provinces could be estimated at 1.7 million people over the 22 months preceding the survey (*Mortality in Eastern DRC. Results from Five Mortality Surveys*, IRC, May 2000).
In 2004, IRC decided to carry out a fourth retrospective mortality survey so as to be able to extrapolate the data gathered to the nationwide level, polling 19,500 households across the country (*Mortality in the DRC: Results from a Nationwide Survey. Conducted April-July 2004, IRC*). IRC concluded that the net mortality attributable to the conflict (for the period August 1998-2004) was 2.1 per 1000, i.e. 3.9 million deaths. However, the survey also concluded that most were not the direct consequence of acts of violence, which accounted for less than 2% of deaths. A fifth IRC survey from May to July running in 11 DRC provinces made it clear that the "humanitarian crisis" was ongoing despite the official end of

20. Conference given by an ECHO representative in DRC during the transition period, as part of the MSF-organised symposium on rebuilding the health system in DRC.
21. R. Caplan, B. Pouligny, "*Histoire et contradictions du state building*", Critique internationale, 28, July-September 2005.

hostilities in 2002: IRC estimated that 2.1 million deaths related to the conflict occurred during the years 2002 to 2007. From August 1998 to 2007, according to IRC, a total of 5.4 million deaths can be attributed to situations provoked by the war and its aftermath as well as to internal conflicts (*Mortality in the Democratic Republic of Congo. An ongoing Crisis, IRC, 2007*).

The conclusions of these epidemiological surveys led IRC to label the situation in DRC as "the world's most deadly [conflict] since the end of World War."[22] This position was used to justify the organisation's operational choices: IRC retargeted its emergency programmes towards providing support for the public health system and for reconstruction. Backed by the estimate that 98% of conflict-related deaths were caused by the destructive and pillaging acts of armed groups, forced displacements and precarious living conditions, in 2004 it adopted a strategy of providing primary health support.[23] IRC also lobbied for MONUC to provide civilians with better protection.

In 2001 and 2005, MSF-Belgium also carried out retrospective surveys that produced data similar to the IRC: these highlighted the excess mortality in zones afflicted by conflict (*MSF, Violence in the Congo and access to care (DRC). Results of five epidemiological surveys, Brussels, December 2001*). Acting on these observations, the Belgian section refocused on frontline zones and transformed the nature of its mission: from programmes mainly intended to support the health system, it switched to emergency projects to reach out to populations impacted by the conflict. MSF-Belgium did, however, feel that it was not possible to extrapolate its results to include the whole country. Moreover, war was not the sole factor accounting for the state of the public health system, excessive mortality rate and difficulties in accessing care. For example, mortality rates in 2005 in provinces far away from any fighting remained extremely high. The 2005 report published by MSF-Belgium compares mortality rates for 2001 in the health zones examined with those in conflict-impacted health zones where MSG was present: mortality rates rose markedly, from 1.1 in 2001 to 1.8 in the case of Kilwa (Katanga), and they soared in health zones far away from the conflict, as was the case in Inongo, where the rate rose from 0.4 in 2001 to 2.2 in 2005.[24]

The IRC surveys led to optimistic claims concerning the potential role of epidemiology in conflict prevention. A paper published in *The Lancet* (2006),

22. B. Coghlan, R. J. Brennan *et al., Mortality in the Democratic Republic of Congo: a nationwide survey, The Lancet*, 367 (9504), 7 January 2006.

23. Statement by Loïc Aubry, a public health specialist with IRC, MDM symposium on rebuilding the DRC public health system, June 2006.

24. MSF, *Access to care, mortality and violence in DRC. Results of 5 epidemiological surveys: Kilwa, Inongo, Basankusu, Lubutu and Bunkeya. March to May 2005,* Brussels, October 2005, p. 21.

for example, claimed that "We can no longer claim ignorance about this [situation […]. In this sense, mortality studies could play a pre-emptive role to provide further justification for peace initiatives when conflicts threaten to break out."[25] The fact remains, however, that the methodology employed in the IRC surveys and the resulting estimated mortality rates remain controversial. Critics[26] contest the robustness of the assumptions underpinning the extrapolations made by IRC epidemiologists in 2001, point to the fragility of data surrounding the cause of death and the number of deaths per household, and stress the difficulty of assessing high mortality caused by the conflict itself in the absence of any credible demographic data describing the population. Yet there can be no doubt that the international attention focused on the IRC's excessive mortality rate data did serve in a very real way to raise the alarm and call attention to the situation.

***

This first section has looked at the DRC background, initiatives and mechanisms from a national perspective. The following section homes in on local actions in Katanga. At the local level, it becomes clear that health system support policies had little impact in many sites where MSF operated. However, certain generalised characteristics can be applied to situations specific to Katanga: the dilapidated state of hospitals and health centres, the impoverishment of the population, the scale of the exactions and their continuation since 2002. Another point to highlight is the convergence between the analyses of governance specific to the DRC, as presented by Timothy Raeymaekers and Koen Vlassenroot,[27] and the local-level governance that MSF missions engage with. Locally, including in the remotest villages of North Katanga, there are public actors (administrators, police officers, internal security agents, members of the armed forces) and public and private health system actors. Even in the most remote zones, emergency actions never take place in an institutional vacuum; in reality, it is necessary to deal with a number of power centres in order to be able to make decisions and take action. This point is borne out by the descriptions of MSF action in North Katanga.

25. E. Depoortere, F. Checchi, "Pre-emptive war epidemiology: lessons from the Democratic Republic of Congo", The Lancet, 367 (9504), 7 January 2006.
26. Cf. HNTS (Health and Nutrition Tracking Service), *Re-examining mortality from the conflict in the Democratic Republic of Congo*, 1998-2006, WHO, 2009.
27. Cf. T. Raeymaekers and K. Vlassenroot, "Reshaping Congolese Statehood in the midst of Crisis and Transition", in U. Engel and P. Nugent (ed.), *Respacing Africa*, Brill, Leiden, Boston, 2009. See also K. Vlassenroot, "Négocier et contester l'ordre public dans l'Est de la République démocratique du Congo", in *Politique africaine*, 111, October 2008, p. 44-67.

2. MSF MISSIONS IN KATANGA. WHY STAY? HOW TO LEAVE?

2.1. WHY KATANGA?

2.1.1. MSF-France: justification for its presence in Katanga

During the 2001-2002 period, MSF-France made efforts to move its operations closer to the areas of North Katanga impacted by violence. This was a choice designed to bring its actions in line with MSF's guiding principle: priority must go to providing medical assistance to people living in critical conditions caused by conflicts. "Before going to Katanga, we were running projects by default as we weren't managing to get into provinces impacted by the conflict, and these were the provinces where our working methods were most suited."[28] More than any other type of situation, open warfare provides a legitimacy for the way that the organisation works. And, in July 2007 when MSF judged that levels of violence by armed groups were under control, the decision was taken to close the mission in Katanga.

For MSF as well as the international community in general, the notions of war and post-war, although somewhat hazy, remain vital categories as they serve as justification for creating a "zone of exception" that provides legitimacy for international rescue missions and makes it possible to delimit them in space and time.

However, as we will see, the choice to enter and remain in Katanga was the result of ad hoc decision-making and compromises whose roots did not lie in the conflict alone. Throughout the mission, the context in Katanga placed the organisation at the heart of competing interests caused in part by the conflict, and in part by the long history of Mobuto's regime and its effects on the health system. This mission forced MSF to negotiate a context for its work that lay at the crossroads of emergency, reconstruction and public health.

2.1.2. The quest for the frontline

References to the conflict are central to the decision-making process, and explain why MSF decided to intervene in Katanga in 2001, as attested to by internal documents of the time. Activity and annual plans justify MSF's presence because of "the dichotomy between the policy of pacification and transition and the

28. Interview with a former head of the DRC programme, Paris, January 2010.

continued existence of extreme levels of violence in the east."[29] The Annual Plan for 2005 similarly cites "the violence that persists in Kivu and North Katanga."[30] From the very first year of its engagement, MSF set in place a mechanism with a dual purpose: partly to offer care to the sick and those displaced by the violence, and partly to combat epidemics.

The mission in Katanga marked the return of MSF-France to areas of DRC affected by violence; MSF had been on the ground in 1996-1997 in Zaire when Rwandan refugees were being pursued.[31] The decision is also viewed, with hindsight, as signalling a return to MSF's founding mandate: priority to medical assistance close to zones of conflict. The fact is that the Congolese experience is a perfect illustration of the antagonisms that existed within MSF concerning its operational policy: some referred to the utter absence of health provision in order to make access to care the central problem to be faced in the country, whilst others disapproved of any strategies that involved playing a part in projects that did not relate directly to the conflict. For MSF France, the decision to enter North Katanga can also be explained by an operational desire to no longer have to deal with the difficulties encountered in setting up a health system support project in the hospital at Bandundu.

MSF-France and the Bandundu hospital

In early 2000, MSF was present in Bas Congo running an assistance programme for Angolan refugees in Kimpese (operational since 1998) and a centre for displaced Congolese at Sicotra, close to Kinshasa. The demands in terms of access to care throughout the region and the difficulties in reaching conflict zones led MSF to commit to a medium-term programme. In August 2000, the decision was taken to support the Bandundu health zones by setting up within the main hospital and providing assistance to three health centres. For MSF, opening a programme in a stable region was the sign of a new ambition: to work on structural pathologies (malaria, respiratory infections, diarrhoea) and to forge ties with actors in the public health system. For a time, MSF was

29. MSF-F, 2004 Annual Plan, p.152.
30. MSF-F, 2005 Annual Plan, p.119.
31. Cf. Laurence Binet, *Traque et massacres des réfugiés rwandais au Zaïre-Congo 1996-1997*, Paris, MSF, 2004.

considering using this programme as leverage to wage a campaign against cost recovery.[32]
The intervention came under severe pressure almost from the start. Negotiations on cost recovery failed; MSF's salary offers were rejected and relationships with the hospital managers became embittered. The programme review cites as a major difficulty MSF's inability to "come up with a suitable intervention project and positioning, its poor understanding of the health system and how it operates, as well as poor management of agreement and salary protocols." With the parties unable to reach agreement, managers in Paris decided to pull out of the programme in 2002.

The failure of the Bandundu operation confirmed the belief, held by many, that this type of programme was not what MSF is about. Katanga, on the other hand, did meet with their approval, as it demanded traditional emergency response-style working methods.
The first exploratory missions to North Katanga in 2001 revealed a situation far removed from the initial concerns. The frontline was stable, and was actually more of a demarcation line between areas administered by Kinshasa and those to the east under the control of RCD-Goma (a party whose armed forces were backed by Rwanda).[33] Although there remained pockets of displaced people, the overall context was closer to chronic crisis than generalised conflict. The first reports MSF issued spoke of a post-conflict situation,[34] a forgotten crisis where the true causes of mortality were endemic in nature. This is underlined by the fact that the third mission was forced to suspend its explorations in order to provide support to an epidemic response programme. The desire to intervene was also driven by the state of the public health system in North Katanga and its relative isolation from international aid mechanisms. In the various reports, the theme of the forgotten crisis was more effective than references to a conflict

32. Isabelle Mouniaman-Nara, *MSF à Bandundu, janvier 2000-juillet 2002*, internal report, MSF (13/10/2002).
33. "From the Lusaka ceasefire agreement in mid-1999 until the end of 2002, frontlines between government forces and the Goma rebels were more or less stable. […], in total, over the entire period following the Lusaka agreement, military clashes between the main protagonists were rare". G. de Villers, *De la guerre aux élections, op. cit.*, p. 132. The RCD-Goma continued to control large sections of North Katanga after 2002.
34. MSF-F exploratory missions, Malemba Nkulu and Kitenge health zones, Haut Lomami administrative district, Katanga province, August 2001.

in arguing for a programme to be opened.[35] The situation changed, however, with the upsurge in fighting between the armed forces of the DRC (FARDC) and militias who had not disarmed after the end of the fighting with RCD-Goma forces and Rwanda. "In North Katanga, the Mai Mai phenomenon arose from the creation, at the instigation of the government in Kinshasa, of popular self-defence forces intended to resist the advance of the RCD and its Rwandan allies. After the end of the war in 1998, the Mai Mai movement in North Katanga […] remained one of the country's primary sources of disturbance and insecurity."[36]

2.1.3. MSF-Belgium: background and dilemmas surrounding the DRC intervention[37]

The origins of MSF-Belgium's presence in the then Zaire can be traced back to the arrival of 35,000 Angolan refugees in Katanga province (formerly Shaba) in 1985. In 1986, the original emergency response project to provide care to the refugees from Angola was expanded to embrace long-term projects for providing structural support to over twenty health zones, the creation of a local NGO, Horizon Santé (1994),[38] to ensure the project's sustainability, and other vertical projects to tackle AIDS (1993) and trypanosomiasis (1996).

The number of emergency situations continued to grow as the health indicators continued to decline. To cite only the largest operations, 1994 saw the flight of one million Rwandan refugees in Kivu and the exodus of persecuted Kasaiens from Shaba (the former name of Katanga province), followed by the ebola epidemic in Kikwit (Bandundu) in 1995. These emergencies led to the creation of an emergency team in 1995, the PUC (*Pool d'Urgence Congo*); initially based in Kinshasa, it extended its reach to cover a large area of the national territory with regional satellites in Lubumbashi, Mbandaka and Kisangani. Other emergencies dealt with were violence against Rwandan refugees moving within the DRC in 1996-1997, cholera epidemics and open warfare (Kinshasa, Kisangani, Mbandaka and Katanga).

The Belgian section was divided in its goals between attempting to make up for

35. Describing the Kitenge and Malemba zones, the report concludes with the following operational recommendations: "both are contexts of extreme precariousness in socio-economic and health terms alike. In both instances, the situation is 'post-conflict' or 'chronic post-emergency' with massive displacement of civilian populations and health structures in disarray. In humanitarian aid terms, all of Kitenge and the Mai-Mai sub-zone in Malemba are forgotten and/or actor-free areas, remembering also that ACF has no medical capabilities in the FAC sub-zone and that no other actors have come forward to provide medical aid in Malemba." August 2001, p.6.

36. G. de Villers, *op. cit.*, p. 193.

37. This paragraph draws on an MSF-Belgium policy paper from 2006 about its activities in the DRC.

38. This project was handed over to Fometro in 2001; MSF remains on the governing board.

the structural shortcomings of the health system and dealing with emergencies created by political and social factors. It based its work on the following premise: "there are two crises in Congo: the crisis of violence, which overlays the other crisis related to the country's public health structures."[39] As Françoise Wuillaume wrote: "in the Congo, MSF (Belgium) is confronted with a timeless existential question: faced with the enormity of the country and its needs, how can accessibility to its projects best be ensured?"[40]

From the late 1980s onward, questions were asked within the Belgian section about the relevance of its emergency programmes for displaced populations, as its ad hoc actions had no impact on the stubbornly high mortality rates. Having identified the system's structural deficit, it then started to work closely with the Ministry of Health and to provide support to isolated populations by setting up in referral hospitals and some local health centres. This first foray into cooperation focused on distributing medicines and providing in-patient and outpatient hospital care by a mixed team of MSF international personnel and ministry staff.[41]

The withdrawal of international donors from the country in the 1990s and the suspension of international aid served to increase the pace of this new way of working: MSF-Belgium formalised this strategy as the "operational district" concept and extended its operational scope to include a large number of provinces. This extension went hand in hand with a reduction in the intensity of its programmes and an increase in indirect aid to districts: international teams ceased to provide care and restricted themselves to supervision. Cooperation occurred at every level: indirect support for the operation of health centres and hospitals, administrative support for zone and district offices and staff training. In Katanga, MSF-Belgium committed itself to involvement in the Kilwa, Pweto and Kasenga zones, as well as three further zones in the inner suburbs of Lubumbashi, the provincial capital.

Changes in the institutions and general context led to a gradual dilution of the district-based approach: the outbreak of warfare in 1998 forced MSF to respond to new emergencies and to diversify its programmes. The Ministry of Health gradually increased its control over districts managed by MSF by reclaiming its rights to appoint medical staff. Furthermore, the La Mancha process that the MSF movement as a whole committed to encouraged sections to focus their

39. Interview with a manager from the Analysis and Advocacy Unit, MSF-B, January 2010.
40. *Discussion sur les interventions de MSF dans les Zones de Santé du Congo Démocratique – Rapport de visite, 08-28 July 2002*, p. 5.
41. This approach was initially described as a spillover strategy.

activities on providing treatments and medical interventions that centred on patient care.
The more deep-seated desire to "act to drive down mortality rates" in the immediate term was backed by mortality surveys run by the Belgian section from 1999 onwards: mortality rates were higher in areas where there was fighting and it became harder to identify the benefits of the district-based approach. From 2005 onwards, MSF-Belgium altered its initial strategy, turning instead to emergency actions in areas impacted by violence caused by armed groups. District support programmes were progressively wound down.

2.2. CONTINUING EMERGENCY: RELEVANCE AND LIMITATIONS OF MSF-FRANCE ACTIONS IN KATANGA

2.2.1. Chronology of MSF-France operations in Katanga

Chronology
A feature of 2000 was the determination to enter Katanga province and move closer to the frontlines in eastern Congo. Acting on a request in Kinshasa from the Commissariat General for Professional Reintegration (CGR), the DRC's official body for displaced persons, and in the light of its contacts with other international bodies active in the area, MSF-France decided to undertake an exploratory mission in North Katanga.
An initial mission in late December 2000 failed as the national security agency (ANR) cancelled all permits for foreigners to enter Katanga during the holiday period. In mid-January, a second attempt was halted following the assassination of President Kabila on 16 January.
A third exploratory mission was conducted by a doctor and a logistics specialist from MSF-France between 19 May and 9 June 2001. After further discussions with the CGR and international organisations present in Kinshasa (MSF-B, ACF USA, CICR, UNOCHA), MSF decided to immediately open a mission in the Kabalo health zone, as a cholera epidemic had broken out in the zone (Mulimi health area). The exploratory mission thus came to

an abrupt halt before all the towns and villages had been evaluated. From January to June 2001, a series of six reports and missions were used to define MSF-France's position.
Despite the greater vulnerability of the Malemba N'Kulu health zone to attacks by the Mai Mai, the focus was placed on the Kitenge zone, also plagued by militia violence. The aim was to have the programme operational before the November rainy season. However, the number of epidemic crises in the Malemba health zone forced MSF-France to come and go between the two health zones, as no decision had been made to commit extra resources. The development of its activities in Kitenge was delayed, and the intervention was not operational until January 2002. MSF-France's operations were to continue up to 2007, moving from the north of the province toward the south as the seat of the violence moved.

2002-2005

Malemba N'Kulu health zone: MSF-France focused on providing care to people fleeing fighting between the DRC armed forces and the Mai Mai, seeking refuge from the exactions of both sides. The intervention provided outpatient services. The primary activity was fighting epidemics: in all, 6,000 cases of cholera were recorded by the four cholera centres; measles was also a significant problem, with 6,373 cases treated and 53,976 children inoculated.
Kitenge health zone: MSF-France concentrated its activities on providing structural support to the referral health centre at Annuarite in Kitenge, as well as to village health centres at Kaloko and Kiléo. The main activity was outpatient consultations (120,000 consultations in three and a half years). Treatment was also provided for outbreaks of measles, malnutrition, typhoid and TB.

2003-2007

Mukanga health zone: following fighting between the Mai Mai and DRC armed forces, MSF-France offered structural support to the health centres at Mukubu, Mukanga, Kyolo and Kasenga: in all, 110,000 consultations were made and 2,000 malnourished children were cared for. Non-Food Items were distributed to 1,992 families.

2004-2007

Ankoro health zone: in 2002, fighting between the DRC armed forces and the Mai Mai in Ankoro forced MSF-France to intervene. The operation started during the final months of the year, with a mobile clinic set up and treating displaced people. The injured were cared for at the hospital in Ankoro. Faced with an epidemic of measles, vaccinations were administered to 24,761 children; 1,562 infected patients were treated.

Starting in 2004, work on setting up a secondary care project aimed at covering the injured and major complications seen by all projects led to MSF taking over management of the hospital at Ankoro, which was fully rehabilitated. Medical and surgical activities were restarted, and care was progressively offered for specific pathologies (TB, HIV, vesicovaginal fistula, malnutrition). Epidemics of typhoid in Kitanda (237 cases) then cholera (166 cases between December 2005 and March 2006) were also treated.

2006

Nyonga health area, lake Upemba: operations by the DRC armed forces to wipe out armed groups led to major population movements. After rehabilitating several health centres, MSF-France handled 20,937 consultations, 582 hospitalisations and 160 births. Obstetric cases were seen at Kikondja, and surgical cases at Ankoro. Non-Food Items were distributed to 473 families. Considerable anti-epidemic work was also done owing to the high endemicity of vibrio along the river banks.

From January to October 2006, the emergency desk dealt with an outbreak of cholera in the Kikondja health zone. Following the detection of cases of measles in the Nyonga region (Butumba and Mukanga), a care plan was devised to prevent it spreading and reduce its lethalness.[42]

2007

Kabondo Dianda health zone: MSF-France intervened in response

42. For details on the emergencies in Katanga in 2006, see Fabrice Resongles, *Revue critique des urgences 2006*, Paris, MSF, p. 43-46.

to a measles epidemic, with 909 cases treated and 73,641 children inoculated. MSF-France also dealt with a cholera outbreak, treating a total of 636 cases.
MSF-France withdrew from Katanga during the first half of 2007.
2008
In early 2008, MSF-France acted in support of the Belgian section during a cholera outbreak in Likassi, in southern Katanga.
In June 2008, MSF-France was active in Tanganyika district in north-east Katanga, acting on a request from MSF-B and the Congo Emergency Team for it to lead a mass vaccination drive in a number of health zones. MSF-France limited its campaign to a single zone. The campaign got underway two months behind schedule, in September 2008.[43]

The various exploratory missions recommended that an emergency response mechanism be put in place. Their conclusions were only partially in agreement with the initial analyses behind deployment of the missions, but the rapid rise in cholera epidemics and the extreme fragility of displaced people constituted solid reasons for intervening in a province where international assistance had very little impact in comparison to Kivu and Orientale provinces, at least between 2001 and 2006, and particularly North Katanga.
The situation in Katanga is worth examining as it offers an illustration of the gap between reality and the situation typologies applied by most international agencies. Three elements, sometimes converging and sometimes conflicting, shaped the complexity and uniqueness of the MSF-France teams' working environment over the years. The internal conflict between the DRC armed forces and various local militias, latent during the early months, worsened as of 2001. Aside from sporadic outbreaks of extreme violence, teams noted the population's poor general health as a result of failures in the public health system, which had deteriorated since the Mobutu era. Finally, the geographical position of the site created logistical problems that remain vivid in many peoples' minds[44] and served to forge the mission's reputation.

43. For more information about this intervention, see Delphine Chedorge, *Revue critique des urgences 2007-2008*, Paris, MSF, June 2009, p. 40.
44. Everybody interviewed emphasised the scale and difficulties of the logistics efforts required by the North Katanga missions.

The unpredictable bouts of pillaging and violence against civilians, difficulties in reaching the populations concerned, demands from people under care for the provision of "structural" care are all realities that have to be taken onboard when characterising the context. It cannot simply be defined as a zone of exception, a conflict zone within which the legitimacy of MSF-France's interventions cannot be challenged. The reality is that MSF-F was in a process of constant negotiation with itself and its environment, seeking to preserve a space for its interventions at the crossroads of emergency, development and public health provision.

2.2.2. Katanga: halfway between an exceptional and an ordinary situation

Emergency organisations generally take the view that the time to pull out is once warfare has ended. This is often a difficult decision to take, and it usually arises once traditional definitions of a zone of exception no longer apply: population movements decrease, violence abates, the State recovers its prerogatives. Needs and context evolve. Emergency aid organisations, which cite international humanitarian law when intervening during periods of conflict, feel that the post-war situation does not provide their interventions with sufficient operational or legal legitimacy. However, as Rony Brauman points out, "the line between an ordinary and an exceptional situation is not one that can easily be drawn. The end of a conflict does not signal an end to its consequences […]."[45]

The experience in Katanga shows the problematic nature of the notion of "exceptional", the keystone of MSF's operational methods and legitimacy. Before MSF-France entered Katanga, there was fighting in the north of the province, but the conflict that pitted the DRC against Rwanda and its RCD-Goma allies was fairly stable by 2002. Regular exactions against civilians started occurring in 2001; these were the work of militia as well as DRC armed forces. However events such as these were not widespread throughout North Katanga, and they did not appear to be coordinated within this part of the province. Population movement in response to attacks and the actions of the armies did not lead to the creation of major displaced person camps or of any specific social structures: "displaced people living in neighbouring villages are often mixed in with the general population."[46]

45. R. Brauman, *La médecine humanitaire*, Paris, PUF, coll. Que sais-je ?, 2009, p.107.

46. Interview with a former medical manager for the Katanga mission. The 2003 medical report also mentions the following difficulty: "in this zone as elsewhere in North Katanga, the status as a displaced or needy person is fairly common, as a major section of the population has been on the move for a varying length of time", MSF-France, 2003 Medical Activity Report, p.13.

In addition, the war had not destroyed the public health and administrative structure in the area, although they were structurally weakened by a fall-off in funding since the second half of the Mobutu era. Its meagre resources were not the result of a state of exception related to the conflict, but were a historical given. The State had not disappeared during the conflict. Its structures remained in place in the form of localised governance that was restrictive and repressive. An MSF-France mission manager puts it this way: "we never considered acting outside the provincial health structures as the bureaucracy was so stifling."[47] This was a paradoxical form of authority, providing administrative continuity that was only partially in contact with central government, and bereft of any of the resources needed to provide a meaningful public health service: "the situation isn't unique to Katanga. You could apply it to the entire Congo, but it's not so extreme in other countries where we're working. Wherever you go in Congo you'll find health centres open, staffed with public servants and a still-functioning organisation, but with absolutely no drugs available."[48]

Thus, the violence in 2002 was all too real, but did not fit the expected pattern of a state of exception. In the face of sporadic localised violence, as well as the catastrophic health system, MSF-F progressively began to set up actions that suited the realities on the ground, negotiating an operational space at the crossroads of the exceptional and the ordinary.

The first concession to the exceptional situation was that MSF-F treated the public health authorities as a partner of first choice, acting as far as possible to place its actions within the context of the public health structures. This policy, which was not much debated at the time, seems all the more surprising given that the Congolese State was party to the conflict via its armed forces, which were responsible for major exactions committed against the civilian populations in Katanga.

In reality, relations between MSF-F and the public health authorities were far from smooth. They swung between a desire to make a partial break from bureaucratic restrictions in order to deliver optimal assistance, and the need to adapt in order to work with the administrative apparatus that continued to organise health actions in the areas where MSF-F worked. "To be honest, I don't think that we ever thought about setting up a structure outside those operated by the health ministry."[49]

47. Interview with an MSF manager, Paris, January 2010.
48. Interview with an MSF manager, Paris, December 2009.
49. Interview with a former MSF manager for the DRC, January 2010.

This ambiguous relationship led MSF-F into negotiations to preserve its objectives and working space; a space that was forever questioned and readjusted, and maintained at the cost of inconsistencies and concessions that at times ran counter to how MSF-F perceived missions in a conflict zone. Hence, building an autonomous working space to meet ad hoc emergencies, in an exceptional situation, required negotiating, and on occasion making concessions over the usual operating framework. A number of recurring elements illustrate this:

- the policy of consistently offering 100% free care in conflict zones was put under severe strain; MSF eventually conceded in certain zones, such as Kitenge,[50] Mukubu and Ankoro, allowing the maintenance of a cost recovery system limiting access to care.[51] After lengthy negotiations, MSF managed to abolish this system in Kitenge and Ankoro;

- aid practices also had to live side-by-side with public health requirements and protocols established by public health authorities: attitudes to vaccination are a good reflection of these tensions. On a number of occasions, MSF-F decided to set up a policy of systematic vaccination of displaced populations, in accordance with its own health protocols.[52] But this policy ran contrary to that of the provincial public health authorities, which attacked MSF-F for acting outside the health resources plan by limiting vaccination to areas where refugees were living. By making ad hoc adjustments to vaccination rates in limited areas, the MSF-F teams were criticised for upsetting national arrangements. In fact, the risk was that raising vaccination rates in certain zones would lead to the halting of WHO funding for Expanded Immunisation Programmes (EIP).[53] This question is all the more critical as it is often difficult to tell the difference between refugee and local populations. In order to safeguard its working space, MSF-F was on a number of occasions obliged to alter the way it worked to suit choices and directives coming from the public health authorities. In this

50. In Kitenge, the health centre where MSF operated belonged to the diocesan works office, a religious body firmly opposed to free care. Negotiations about cost recovery and wages for the centre's staff spread over several months and hindered activities within the health zone. Interview with a former doctor to the mission, Paris, January 2010.

51. Studies carried out by a field manager in Ankoro, based on questionnaires returned by the local population, show that disappearance of currency meant that even households that were not at all destitute were unable to access care. The 2003 annual medical report notes increased activity at the health centre in Kitenge, once cost recovery had been abandoned.

52. According to MSF's guide to refugee health in emergency situations, immunisation against measles is the second highest priority, immediately after assessing needs and the general situation. Vaccinations can be selective (with prior assessment of individual status) or non-selective (no assessment of individual status). Even where public health authorities are involved in the immunisation programme, MSF recommends non-selective vaccination (cf. Médecins Sans Frontières, *Refugee Health, an approach to emergency situations*, 2008, p. 59).

53. This question was raised in interviews on a number of occasions by actors from MSF (Paris, 2009, 2010).

way, MSF-F obtained permission to vaccinate, but on condition that it expanded its immunisation policy to include all antigens recommended under the terms of the national protocols. During another emergency situation, it could only obtain authorisation to proceed by expanding its vaccination campaign to include zones unaffected by armed groups.[54]

The health resources plan and its ramifications were also the topic of negotiations. MSF-F relied on the existing system's human and structural resources, but it made its investments according to objectives that it defined and pursued alone. These objectives occasionally ran counter to the authority's demands in terms of health coverage. Sometimes an ad hoc intervention by MSF-F occurred outside the established referral system, and its support for certain centres instead of others meant that the health resources plan had to be altered. But it was a strategy that survived thanks to the provision of intermittent aid to structures that were disadvantaged by MSF-F's activities. The organisation offered redress in a range of ways, such as support for national vaccination campaigns and or the construction of buildings for the disadvantaged structures.[55] These negotiations did not always prove sufficient to free MSF-F from the problems of dealing with the province's administrative and health arrangements: setting up a referral mechanism alongside the ordinary mechanism for providing care for medical complications was not welcomed by managers where they felt this would disadvantage their health zones.

ANKORO

MSF's intervention in Ankoro dates back almost to the beginning of the mission to the province. In December 2002, MSF decided to support the referral hospital and a number of health structures in outlying villages over a two-month period.

In 2003, MSF managers decided to take charge of managing Ankoro hospital for the treatment of severe illness and injury. This outlay was justified by the hospital's "ideal" location, "equidistant from the two zones most effected by the violence and accessible from

54. Interview with medial and non-medical managers in the DRC, Paris, January 2010.

55. Interview with a former member of the board of governors (Paris): in 2002, MSF operated at a health centre run by the office of central diocesan works in Kitenge. As a way of recompensing the public sector, which was disadvantaged by this choice, shortly before leaving Kitenge the organisation financed construction of buildings to be used in the creation of a public referral health centre.

the RCD zone."[56] The objectives were ambitious: the hospital was to be totally rehabilitated (electricity, roof, water supply, equipment, etc), with MSF assisting with administration, staff training and setting up a system for charging a flat rate for healthcare. The project had twin goals: to provide local care to the people of Ankoro, and to act as a referral hospital for medical-surgical emergencies from neighbouring health zones.

The results were mixed by the time the programme closed in 2007. The hospital had kick-started quality and accessible primary care, but it was not possible to systematically achieve the goal of making it a referral structure for secondary care. Logistical difficulties coupled with administrative reticence prevented the referrals system from succeeding.

In a context of neither war nor peace, but of chronic violence against civilians, the Ankoro was an operational choice, signifying MSF's desire to develop and strengthen secondary care in a context where such a choice was neither usual or easy.

The project at the Ankoro hospital is very revealing in that it illustrates MSF's difficulties in reaching agreements with the numerous different local authorities, both medical and governmental, whose approval it needed: these are not one-off negotiations, but an on-going dialogue that has to be permanently nurtured. Intended as the secondary care referral structure for all zones surrounding Ankoro, the hospital never truly fulfilled this mission owing to logistical difficulties of accessing it, patient reluctance to be transferred when required to travel along unmade roads, and a lack of enthusiasm by Head doctors to refer patients to a location outside the area they administered. MSF-F's presence in a given area represented a coveted financial and symbolic resource. Its action upset political and social balances and created jealousy between administrations, which rebounded on the organisation's activities.[57]

56. MSF project files, 2003, p. 5. Part of North Katanga was under the control of the government appointed by the RCD-Goma; the other part, where MSF-F operated, answered to the Kinshasa government. As Ankoro lies on the river that served as a demarcation line, the hospital was accessible to people from both sides.
57. Interview with MSF managers formerly in charge of the DRC, Paris, January 2010.

2.2.3. An emergency after all?

It is generally difficult to decide exactly where the line lies between exceptional situations and ordinary situations, and this applies equally to the situation in North Katanga. MSF dealt with the exceptional and the ordinary in parallel, emergencies relating to armed conflict, destruction, exactions and the chronic inadequacies of the health system. This situation generated two types of difficulty for the teams in the field:

- the reinvigorated structures and new prospects made possible by MSF-F's interventions in the health system led to a rapid upsurge in activity at health centres where MSF-F treated both refugee and local populations alike. The high incidence of infectious pathologies required that the associated comorbidities also be treated, enlarging the scope of the medical care offered. TB treatments are a good illustration of the difficulties encountered: medical actors in the field want to respond as the numbers of cases rise. But the nature of the treatment, the major risk of resistance if treatments are not followed, led some managers to follow WHO recommendations and national protocols, refusing to enlarge the scope of intervention. Attitudes to TB, which was not at the time a reason for emergency intervention by MSF-F, varied amongst practitioners, but this did not stop treatment being offered at Kitenge and other projects, such as Ankoro;
- in operational terms, emergency response requires a complex mechanism to be put in place. Emergencies arose when villages were attacked then subject to endless exactions, all within zones that were themselves enclaves; MSF-F was therefore required to commit considerable mobile logistics resources. At the same time, the weakness of the health system justified the considerable sums that MSF-F committed to the referral structures it managed. This twin-track approach cost a lot of money and led to questions being asked within the organisation about the direction of its action and objectives. Dealing with emergencies is a process that "requires considerable resources but all too often only involves reaching small pockets of the population, sometimes several days after the crisis has ended."[58] Some field workers found these situations frustrating: "we go in and support the population, we help them through the crisis period until the time comes when they are able to resume the same miserable lives that they had before being displaced. I feel it's like we say to them, well, you're in the shit, and when the shit rises above your head, we'll help you

58. Interview with a former field manager, Paris, January 2010. During the course of 2004, MSF-F attempted to reach displaced populations in the Ankoro health zone. Logistical obstacles meant that MSF-F only reached them once the situation had stabilised. The intended NFI distribution then became utterly pointless.

breath. When you manage to get you head above the surface we'll leave... but you'll still be in the shit! That sums up the chronic emergencies of the situation in Katanga!"[59] These ad hoc responses contrasted with the major workload going on in the health centres. They were meeting fast-growing demands for treatment, yet this local healthcare mission brought into focus the competing antagonisms. Secondary for some, "chronic emergency"[60] for others, the mission was felt to be legitimate only because the violence, and hence the emergencies, persisted. The emergency situation explains the stopping and starting of medical support at health centres. However, the notion of emergency is not easy to grasp, different interpretations and uses of it are possible, and it can therefore justify various operational choices; how to decide between them when faced with a situation where armed violence could break out at any moment, dissipate, then settle in a particular area without directly impacting the neighbouring areas, but leading to a movement of refugees into them, for instance, into the urban centres at Ankoro, Kitenge and Malemba N'kulu? And then there were new outbreaks of violence, new emergencies, and the same process began again, and again responses had to be found.

The unstable nature of the line between an exceptional situation and an ordinary one makes taking decisions more complicated, particularly the decision to close a programme. On a number of occasions, plans to pull out were postponed because of the reappearance of sporadic fighting and the reservations expressed by teams in the field. For instance, the proposed closure of the Kitenge centre in 2004 was hotly disputed: the on-site team felt that the increase in activity since 2003, the local population's precarious health situation and the agreement, after long negotiations, to provide free care all justified maintaining the medical activities and opposing the position of the operational managers in Paris. "The announcement of the closure of the Kitenge centre went down badly with the field teams. They accused us of being out of touch with reality, of having an overly-theoretical conception of what constituted an emergency, one that they did not share. They felt the Kitenge emergency to be on going. I was called a murderer."[61] Head office felt that the priority at the time was to concentrate operations on areas where the populace was directly impacted by attacks from armed groups and soldiers.

59. Internal MSF correspondence between managers, MSF, 2005.
60. 2003 Medical Report.
61. Interview with a medical manager at the time, Paris, January 2010.

2.2.4. How MSF-Belgium managed the ordinary and the exceptional: the case of the Mitwaba project

Starting in 2005, MSF-B recentred its activities on conflict zones, giving rise to new emergency response programmes. Following the upsurge in violence in the Mitwaba health zone (North Katanga) in 2004, MSF-B decided to open a care programme for refugees, returnees and residents. The project consisted of "making contact with isolated groups thanks to a significant mobile and referral capability" through use of "integrated action if necessary."[62] Drawing on the lessons of the district-based approach and its limitations during the early years of the conflict, the Belgian section was worried to see its programmes being extended and gradually meeting ordinary health needs.

With this in mind, it attempted to define intervention objectives that could be measured by a set of indicators. The special attention paid to the criteria for entering and leaving the programme can be explained "by the fact that the health situation in the country is generally poor, and that it is therefore hard to distinguish between structural problems at the origin of the worrying indicators for healthcare, and an exceptional situation that increases the vulnerability of a given population."[63] In order to justify its decision to pull out, MSF-B turned to evaluation tools that tracked the evolving context. The mechanism consisted of "analysing the persistence of the consequences of displacement on the people receiving assistance". It also distinguished between populations: the resident population was aided for so long as it suffered the consequences of the presence of refugees; aid to returnees continued "for so long as the population has not regained its autonomy, i.e. for so long as it remains dependent on WFP aid". Officially, the MSF-B project was to provide medical and healthcare assistance to displaced people and the local population in the Mitwaba health zones via "a minimum surgical and obstetric capacity."[64] MSF-B made efforts to break with the mindset of its previous action: "we will make every effort to act outside the health resources plan and only intervene to meet specific needs. However, it is hard to change professional habits. This is not helped by MSF-B's traditional relationship with the Congolese authorities."[65]

MSF-B's worries lay partly in the context in Katanga, and partly in the section's history in the DRC. Beyond the goals set out in writing, there existed operational practices that tended to hybridise the Mitwaba project's objectives: it was

62. MSF-Belgium, Mitwaba project document, November 2006.
63. MSF-Belgium, Mitwaba project document, November 2006.
64. Interview with a former desk manager, Brussels, January 2010.
65. Interview with a former desk manager, Brussels, January 2010.

hard for the teams to restrict their actions to just the target populations, and the section continued to ponder the issue of access to care. Such attitudes and habits blurred the programme objectives.

The project to disengage from Mitwaba was evidence of these conflicting currents. In the face of a situation characterised by the great distress and vulnerability of the population, the disengagement strategy again referred to context indicators to justify the departure: "now that the rebels have been disarmed and the zone stabilised, and in the absence of WFP food distribution during the months of June and July, displaced populations have started to return to their villages and their numbers have fallen sharply."[66]

Furthermore, the disengagement project involved handing over several centres to the health zone authorities: identification of the human resources needed for the zone to function, appointing MSF staff and the construction of a maternity building were all part of the exit strategy agenda[67].

The historical ambivalence of MSF-B's position in the DRC led the organisation to seek the optimal operational compromise. Ever since its establishment in the former Zaire, and acting on the basis of mortality studies, the Belgian section had been seeking a healthcare model and was looking for an operational strategy that would have the greatest impact on the population's health.

As part of its search for a new healthcare model, in 2007 MSF-B decided to invest in a referral hospital within a so-called post-conflict zone, but one with high mortality rates, where the populations suffered from limited medical provision, which many could not access because they were unable to pay.

MSF-B's objective in fitting out a hospital with the technical equipment to provide a variety of basic services was to quickly reduce mortality and morbidity rates, then build an efficient primary care and referral system, and finally set up a viable funding system so that it might be possible to hand the facility over to the Congolese authorities. A combination of two differing, even contradictory, strategies, the hospital at Lubutu was classed as an experimental project that might be adopted more widely if it succeeded, a model for specific post-conflict intervention.[68]

66. Dr Gbané, proposal to disengage from the Mitwaba project, MSF-Belgium.
67. Dr Gbané, proposal to disengage from the Mitwaba project, MSF-Belgium.
68. MSF-Belgium, Lubutu project document, pp.1-3, 2009.

2.3. PREPARING FOR DEPARTURE

It is never easy to close a mission. It is harder still when the crisis persists and the lines that divide an ordinary situation from an exceptional one are regularly discussed, re-evaluated and redrawn.

This uncertainty, and the fear of being trapped in a situation where providing assistance would no longer meet MSF's principles for taking action, led managers to study changes in the environment to try to determine whether or not they felt these changes justified continuing operations. In the case of Katanga, the notion of conflict was the essential factor. It explained the organisation's arrival in the province, and justified opening up a humanitarian working space that the organisation altered as it refined its ideas about the context for its intervention.

However, analysis of the missions in Katanga raises the question of whether the conflicts were the sole motivation for withdrawing or maintaining missions. MSF-F's working space has never been a given. It is the fruit of constant negotiation within multiple parameters, among which variations in the intensity and mobility of fighting are not always decisive.

Various factors and institutional interests played a part in the decision to withdraw. This was the justification for quitting the province offered by MSF-F in July 2007: "the context showed signs of stabilising and there was a marked downturn in violence, so we decided to reposition ourselves starting in 2006: either we changed the objectives for our work, or we transferred operations and provided support to teams working in zones where the violence remained very high. We took our decision. The presence of other MSF sections in Katanga as well as budgetary and operational considerations all pointed to the need to strengthen and expand the programmes we were running in Kivu."[69]

The withdrawal from Katanga was often felt by actors within the organisation to be the immediate consequence of the progressive return to normal of the context in the province. However, the fact remains that other parameters were involved in making the decision: the presence of several MSF sections in Katanga, the influence of its budgetary position, and the logistical and operational constraints under which the Congolese missions operated. The decision to pull out was less the fruit of any one event than it was the result of a slowly matur-

69. Interview with an MSF-F operations manager, Paris, December 2009.

ing process. The questions that appeared gradually in the reports illustrated people's doubts as to the legitimacy of the programmes in Katanga.
The organisation's use in internal documents of certain terms rather than others makes it possible to track the growing attraction of a withdrawal over all other options.
The notion of post-conflict, referred to in the early reports made by the exploratory missions,[70] disappeared in step with MSF-F's decision to enter Katanga to offer emergency health care in response to the violence of the armed groups.[71]
The interviews reveal a more nuanced reality: the descriptions of the context varied as a function of the moment and location. The term post-conflict crops up orally on a number of occasions when describing the environment that teams were working in. It is a term subverted, however, by the institutional texts: the 2006 country data sheet refers to Ankoro and Mukubu as "zones of violence"[72] with a population in need of medical care; previously they were termed "terrains of conflict". From 2007 on, the presence of MSF-F in these two health zones was motivated by the necessity of providing care to "indirect victims of the conflict."[73] As the decision to withdraw began to gather speed within the internal debates, so the term post-conflict made a reappearance in the texts: the 2007 Mukubu project sheet shows teams wondering whether "they are not overly wedded to an operational pattern of providing assistance to victims of conflict in a situation of post-conflict"[74]. On this occasion, the presence of MSF-F is explained by the "fragility of the health situation of returning populations" and the "nascent post-conflict situation" which "offers an uncertain period of reconciliation."[75]

***

Were the notions of conflict and post-conflict genuinely of any assistance in understanding the context in Katanga? They served in fact more as political labels that were used as justifications for operational decisions: labelling a situation as "conflict" legitimises the commencement and pursuit of medical assistance, but from the moment that such a label becomes uncertain, operations underway start to be called into question, and their interruption may be debated

70. MSF, exploratory missions summary report.
71. Refer to the various annual plans.
72. MSF, DRC 2006 country sheet, p. 2.
73. MSF, DRC 2007 country sheet, p. 3.
74. MSF, internal document, Mukubu objectives 2007, p. 4.
75. MSF, internal document, Mukubu objectives 2007, p. 5.

or decided by the operational centre, resulting in tensions between operational managers and actors in the field. In the case of North Katanga, on a number of occasions differences of opinion arose concerning MSF's actions and the way that it used its resources. We have attempted to describe a few of these moments when the two mindsets clashed: the mandate versus the need. These opposing currents become evident when, for example, actors in the field judged that the decision to withdraw made by the operational centre was inappropriate, because the needs on the ground justified continuing medical assistance. They therefore opposed the mandate-driven approach: the mandate refers to a scale of values made explicit in the institutional messages; it concerns prioritising "medical assistance to populations whose living conditions are in a critical state as the result of conflict". It is this type of situation where the organisation's action is the most legitimate, the least open to criticism. The more that the situation diverges from this definition, the more that the actions undertaken come in for criticism by those who favour the mandate-based approach, and it is at these times that regular disagreements between the two different approaches arise. However, our study also shows that this situation of opposing viewpoints does not always result in clear-cut decisions. It is not, in fact, incompatible with simultaneously maintaining emergency operations in response to violence committed by armed groups, as well as providing support to hospitals and health centres, support that endures beyond spikes in violence against civilians. Everybody agrees that there is a difference between post-conflict and conflict, but the decision of where to draw the line fluctuates, unless a stable definition can be proposed (and imposed?), something that was a regular source of internal divisions from 2001 to 2006 in North Katanga.

Chapter II
MSF sections and the Reconstruction agenda in post-Taylor Liberia (2003-2008)

Jean-Hervé Jézéquel, Paris, MSF-Crash

The passage from a time of war to post-conflict raises the question of the changing face of the aid mechanisms set up by MSF and the attitudes that lend legitimacy to its operations. Times of war, often thought of as being the core activity of MSF teams, are also times of certainty and clarity: war is viewed as being the most legitimate cause for intervention by MSF. Once war ceases, the certainty evaporates: as combat comes to a halt, so does the initial motivation for the deployment of MSF teams: to provide assistance to populations who find themselves victims of a conflict.

How do different MSF sections navigate the shift from war to post-war? How can they best (re)define programmes and choose beneficiaries in contexts where the primary driver for deployment has disappeared? How, and for what reasons, can they make the choice whether to stay or go? How do MSF sections adapt to a new environment characterised by the deployment of a more concerted and, more importantly, a more ambitious aid effort? This case study looks at Liberia and attempts to answer these questions by tracking the way that the various MSF sections adapted to the challenges of the post-war context over the five-year period following the cessation of hostilities.[76]

In the Liberian case, these reconfigurations occurred primarily against a background of profound changes in the external environment, and a working space progressively saturated by other actors and viewpoints tied in with Reconstruction, an imperative that weighed more and more heavily on intervention possibilities. The way in which the MSF sections reacted to this environment

76. Liberia was chosen for several reasons: we wanted to look at a country where the end of war was very clear to all actors, not a hybrid situation between war and peace. Liberia is also a country were MSF's presence has been both widespread and relatively lengthy; we wanted to examine the influence, or lack of it, of MSF's presence and history in the country on the reconfiguration of its post-war operations; finally, the author's familiarity with the Liberian context also played a part in determining which country to study.

and its specific restrictions depended on a series of dynamics specific to each section. Different sections interpreted the post-conflict notion in different ways that reflected their own history and perception of MSF's mandate and missions, but were also influenced by more short-term factors: important subjects at the time, such as surgical provision and programmes for victims of sexual violence, balances of power at head office, etc.

After setting out the elements essential to an understanding of the Liberian context (and noting the extent to which it represented a testing ground for managing post-conflict situations), we will then describe and compare the operational choices made by the three MSF sections in Liberia (MSF France, MSF Belgium and MSF Switzerland). Whilst underlining the differences between the choices made, we will show that the reconfiguration of each section's operations was the upshot of a fairly consensual and shared vision of the challenges of post-conflict Liberia: each section questioned what its role in the reconstruction of the country could be, even though each in turn came up with a different answer. This attitude, which reduces the post-conflict notion to the challenges of transition and reconstruction, was greatly influenced by the interpretations produced by actors involved in post-conflict management. In the final section, we suggest that a more critical position vis-à-vis this mindset and a more politically-focused analysis of the post-conflict context could radically alter the way that MSF sections perceive the humanitarian challenges of post-Taylor Liberia.

1. THE LIBERIAN CONTEXT: THE END OF WAR AND INTERNATIONAL POST-CONFLICT MANAGEMENT

1.1. A SHORT HISTORY OF THE POST-CONFLICT PHASE

War erupted in Liberia in December 1989 when a small group of armed men under Charles Taylor seized several towns in Nimba, in the north of the country. The country was no stranger to armed conflict; the 1980s had already witnessed their share of fighting, including the rice riots and police violence in Monrovia in 1979, Samuel Doe's bloody 1980 coup, and the widespread repression in Nimba after Thomas Quiwonkpa's failed coup in 1985. A longer study of the country's policing practices would reveal the preponderance of forms of phys-

ical violence during "times of peace."[77] Nonetheless, 1989 did mark a step change in terms of levels of mass violence: with the rapid multiplication of rebel movements and self-defence groups, Liberia sank into civil war (Ellis, 1999). Liberia came to symbolise the failed, or shadow, State that began to emerge in Africa during the 1990s.[78] Despite criticism of the notion of the failed State by some academics (Bayart, Ellis, Reno), it was an idea that took root during the years 1990-2000, in particular within networks linked to the "new liberal interventionism" (to adopt a phrase used by R. Banégas and R. Marchal in *Politique africaine*, issue 98, 2005). During the 2000s, it eased the path, and provided legitimacy for, intervention by the international community as it got involved in reconstructing failed States in the name of a durable peace.

It is interesting to note the extent to which humanitarian aid was mobilised as part of this international management of the war. During the final three years of the conflict (2001-2003), humanitarian aid became party first to the containment then, following September 2001, the eviction of the Taylor regime. It was an era that also saw the failed State notion steadily replaced by that of the rogue State (Jézéquel, in Weissman, *A l'ombre des guerres justes* [In the Shadow of Just Wars], 2003): the Taylor regime was frequently described as the primary motor for violence in the sub-region, accused of ties to terrorist networks via so-called blood diamonds. Rogue State was more than just a label, like Failed State. It was a description that both announced and justified a process of financial disengagement of the international community from Liberia. For there could no longer be any question of making resources available to a State that diverted them in order to wage war or to finance international terrorists and criminal networks. There was therefore a sharp fall-off in humanitarian aid coming into the country as of the early 2000s (with a parallel increase in resources allocated to neighbouring Sierra Leone and Guinea). To this cutback was added a UN embargo on trade in arms and the country's main resources (wood and diamonds). From

77. Certain forms of torture used by militia during the war explicitly mimicked abuses employed by the Liberian Frontier Force during peacetime to collect taxes and duty (Interview with a Liberian ACF employee, Kolahun, January 2007).

78. The idea of a shadow State was popularised by William Reno (*Warlord Politics and African States,* 1998), who applied it to Sierra Leone and Liberia (as well as Congo, Somalia and Nigeria). There is, in fact, a disparity between Reno's concept of the shadow State and the superficial way the term it is used by the press, NGOs and other experts. These groups feel that a shadow State denotes a situation where the State has collapsed, leaving a few official trappings but with nothing to back them up, mere empty shells (see for instance J. P. Pham, *Liberia. Portrait of a Failed State*, 2004). Reno, on the other hand, felt that a shadow State represented a new system of patronage that emerged in a number of African countries with the end of the Cold War. The governing elites encouraged the growth of informal markets to offset the decline in central authority. The State, far from disappearing, was regrouping in a privatised form that generally embraced illegal activities and organized crime.

the late 1990s until the fall of the Taylor regime, MSF teams were working in a context where the UN was providing the bare minimum and other international NGOs, cut off from funds, were very thin on the ground.

The context for the intervention was by no means easy (security for the teams, militia instrumentalisation of aid) but it was very rewarding (venturing where others did not go, a sense of filling a true medical need). Aside from the safety aspects, the restrictions on MSF's operations were relatively few: within a humanitarian space left empty by many actors, MSF was fairly free to undertake its operations as it saw fit. Negotiations with the Liberian authorities, especially representatives from the health ministry, were not necessarily straightforward, but MSF was seen as a trusted partner and it maintained regular contact with top health officials.[79]

The situation was reversed after 2003: the return of a large-scale UN and donor presence, with an impressive number of NGOs following in their wake, profoundly altered the context of the intervention. At the political level, the institutional and official expression of the Liberian government progressively superseded the former shadow State (in the sense meant by Reno). It became harder to stand out in a space now crawling with white 4x4s. It became problematic to independently decide on a policy within a space now featuring several coordination structures, and where new framework planning policies were regularly published[80].

1.2. POST-TAYLOR LIBERIA: AN INTERNATIONAL TESTING ROUND FOR STATE RECONSTRUCTION POLICIES

August 2003 was the tipping point when the conflict entered its final phase: with the arrival of the first contingent of Nigerian ECOMIL forces,[81] Charles Taylor handed power over to Vice-president Moses Blah and left to go into exile in Nigeria. The temporary ceasefire was followed on 18 August by a peace agreement signed in Ghana between the various armed factions. They agreed to form an interim government led by Gyude Bryant, a Liberian businessman acceptable to the various armed groups and the international community. On 19 Septem-

79. To the extent that, at times, MSF had a reputation for supporting the Taylor regime.

80. The idea of planning and coordinating interventions did not completely disappear during the war, but this type of approach increased massively following the fall of Taylor.

81. As the armed wing of ECOWAS (Economic Community of West African States), west African troops serving under the ECOMIL banner were deployed to Monrovia immediately after Taylor went into exile in August 2003. Some of these troops were later incorporated in the UN peace-keeping mission (UNMIL), which took over in October 2003.

ber, the UN Security Council decided on the creation of a UN mission for Liberia (UNMIL), which would eventually number up to 15,000 soldiers (at the time it was the largest ever UN peace-keeping mission, for a country with a population of just 3.5 million). Elections were scheduled for October 2005. In the meantime, the country was to be run by the National Transitional Government of Liberia (NTGL) under Gyude Bryant and with the support of (or, according to some, under the control of) the international community.

Unobtrusive under Taylor, international institutions poured into Liberia as of the second half of 2003. The institutions wanted to cooperate with the interim government to help address the wounds left by a long civil conflict as well as, in the short term, deal with the consequences of the past few months of fighting, which had been particularly hard on the Liberian people. The reputation for corruption that the transition government soon earned served to curb the desire to cooperate with the Liberian authorities, until the election of Ellen Johnson-Sirleaf in late 2005.

Immediate post-war humanitarian challenges (2003-2004)

There were three major sets of problems that faced aid professionals in the post-war situation: the amount of destruction, the situation of the displaced and refugees, and the particular problem of Monrovia.

During the final phase of the Liberian civil war (1999-2003), entire regions of Liberia remained beyond the reach of international aid for months if not years. This was particularly true of Lofa, a region lying on the border with Guinea and Sierra Leone in the north west of the country, where no organisation had been able to do any meaningful work since fighting flared up again in late 1999/early 2000. Witnesses and specialists both stress the high levels of destruction experienced during these final months of the conflict. According to Danny Hoffman, a specialist on armed groups in the Mano River, the final offensives undertaken by Liberians United for Reconciliation and Democracy (LURD) between 2001 and 2003 were characterised by a scorched earth policy not before seen in the Liberian conflict. It was a strategy directly rooted in combatants' perceptions of the aid system: the greater the destruction and atrocities, the more the aid would flow and the fighters

would be able to reap its benefits once the fighting came to an end. Hoffman also draws a direct link between warfare strategies, humanitarian aid and post-war dynamics. It was almost as if the armed groups themselves had taken on board the ERD continuum (Emergency/Rehabilitation/Development). Whatever the merits of Hoffman's analysis,[82] areas most-affected by LURD (Lofa and, to a lesser degree, northern Nimba) were soon to be the places that received the most assistance.

Post-Taylor Liberia was also beset by the problem of populations in flight. The UN estimated that when the war ended almost 500,000 Liberians were internally displaced (mainly in the camps at Bong, in the centre of the country, and around Monrovia) and a further 340,000 were refugees in neighbouring countries of the sub-region (primarily Guinea, Ivory Coast, Sierra Leone and Ghana). A total of almost one Liberian in every four had to move because of the conflict. As soon as the fighting came to end, the question arose of their repatriation or resettlement in their home regions.

Finally, there is the special case of Monrovia. During the first months of hostilities, a mass of displaced people flooded into the city fleeing the advancing fighting. In addition to the problem of refugees living in a belt of camps surrounding the city was the issue of the squatters who crammed into every 'available' building in town. It was impossible to count Monrovia's population (unlike the camp-dwellers). So, guesses were made: there were an estimated 1 to 1.5 million people living in Greater Monrovia (the city and its outlying regions), i.e. almost one Liberian in 3.

The 2005 presidential elections were won by the international community's preferred candidate, Ellen Johnson-Sirleaf, a Harvard-educated economist and former UNDP official. The government she installed in 2006 comprised politicians and technocrats, many of whom had experience of the US or international

82. In my opinion, Hoffman's analysis underestimates the diversity of the dynamics the rebels had to deal with. For example, it's clear that LURD commanders in Monrovia attempted to restrain the troops—with limited success—in order to limit the amount of pillage and destruction that occurred. They were trying to give the LURD a respectable image—tolerable might be a better word—and to avoid the international intervention that Taylor was calling for to bolster his chances of retaining power.

bodies. Johnson-Sirleaf removed the former militia members who had been a feature of the transition government.

Liberia became a vast experiment, where the UN, World Bank and major donors (ECHO, USAID) tested out techniques for State reconstruction. US and European technical advisors, some of them only recently graduated, came to "assist" the various ministries. Not just the institutions, but the whole political, economic and social order needed rebuilding, as they were thought to have been totally "destructured" after thirteen years of fighting. An agenda on this scale required setting up systems for coordinating the aid actors amongst themselves, and with the Liberian authorities. The two main post-war priorities of the time were the disarmament and reintegration of former fighters (and more generally the restructuring of the security forces, the number one priority for government and international actors alike), and the return of refugees and displaced populations to their home regions.

It is helpful to take a longer view of the focus on political re-engineering in post-Taylor Liberia. Mark Duffield has shown how much the 1990s served to crystallise problems of war and security in a development context (Duffield 2007). This issue was clearly relevant to Liberia, where the Taylor regime was not only accused of fomenting regional unrest (Guinea, Sierra Leone, Ivory Coast) but of using blood diamonds to help finance terrorist networks. The aim of Liberian reconstruction policies was to do away with this two-pronged regional and global threat. It is instructive to note how the messages coming from the new Liberian regime dovetailed into this security dimension. During her first trips as president, Johnson-Sirleaf discussed a political vision that she referred to as the New Liberia, a country built upon new foundations and making a clean break from the old divisions between natives and descendants of the African-American colonisers. One of the central components of her message was security, which Johnson-Sirleaf stated would be her topmost priority: security was what the country needed above all. Today, we might legitimately wonder whether Johnson-Sirleaf was expressing the wishes of the Liberian people—or of the international community.

However, it would be a mistake to overestimate the coherence of this "international testing ground". A number of mechanisms were put in place with agendas that were more competing than complementary. Starting in 2005, the UN experimented with reforms to the clusters[83] that supported its integrated

83. "*The cluster approach was introduced as part of humanitarian reform in 2005. It seeks to make humanitarian assistance more effective by introducing a system of sectoral coordination with designated lead organizations.*" (IASC Cluster Approach Evaluation, April 2010).

missions[84]—which in the Liberian case were placed under the military command of UNMIL. Working in this way caused some tensions with the NGO community as well as civilian branches of the UN, as is evidenced by the eviction of the OCHA.[85] The World Bank and the main donors set up specific forums within which they developed their own visions of reconstruction, and which they encouraged the NGOs to join.

1.3. RECONSTRUCTION: AN OMNIPRESENT ISSUE

The post-war period saw the convergence of a number of viewpoints, all seeking to stress the legitimacy of international involvement in Liberia: the necessity of rebuilding a failed State, the ERD continuum and the establishment of a proper bureaucratic aid system within the framework of the cluster reforms, and the New Liberia. The mechanisms that then emerged changed the working conditions for humanitarian actors, especially those that had been operating in Liberia before the new arrivals. Some aid operations were ruled out once it became clear that they did not fit with the main donors' political priorities: NGOs were unable to find funds if their projects did not sit within the political orientations or zones defined as being priorities (underserved counties, i.e. the rural interior). For example, it was hard to find funds for providing nutritional support in urban areas, whereas these were available for work in the countryside. However, studies conducted by Action Against Hunger on a number of occasions pointed to child malnutrition being more problematic in areas of Monrovia than in the interior. Furthermore, rightly or wrongly, messages concerning the need to coordinate aid were perceived as being attempts to force NGOs to accept an agenda driven by State actors and international institutions (UN and/or financial). NGOs like MSF, which took the decision to remain on the margins of the coordination process (adopting observer status at most) and which,

84. "*An Integrated Mission is an instrument with which the UN seeks to help countries in the transition from war to lasting peace, or to address a similarly complex situation that requires a system-wide UN response, through subsuming actors and approaches within an overall political-strategic crisis management framework.*" (Report on Integrated Missions, UN ECHA Core Group, May 2005).

85. Within the framework of an integrated mission, the role of coordinating humanitarian assistance filled by UNMIL (Humanitarian Coordination Section-HCS) provoked endless tensions with the OCHA mission in Liberia. The OCHA is a UN agency that is generally put in charge of coordinating humanitarian efforts. In Liberia, it was deprived of its main *raison d'être* and forced to leave the country in November 2004. Many NGOs expressed disappointment when it left, taking the view that it robbed the country of an "independent" coordination body. A number of subsequent OCHA reports were critical of the lack of experience in coordination of the HCS staff, blaming them for a number of failures in operations to resettle refugees and displaced persons (for example: OCHA Follow-up Mission to Liberia, May 2005).

depending on the particular section, had objectives that differed to varying degrees from those of the reconstruction process, were nonetheless unable to fully escape these pressures. Teams were confronted by the omnipresent emphasis on reconstruction and by intrusive arrangements that, although far from all embracing, did nonetheless tend to reduce the freedom of manoeuvre available to humanitarian actors. These arrangements were not necessarily new, and similar arrangements applied in time of war, but they seemed to be harder to resist or avoid in a post-war environment. They appeared more coherent and entrenched in a post-conflict climate, strengthened by the reinvigorated legitimacy of a peacetime State and its shared conviction of the importance of reconstruction.

2. MSF'S OPERATIONAL PRACTICES IN LIBERIA (2003-2008)

The following pages are devoted to describing operations run by three MSF sections (France, Belgium and Switzerland) in Liberia between 2003 and 2008. We also distinguish between the periods before and after the election of Ellen Johnson-Sirleaf.

2.1. WAR IS OVER–BUT THE FIGHTING GOES ON (2003-2005)

In Liberia, the immediate post-war period was at first thought of as a time of instability, neither peace nor war. The 2003-2004 period was indeed a time of deep political uncertainty: how troublesome would Charles Taylor prove to be from his Nigerian exile? Would the leaders of the former rebel groups play the peace and reconciliation game? Would they prove strong enough to contain the frustrations of their former fighters?

On the one hand, the genuine political advances were cause for optimism: former fighters were turning in their weapons and refugees and displaced people were returning, notwithstanding a few local incidents and delays. On the other hand, the regular outbreaks of violence encouraged actors operating in Liberia to be cautious (attack on the UN office in Gbarngba in 2004, violent demonstrations at the Liberia University campus and the main markets in Monrovia, an upsurge in urban crime, etc.). It is important to remember this uncertain atmosphere when judging MSF's operations at the time: it is only in retrospect that 2003

came to herald the start of the post-conflict phase. Only looking back is it clear that the war was over, and actors at the time did not have the benefit of hindsight. This is all the more true when you consider that Liberia had already lived through a failed post-war period: after the peace agreements were signed and Charles Taylor elected president in 1997, the country was officially declared to be in a state of "post-conflict". Two years later, in late 1999, war broke out again in the north of the country, forcing tens of thousands to flee homes they had only recently returned to.

The post-war phase was initially approached by the MSF sections with analysis mechanisms similar to those that prevailed during the conflict. Indeed, at first the various sections developed operations that were fairly similar to each other: a presence in Monrovia working in primary and secondary care structures, and activities in the interior in zones where fighting had occurred or that were still in the hands of factions that had yet to disarm.

This way of thinking was a hangover from the war, and its influence was felt strongly during the first post-conflict years in the way that the MSF sections dealt with their relations with the UN and donors. The question of independence from the UNMIL military force was also a concern shared by all the sections; it was an issue particularly relevant to deployments beyond Monrovia. The prospect of a possible renewed outbreak of fighting caused MSF to keep its distance from UNMIL, to the extent that, like the French section in Lofa, it refused to make use of its medical evacuation capacities. The teams were concerned not to be thought of as connected to the international forces, which would compromise their access on the ground were fighting to break out again.

In more general terms, the MSF sections stayed away from, or at the margins of, the coordination forums set up by/for aid actors (they joined most often in the role of observers, a position that they would fight to retain in the coming years, especially during the cluster reform process). In May 2006, the mission heads of the various MSF sections present in Liberia signed a joint declaration stating that MSF would not join any clusters,[86] but that it would seek observer status.

Yet whilst aid to Liberia tripled year-on-year (from US$14 million in 2002, to US$50 million in 2003, to US$147 million in 2004),[87] the three MSF sections examined here accepted ECHO funding that comprised a far from negligible portion of their budgets (40% of the MSF-B project to support primary care

86. On the subject of clusters, see footnote 83.
87. Sources: reliefweb.org.

structures in Monrovia in 2006, up to 2/3 for Benson Hospital). The part played by European funding in the overall mission budgets was debated internally, especially within the French section.[88] Some feared that MSF would be instrumentalised to push the European agency's political agenda. Ironically though, our interviews with ECHO managers suggest that the opposite applied; a number of incoming ECHO managers were former MSF-B staffers. Indeed, ECHO's emphasis on secondary care in Liberia differed from the European agency's usual approach.[89] Opinions on this are divided, but some claim to identify in ECHO's priorities the influence of operational choices made by MSF, which was heavily involved with Monrovia's hospitals.

2.1.1. MSF-France: "A wise man in times of peace prepares for war"

The French section had a presence in Liberia from 1990. With the exception of a few days during the summer of 2003 when it was evacuated, it had provided a more or less continuous presence in Monrovia, even during periods of fighting. The head office coordination team had many years experience of the country, which had already know successive phases of calm and violence (especially the two years of "peace" that followed Taylor's 1997 election).

In 2003-2004, the coordination team felt that the peace was fragile and the risks of renewed violence all too real: "We didn't know what was going to happen, but our political analysis tended to indicate that a renewed outbreak of fighting in the sub-region was possible"[90]. Of the three projects that the section was managing post-2003, two were new openings (Mamba Point Hospital and the Lofa project) set up in anticipation of the possibility of renewed fighting. Only the Lofa project was the continuation of a previous action (the Bong displaced persons camp). Within a context explicitly referred to as "artificial peace,[91] specific post-conflict problems had yet to arise.

Openings: the Mamba Point Hospital (MPH) and Lofa projects

The opening of the MPH project, a private 140-bed[92] hospital wholly managed

88. The reasons for this included the fact that ECHO repeatedly requested MSF-F to increase visibility of ECHO's financial contribution to its projects. The question of the share of ECHO-derived funding for the various MSF sections was also raised by the Spanish section in relation to the Benson project in 2007 (*Field visit report Liberia*, MSF-Spain, 15-22 January 2006).

89. Interview with ECHO Monrovia representative, February 2009.

90. Interview with a member of the head office coordination team.

91. In the words of a member of the Paris coordination team.

92. This number varied between 2003 and 2007. The number given here is the number of beds during the first year of operation (specifically, in June 2004, after the MPH 2004 half-yearly medical report).

by MSF, is a good illustration of the way that a project is put together, being a combination of an analysis of the context and the internal dynamics of the Paris head office. The idea of a project to open a referral hospital in Monrovia dated back to the early 2000s.[93] Some of the teams felt at the time that Monrovia's health system was in a catastrophic state, especially regarding secondary care. When the LURD assault on Monrovia started to become a reality in 2000-2001, some started to plan for possible fighting close to, or within, the capital itself. Consequently, a project for an urban hospital was sent to the operations department. In the end, the project was rejected for two main reasons: firstly, head office decided to emphasize mobility and agility so that MSF teams could follow the fighting and displaced people, rather than undertake a static, and costly, programme in Monrovia; secondly, the idea of investing in a hospital structure was considered to be too demanding, too complex and not suitable owing to the volatility of the situation. The outbreak of fighting in the summer of 2003 heralded a renewed interest in the project.

During the siege of Monrovia (June to August 2003), MSF teams were isolated within the Mamba Point neighbourhood, and were treating injuries from gunshots and mortar fragments. Lacking an appropriate structure, the expatriates' house was transformed into a makeshift hospital that performed over 1,000 operations during the summer of 2003. Once the fighting ceased and Charles Taylor had left, another project for a city hospital was submitted to the Paris coordination team.

The request to open a new structure was based on two factors. First, Monrovia's flagrant lack of secondary structures and in-patient facilities. Second, and perhaps more importantly, the desk team felt that the country's situation remained volatile: faced with the prospect of renewed fighting and violence, the team wanted to be able to call on a structure suited to caring for the wounded, and was reluctant to repeat summer 2003's experience of the "make-do emergency."[94]

The project gained political backing from the operations division and technical support from the medical department, which was increasingly interested in surgical provision.[95] A project for a private hospital in an urban area was a relatively novel idea. It was soon to take its place amongst other similar schemes, such as in Port au Prince, Haiti, and Port Harcourt, Nigeria.

The MSF hospital opened in Mamba Point, the area where the embassies were

93. The information referred to here came from interviews with former Paris coordination team heads and ex-Heads of Mission.

94. Interview with MSF-F Liberia Desk, 2008.

95. Interview with MSF-F Liberia Desk, 2009.

located, in November 2003. Unlike the hospital project opened by MSF-B at Redemption Hospital in 1999, which was run jointly with Liberian Ministry of Health backing and staff, the MPH was entirely private and was run under the entire responsibility of the French section. In this way, a project designed at the height of the fighting came into being once combat had ceased.
However, the exact nature of this hospital project remained ambiguous. It was originally designed to provide emergency treatment. But, in post-Taylor Liberia, what qualified exactly as an emergency? Some felt that this meant providing care to victims of "armed" or "collective" violence. Yet for five years, the hospital only ever had to treat two waves of patients injured in outbreaks of collective violence (the riots in December 2003 and October 2004). The MPH was tied in to a Liberian conflict that was thought to be about to break out again...but never did. Others therefore felt that the definition of what constituted an emergency should be extended to include a raft of acute cases that required immediate care.[96] Patients in this category were hardly in short supply, given the state of the Liberian capital's health system and the dearth of secondary care structures. Yet the character of the MPH was changing and it progressively became a general hospital, raising the question of what exactly were the limits to the types of care on offer?[97] This also raised the question of MSF's role in a context free of the conflict and collective violence that were then felt to be its core activity. The MPH, designed in wartime and established post-war to treat victims of collective violence, was turning into a "transition hospital" that had to make up for the shortfall in secondary care provision in Monrovia until such time as the health system could be re-established.

MSF-F also opened another project, in the region of Lofa, after combat ceased: MSF ran two small structures offering out-patient and in-patient care (OPD/IPD); these structures were located within health ministry premises at Kolahun, and in private premises at Foya. The medical services were provided to people living locally: families of former fighters, those unable to flee during the war, and returnees, whose numbers grew little-by-little until disarmament.[98] MSF-F wanted to deploy to zones long deserted by aid organisations since the heavy

96. "Mamba Point Hospital is an emergency hospital…but… what is an emergency??? It is very difficult to define this word… In Liberia there are "just hospitals", nobody knows about emergency hospitals, for that reason we decided to start to talk about acute cases… " (End of mission report, MPH project coordinator, July 2004).
97. After five months in operation, the MPH project coordinator felt that: "It is likely that the hospital will become more of a general hospital than an emergency hospital, as it was originally conceived." (MPH project coordinator report, April 2004).
98. Kolahun was one of the last towns in Liberia to be disarmed, in 2005.

fighting started (Lofa was almost inaccessible from late 1999/early 2000 to late 2003). The MSF-F teams wanted to go "where others don't go, stopped going to, or haven't got to yet." After the fall of the Taylor regime, a growing number of NGOs and UN agencies started to (re)deploy to Liberia. The situation was in contrast to the relative vacuum in which MSF teams operated during the early 2000s. Initially, these organisations remained in Monrovia and a handful of areas secured by UNMIL (primarily the route to the camps at Bong and the town of Gbarngba). The rest of the country lacked outside aid… and often any remaining population.[99] Initial explorations in Lofa discovered areas very badly impacted by physical destruction, far more extensive than in the centre or south of the country. MSF's deployment to north Lofa was also in response to a geopolitical analysis of the risks of a return to armed violence in the sub-region: the proximity to Guinea and Sierra Leone were factors in the decision to deploy in northwest Lofa rather than another region. Lofa was a staging post for LURD, a group that MSF head office felt was the most likely to initiate a renewal in fighting.[100]

A mission under question: MPH and the Lofa Project

As the peace became increasingly well entrenched, so a number of questions were asked internally about projects that were essentially designed with the idea that fighting would break out. This did not necessarily lead to challenging the validity of these operations, rather to a request that they be modified, a request that came as much from head office as it did from teams on the ground. Few of these questions concerned the Bong project, which centred on providing healthcare access to internally displaced persons: as the camps were slowly emptying of their population thanks to return programmes set up by the HCR, plans were made for progressively winding up their activities.

In Monrovia, the question of the range of care to be provided at the MPH arose very quickly: where to set the limits, and what should be the quality, of the health care on offer? Despite head office reticence about expanding a project that was meant to focus on "emergencies", the MPH grew relatively quickly; its levels of activity exceeded what the initial plans, and it become more complex from the medical standpoint.

The surgical unit, however, which was designed to treat victims of violence, was

99. The relative vacuum in of Lofa initially led to debate within MSF about the value in deploying to such areas. At first, the worry was that there would not be enough to do. There was also debate about providing a false sense of security to refugees and displaced people, accelerating their premature return. Interview with ex-head-office coordinator.

100. This is a view I share with the coordination team of the time.

not doing so. It was working: it was simply that its activities were not related to violence but rather to the lack of equivalent structures accessible to the Liberian population. The project was also handicapped by a series of problems surrounding management of human resources: a handful of upsetting instances of misappropriation or corruption, conflicts with staff, a series of legal actions (concerning labour law as well as sexual offences involving team members), sometimes extreme tension with the returning Liberian authorities (especially the labour ministry). The question arose as to whether the scope of the MPH should be restricted, allowing it to concentrate on one or two specialities. Paediatrics and mother and infant care, often a focus for humanitarian actors, were already being offered by other MSF sections. For a time there was talk of refocusing on "adult male" patients, the idea being that this group was often overlooked by other aid actors, but the project, focusing as it did on an unusual patient category, never really took off. The innumerable problems of day-to-day management appeared to prevent any in-depth analysis taking place about far-reaching reforms: reading the coordinators' and mission heads' monthly reports leaves the impression that the numerous technical challenges that cropped up at various levels in the hospital's operation effectively paralysed any discussion of the political positioning of a project such as this within the overall scheme of things in Monrovia. In 2005, the project's results seemed ambiguous: the structure was very busy, but the value of continuing the experiment was questioned because of the amount of energy needed to make it function. It was also hard to justify maintaining a project like this within the relatively peaceful context of Liberia in the post-Taylor years. Did the problem really lie in a post-conflict context where MSF found it hard to establish its place? It might in fact be that what was under question at the time was the idea of what constituted a "legitimate mission" for MSF: the options discussed internally concerning the range of "operational possibilities" offered little chance of a lasting future for the MPH project. This shows that, in 2005, the idea that it was possible to decide to commit long-term support to a population impacted by a war as sustained and violent as in Liberia was not yet common currency. Conversely, in 2010, such an idea was adopted in order to aid the population of Haiti, afflicted by a natural disaster and a singular past. Yet, however singular that country's past, it would be wrong to deny echoes of the Liberian experience.

The problem in Lofa was of a wholly different nature. Here, the question of MSF's position within the international aid effort and post-war management of Liberia arose more explicitly. Because of the security situation and the rules imposed by UNMIL, humanitarian organisations that ventured into these areas

were at first something of a rarity. The ICRC and MSF-F were the only specialist medical organisations with a presence in Lofa, one of the country's most populated regions prior to the war, and they agreed on a way of sharing the work between them: MSF-F deployed in west Lofa, ICRC in the east. In reality, this agreement masked a deep-rooted misunderstanding about the role the other was to play in the aftermath of the war. For the ICRC, the Liberian conflict was over, despite the lingering tensions. It wanted to play a part in the reconstruction of a health system utterly destroyed by the fighting. So the ICRC set about rehabilitating and reinstating health services and prepared for the return of Lofa's population of refugees and displaced people.

MSF France did not share this vision of its role, or the same analysis of the political situation: rather than supporting health centres with the aim of fulfilling a health plan, MSF-F concentrated on two localities with the intention of delivering quality care. It refused to join in the rehabilitation and supervision of health units, despite encouragement from the ICRC (which felt betrayed by this). There are several ways of accounting for MSF-F's refusal. Playing from time to time a substitution role (there were no public health structures in this part of Lofa at the time) and eager to ensure the quality of the care it provided, MSF-F had neither the financial nor the human resources to get involved in a large number of health structures in this part of Lofa: its way of working (complete substitution) was far costlier than that of the ICRC (support for health centres starting up again).

Beyond even the question of resources, MSF-F had absolutely no desire to play a major role in rehabilitating the health system in Lofa. We have already stated that the organisation considered it highly likely that fighting would break out again. It felt that a policy of reconstruction was premature, as well as sending a dangerous signal to refugees who might think that their safety was now assured. More generally, since the 1990s MSF-F had been unwilling to help promote policies for the rehabilitation of public health systems. After some "unhappy" experiences (at least, that was how they were perceived) in Guinea and Chad during the 1990s, it took the view that managing health districts was not something that fitted its capacities or remit.[101] This was a position that led to a degree of tension within the teams: some members could not understand why certain zones were left without any access to care at a moment when MSF was the only actor able to intervene. Populations in some localities, such as Gondolahun

101. A far more meticulous historical study is needed concerning the French section's reluctance to engage in rehabilitating healthcare systems.

(south of Kolahun) exerted pressure on the Lofa teams. A limited quantity of medicines was distributed via ad hoc mobile clinics, but all in all the coordination teams in Monrovia and Paris remained set in their opposition. MSF-F wished to stay as far as possible outside of any engagement with reconstruction. This position was in stark contrast to operations in Nimba, a region close to Lofa, undertaken by MSF's Swiss section.

2.1.2. MSF-Switzerland: strategic positioning in an unstable region

MSF-Switzerland (MSF-CH) had not been in Liberia as long as the French section. The Swiss section organised its first activities in the second half of the 1990s. Between 1996 and 1999, it operated in Bong and Nimba, where it provided support to health centres and took part in vaccination campaigns. Curiously, it pulled out of Liberia in late 1999, when northern Liberia was again experiencing armed instability, but not yet Bong and Nimba. The Swiss section handed over its activities to local and international NGOs.[102]

MSF-CH returned to Liberia in 2002 when the fighting stepped up. After an unproductive exploratory mission in Monrovia, in early 2003 it finally decided to return to a region it knew, southern Nimba, after it saw an influx of Ivorian refugees. So MSF-CH was attracted not so much by the Liberian conflict as by the effects of the Ivorian crisis.[103] The Operational Center of Geneva (OCG) was already tackling this issue in Guinée forestière, in the N'Zérékoré area, where it operated in Liberian and Ivorian refugee camps. However, when the MODEL rebel group was created in March 2003 to open a second anti-Taylor front in the Ivory Coast, and fighting spread to the Nimba region, the organisation was forced to suspend its activities in the country, this time for security reasons.[104]

Return to post-Taylor Liberia: strategic aspirations or operational conformism?

MSF-CH relaunched its operations in August-September as a fragile peace arrived in the wake of Taylor's departure. Following two exploratory missions, the first in Monrovia in September and the second in October in Nimba together with MSF-Holland, it set up two projects.

1/ In Monrovia, the project consisted of managing a private secondary care struc-

102. Liberia Memory Project.

103. The fighting that broke out in Ivory Coast in September 2002 sent a wave of Ivorian refugees into Guinea and eastern Liberia.

104. MSF-Switzerland did not remain totally inactive. In June 2003, it published *Liberian stories*, a series of witness accounts on what happened to Liberian populations caught up in the cycle of violence and forced displacements.

ture in Benson Hospital and supporting two urban health units in Logan and Red Light, two of the capital's working-class neighbourhoods. The Benson Hospital (80 beds and an OPD) is located in the Paynesville neighbourhood, a disadvantaged area of Greater Monrovia. It provides paediatric and obstetrical care, and aims to specialise increasingly in women's and children's health (POA 2004). In 2005, an SGBV (Sexual and Gender Based Violence) unit was opened to provide different forms of support—healthcare, psychological support and legal advice—to women victims of sexual violence. However, the financial difficulties experienced by the Swiss section in 2004 forced it to abandon the costly Benson Hospital project, which was then taken over by MSF Spain (MSF-E). The Spanish section was looking to set up in Liberia and arrived with available funding. After 2004, the Swiss section therefore concentrated on southern Nimba, while MSF-E focused on Monrovia. The two sections used a shared coordination system in the Liberian capital.

2/ In Nimba, the initial project centred on a clinic and small Therapeutic Feeding Centre (TFC) located in the Ivorian refugee camp in Saclepea, along with mobile clinics for pockets of Ivorian refugees and, more especially, the neighbouring Liberian population. MSF-CH's presence in Nimba in 2004 is explained by the section's history in Liberia: it returned to this region because it was familiar with it and had operated there twice during the war. Although Nimba did not totally escape the fighting, it was not the region hardest hit by the latest wave of clashes. Similarly to MSF-F, MSF-CH's interest in Nimba lay in a geopolitical analysis of the Mano River conflicts. Certain members at head office felt that the cycle of armed violence in West Africa was far from over. In view of its proximity to two areas experiencing major tensions, Guinée forestière and the Ivorian West, Nimba seemed to be a useful area for deployment, particularly since the Swiss section was already in place on the other side of the Guinean border (in camps around N'Zéréckoré). In this context, Nimba represented a pre-positioning area[105] close to several sensitive regions.[106] Nevertheless, this analysis did not seem to take into account that the region was also home to inter-community tensions and the pro-Taylor militia who had withdrawn there. The fact remains that, as for MSF-F, the initial post-conflict period was first

105. This pre-positioning policy did, however, cause division at head office. Without rejecting the relevance of the geopolitical analysis, certain MSF-CH members felt that pre-positioning tactics are usually bound to fail (interview with the Liberia desk, Geneva).

106. In late 2004, the troubles in Ivory Coast and arrival of a fresh wave of 15,000 Ivorian refugees in an area close to Saclepea partially justified the pre-positioning advocates. The aid MSF-CH gave to these refugees was, however, limited due to the presence of the HCR and a health situation that did not appear disastrous (MSF-CH, PR 25/11/2004).

analysed with wartime tools. The aim here is not to criticize this analysis after this event, knowing that the war did not actually start up again, but rather to underline the extent to which the conditions initially governing MSF projects in post-Taylor Liberia were linked to practices, or even reflexes, acquired when Taylor was in power.

Nonetheless, the opinions expressed during interviews differ on the subject of the impact of geopolitical analysis on the Swiss section's choices. Some people felt that it was nothing more than a pretext concocted after the event to justify a deployment resulting from a degree of inertia ("we were already familiar with it") or a tag-along attitude ("we had to be there too") rather than an in-depth analysis of the post-2003 situation in Liberia.[107] On the other hand, some other documents suggest a more long-term goal and interest in the question of access to healthcare in Nimba. In January 2003, when the war was far from over, the annual action plan revealed a more voluntarist approach and a desire to build an operation in Nimba with more than an emergency scope. "[This] part of the country [...] has already been identified as a potential area of a longer-term intervention. Now it seems to be a priority to identify – apart from the zone of intervention – priority needs of the population living in this remote, but rather stable part of the country."

In the end, MSF-CH's interest in Nimba in post-Taylor Liberia was no doubt the result of a combination of several hard-to-separate dynamics: a desire to preposition itself in the Mano River conflicts, an interest in areas soon to be described as "a health desert"[108] and possibly also a certain degree of inertia and/or a tag-along attitude that took on more importance over the years.

MSF-CH in Nimba: from tents to brick walls

Whatever the reality, MSF-CH's activities in Nimba quickly went beyond the context of the Ivorian refugee camp in Saclepea. The teams were convinced that the Liberian displaced residents' needs were as significant if not more urgent than those of Ivorian refugees.[109] Healthcare was thus offered to everyone, regardless of their official status (resident, IDP or refugee). It initially centred on three areas: external consultations (OPD), hospital beds (IPD, including a small nutritional unit) and a maternity ward. Activities were also extended geographically. In contrast to MSF-F's activities in Lofa at the same time, the Swiss section tried to spread to the south of Nimba with the goal of covering the area. It organised

107. Interviews with members of the Liberia Desk, Geneva, November 2008.
108. The expression is used for Liberia in the January 2005 POA.
109. The 2003 POA already revealed a desire to provide aid to Liberians and not just Ivorian refugees.

a mobile clinic that "goes to regions where there are not presently any operational health structures and where security remains tenuous" (activity report, 2003-2004). In 2004, the Swiss took another step in the same direction by providing direct support for fixed health units (two to begin with, then up to eight). MSF-CH rehabilitated or rebuilt structures, subsidised staff and supervised medical activities.[110] The team put a lot into training staff both at Saclepea and at the fixed units. These activities and its vaccination campaigns led it to work increasingly frequently with the County Health Team (CHT, local representative of the Ministry of Health) that, unlike in areas such as Lofa, had not completely disappeared during the last months of the conflict.

How can this broadening of activities be justified? On the one hand, mobile clinics in this area came up against a great many logistical difficulties and ended up being particularly testing for the teams. On the other hand, monthly activity reports highlighted that the rehabilitation of permanent structures also aimed for medium- and long-term goals: it served firstly to prepare for the population's return (a little like the ICRC in eastern Lofa) and then to reflect a desire to ensure that the structures support by MSF "reintegrate the public health network." In 2004, MSF-CH thus began to raise the question of its participation in rebuilding the Liberian healthcare system. However, unlike the activities that developed substantially, discussions on what such participation in the reconstruction process implied did not get very far.

The broadening of activities seemed to be primarily initiated by local teams. The head office naturally followed what was going on in the field and gave their backing to these extensions, but it did not seem to be driving deliberations on the specific targets and the expected implications of such participation in rebuilding a health district. Furthermore, activity reports do not show total commitment to this goal: they oscillated between support for refugee populations and the idea of an investigation of "health deserts."

The project sometimes gave the impression of freewheeling, especially since the financial stakes were not very high. The autonomy enjoyed by MSF-CH's Nimba teams contrasts with how the MSF-F teams in Lofa were sometimes reined in by a Paris-based coordination team far more cautious about the consequences of an extension of its activities (in both time and space).

The Liberian mission hardly gave rise to any debate or particular controversy within the Swiss section. The handover of the Benson Hospital to MSF-E resulted

110. Zekepa, Mehnla, Dialah, Yarwein, Zuaplay, Behwallay, Lepula and, of course, Saclepea (Liberia Memory Project).

from the financial difficulties experienced by the Swiss section and not a desire to pull out of the Liberian project. On the contrary, it was planned to step up specialization at Benson in children's and women's health. At head office, a working group on sexual violence was pushing hard for the problem to be included in Liberian programmes. And when the Spanish section took over the Benson project in 2004, Barcelona's initial reluctance to get involved in this issue[111] led MSF-CH to focus on it in Nimba. The post-conflict situation thus seemed to be favourable to the development of slightly "new" or experimental programmes[112]: the end of fighting caused some missions to lose their purpose, and they were then able to switch to more experimental projects. The OCG approached the post-conflict situation in Liberia under this angle.[113] Otherwise, the questions of specific post-conflict challenges and MSF's role in this type of context were hardly discussed, at least in the archives consulted.[114] This is especially surprising in that, in contrast to MSF-F in Lofa, very early on MSF-CH put its finger on the question of the rehabilitation of the health system by means of its activities in Nimba.

2.1.3. MSF-B: NO CHANGE BETWEEN AT-WAR AND POST-WAR

Like the French section, MSF-B had a long history of presence in Liberia, specifically Monrovia. Since 1999, it had been providing support to the public Redemption Hospital in the capital, particularly the obstetrics and gynaecological departments,[115] as well as five public health centres in working-class neighbourhoods. In parallel with the support provided to public structures, in November 2002 MSF-B also opened a paediatrics department, including a TFC, at Island Hospital, a private structure whose premises it rented to install over 180 beds.[116]

111. MSF-CH, 2005 POA.

112. MSF-CH, 2004 POA: "Projects targeting women (gynaecology/obstetrics, MCH) and children (paediatric care) have been opened or reinforced. These projects have been set up mainly in conflict or post-conflict zones (e.g. Afghanistan, Liberia)."

113. The other possible point was lobbying activity in favour of free healthcare that the 2004 POA prepared for in case the transition government decided to re-introduce the question of cost recovery. This was not the case in 2004.

114. There was some discussion in the Swiss section, as revealed by passages in the 2003 POA on public health. These deliberations were, however, expressed in ambiguous terms; "curative and preventive medical action must remain at the very heart of our projects, while public health objectives will have to be subordinated to this central goal" (MSF-CH, 2003 POA 2003). It does not seem that debate on MSF's role in public health systems affected operations run in Liberia (or vice versa) in the first post-conflict years.

115. This former market became a hospital in the 1980s. The structure was supported by MSF International in the second half of the 1990s, then by MSF-B as of 1999-2000. MSF's tasks included supervising activities, supplies, training and payment of incentives, often the main form of staff remuneration. The degree of MSF involvement varied according to the departments.

116. We do not know if Island Hospital opened due to lack of space at Redemption (which did have a paediatrics department) or if MSF-B wanted to develop its own structure to avoid the many tensions caused by working in a public structure with staff belonging to the Ministry of Health.

Alongside these operational activities, MSF-B also played an advisory and lobbying role for healthcare actors in Liberia. The section alternately defended then criticised the introduction of a healthcare system based on sharing/recovering costs in Liberia.[117]

The final months of the war, in June and August 2003, were marked by a major cutback in activities and withdrawal to the Mamba Point expatriates' house, converted into a hospital. As soon as it could, the Belgian section opened a Cholera Treatment Unit (CTU) at JFK Hospital.[118]

Once the fighting was over and Taylor had left, the Belgian section relaunched and extended its activities in Monrovian neighbourhoods, maintaining a CTU at JFK Hospital and returning to secondary care structures (Redemption and Island hospitals) and primary structures (the five MOH health centres in working-class neighbourhoods). MSF-B also extended its activities to the displaced persons camps surrounding the city; it opened three healthcare units that it fully managed. The section undertook major rehabilitation work in the structures it supported, particularly at Redemption Hospital.

Outside Monrovia, like other MSF sections, MSF-B initiated various exploratory missions in the counties most affected by the fighting, even (and especially?) when UNMIL had not declared them safety zones. While MSF-F went into Lofa and MSF-CH into Nimba, MSF-B decided to deploy its activities towards the east, in Grand Gedeh county. It provided support for two public structures there: the Zwedru hospital and Ziah Town health centre. Similarly to the French section, it did not really seek to cover an entire health zone.

Overall, it is clear that MSF-B's operational deployment in the immediate post-conflict period is similar to that of the two other sections examined above: a secondary service in Monrovia, aid for displaced people and deployment in areas affected by the conflict and still almost empty of other humanitarian organizations.

Nevertheless, there are a few notable differences. Firstly, MSF-B played a far more important role in Monrovia: in addition to its hospital-based activities, it managed a primary healthcare network. It was also far more involved in working with the Liberian authorities. Rather than a post-war choice, this represents continuity with the conflict period. Compared to the French and Swiss sections, MSF-B had less of a tendency to plan its activities based on a possible renewal of hostilities in Liberia or the surrounding areas. It is true that since Zwedru,

117. See, for example, "What health, what health care for Monrovia? What role for MSF projects? Analysis of MSF's role in Monrovia's health care system", Dr. Mit Phillips, November 1997.

118. The city's main hospital, a private institution whose staff were partially remunerated by the MOH.

Brussels had been keeping an eye on the Ivorian west, but its main concerns were already elsewhere. They centred on the part played by the NGO in a Liberian health system that was officially being rebuilt. What role should it play in the post-war context and health system rebuilding process?

Initially, the MSF-B mission seemed to be moving towards a marked decrease in its activities, starting in 2005. Without waiting for the presidential elections, which some feared would trigger a new cycle of violence, the Belgian section officially planned to handover projects for supporting Liberian structures.[119] For instance, between March and September 2005, MSF-B withdrew from three of the five urban health centres it supported (after rehabilitation, and usually leaving behind a three-month stock of medicine). In December, the three clinics in the displaced person camps were also closed. In Grand Gedeh, MSF-B handed over its Ziah Town activities to Merlin and planned to close it Zwedru project in June 2006.[120] And, most importantly, handover of the Redemption Hospital to the Ministry of Health officially began, with MSF medical staff leaving in late November, but came up against numerous difficulties, such as accumulated delays, very tense negotiations with staff, and press accusations saying MSF was abandoning the population. In September 2004, the MSF teams had already experienced a fairly violent strike by the redemption Hospital staff, who were protesting MSF not respecting incentive scales set up by the ministry. This strike possibly influenced MSF-B's decision to withdraw from the structure and hand over to the ministry. In December 2005, a head office press release officially announced MSF-B's withdrawal from Redemption Hospital according to a progressive timetable lasting until June 2006. As for Island Hospital, MSF-B also opened discussions on the possibility of the ministry taking over the new structure: in January 2006, it suspended admissions and opened closely-argued negotiations with the health authorities. As the section most with the closest working ties to the ministry, MSF-B gave the impression of also being the section closest to withdrawing. However, it went on not to be the first section to leave Liberia, but the last.

***

In the immediate post-war period, operations and analyses developed by the different MSF sections tended to converge. This unstable period was still essen-

119. Annual Report Form, Support to Primary and Secondary Health Care in Monrovia Liberia, Project, (cited by the *Liberia Memory Project*, 2007).

120. The opening of a programme in late 2005 to care for tuberculosis patients at Zwedru hospital held up the withdrawal.

tially seen through the prism of war and the possible renewal of hostilities (certainly more so for MSF-F and MSF-CH than MSF-B). The period was characterised by the wish to stand out from other NGOs and the UN system, particularly by deploying in remote areas and zones not classified as safe according to UNMIL criteria (here again, MSF-B moved away from this position, at the end of the period).

Between 2003 and 2005, reconstruction was not yet a central question for MSF sections: the continuing uncertainty reigning in Liberia, a weak transition government without the confidence of donors, and the as yet incomplete deployment of the UN and aid organisations meant that many observers continued to describe the situation as "post emergency", without a strong reconstruction imperative (in comparison with later years). It was therefore easy to avoid the political and mental reconstruction context—until 2005, when the MSF teams had to face the issue: during the tensions opposing MSF-F and the ICRC in Lofa, when MSF-CH extended its activities in Nimba, and during MSF-B's difficult withdrawal from Redemption Hospital. During the period that followed Ellen Johnson-Sirleaf's election, the question of the relationship between MSF projects and reconstruction policies became increasingly weighty and the different sections' operational solutions diverged more markedly.

2.2 GETTING CAUGHT UP IN PEACE (2005-2009)

2005 was a watershed year. It opened with the UNMIL announcing the end of the disarmament process and HCR the official start of operations to resettle refugees and displaced persons. It ended with the election of President Ellen Johnson-Sirleaf, who emerged as the international community's favourite candidate. It saw the end of the transition government, compromised by the presence of former armed factions, and the return of a real civilian government fuelled by the desire to break with past policies: President Sirleaf announced her intention to build a New Liberia.

In this political context, offering more stability and more reassurance for the international community, measures to coordinate transition and reconstruction policies were stepped up. These measures explicitly aimed to incorporate the activities of humanitarian organisations in medium- and long-term development goals. The International Financial Institutions (IFI) set up planning tools seeking to help Liberia return to the fold. Similarly, mechanisms for putting figures on the state of the country, its people and its economy served to guide

reconstruction policies. The process was not new. The task of coordinating and supervising the various actors' activities in terms of transition policies was already underway in 2003, but it became increasingly pressing and present with the end of disarmament and Johnson-Sirleaf's election. An increasing number of texts therefore mapped out the needs of the State and the Liberian people: in the healthcare sector, the National Health Plan was drawn up in 2006 to cover the 2007-2011 period. These texts thus delineated the different non-governmental actors' scope of action. The World Bank returned to Liberia, the UN introduced and tested out the clusters reform in the field, and the Liberian administration was repopulated out and planned to take back control of the country.

As the prospect of renewed fighting diminished and enduring peace took it place, the issues of reconstruction—of the State, but also more broadly of a political, economic and social order—had an increasing impact on humanitarian actors' thoughts and actions.

As far as the MSF sections were concerned, this served to give more force to the question of the legitimacy of its presence, as well as the relationship between aid organisations. In the immediate post-war period, the different sections were unanimous in insisting on the need to keep a distance from UN coordination bodies, particularity those controlled by UNMIL. This position evolved and took on different shades in the years that followed.

As the country settled into peace, international actors' priorities began to centre less on maintaining a fragile peace, which seemed to have more or less been achieved, and far more on reconstruction of a "failed State". The challenge of reconstruction seemed in some ways to be more technical and less political than that of upholding peace. In the eyes of certain actors, including a number of MSF sections, it justified moving cautiously closer to aid bodies. Consequently, the MSF International Office carried out a study on the way in which the various coordination mechanisms set up after the war enabled certain major international actors, like the World Bank and leading donors like USAID, to impose their vision of Reconstruction, aside from the clusters reform. The report felt that if the MSF sections wanted a role in post-conflict Liberia, they had to seek a balance between adhering to the principle of independence and judicious participation in coordination mechanisms.[121]

121. Katharine Derderian, Liberia and the Humanitarian Reform, MSF, International Office, October 2006.

2.2.1 MSF-F activities 2005-2007: adapt or leave

As peace seemed to have settled in for good, the MSF-F mission in Liberia was entering a phase of internal questioning. Although the return of lasting peace removed MSF's main reason for being in the country, the health situation two years after fighting was over was still worrying, and armed violence had not disappeared, but found an outlet in urban crime. A presentation made by the desk team in September 2005 summed up the teams' dilemma: "In conclusion, we can say that the war is over but the situation is very difficult for the population, with organised crime and oversight by the UN and private companies."[122] The concept of "artificial peace", used in the immediate post-war period, fizzled out. Starting in March 2005, the Head of Mission declared in favour of closing the mission. "It seems vital to limit our intervention criteria and maybe learn to leave even earlier, as soon as the acute phase of the crisis is over." His viewpoint was grounded in a perception of MSF as an "emergency organisation" with no part to play outside acute crisis situations. In the post-conflict context, MSF-F had trouble making a distinction: a growing number of NGOs were intervening in Liberia and deploying in a country officially considered as safe. This fairly substantial presence of "other humanitarian organisations" was felt not only to be a nuisance but also a risk. The Head of Mission felt that the mission could eventually be instrumentalised by the coordination bodies seeking control over reconstruction policies. In 2005 he wrote: "[Leaving earlier] will prevent us from falling victim to the opportunism of international donors, which are well aware that it is wiser to use humanitarian organisations' know-how to fulfil their moral obligation to help the reconstruction and development process."

Closure of the Bong and Lofa projects

The Bong and Lofa projects were heading towards closure. The question of closing the Bong project did not need debating: the displaced persons camps were emptying, people were going home. Nevertheless, the end of the project in 2006 triggered major conflicts with some of the national staff who took the dismissals badly. In Lofa, the situation changed significantly in two years: with the end of disarmament and operations to resettle refugees organised by the HCR, a great many NGOs were deploying in the area. The first isolated humanitarian organisations (ICRC and MSF) were followed by organisations centred more on development and reconstruction. In a context where stabilisation was in progress, MSF-F decided to profit from the presence of these organisations to hand over

122. Extract from the operations report, MSF-F, 27/09/2005.

its activities. In Kolahun, IMC agreed to take over MSF projects and all the staff thanks to funding from ECHO. A smooth transition took place in early 2007. In Foya, no one wanted to take over the MSF clinic, built within a private structure unlike at Kolahun. Foya did have another healthcare structure, but the team judged it to be far from adequate in terms of quality and its healthcare was not free. The departure from Foya was painful. Planned for late 2006, it was postponed several times: the teams found it hard to resign themselves to closure and the town's residents physically opposed MSF's departure.[123]

Closing MPH

The situation was even more delicate in Monrovia. Unlike Lofa, where the level of activities was judged to be moderate and the return of refugee populations was speeding up, the Mamba Point Hospital was a highly active structure from the very start, described in reports as a centre often close to breaking point. The structure was much debated at head office: there were those who pointed the finger at a structure that never functioned in line with initial intentions (caring for victims of the violence) and served as the referral hospital for Central Monrovia's well-off middle classes; others responded that the MPH was an innovative project at the leading edge of the movement's efforts to provide hospital care.

The teams in the field were wearing themselves out dealing with a difficult context: recurrent problems with human resources,[124] numerous conflicts with the Liberian authorities, problems in terms of the medical techniques for specific pathologies MSF had to tackle,[125] the feeling of patients at the end of their ropes who could no longer be helped, etc. Debate over the project's future really began in 2005, when the teams became aware that Liberia was entering a period of enduring peace,[126] and a Head of Mission arrived and directly raised the question of

123. Interview with a former field manager on the Lofa project.

124. The field teams felt in particular that, compared to crises more extensively covered by the media, the Liberian mission was not prioritised in the allocation of experienced staff.

125. In 2005, almost a quarter of deaths at the Mamba Point Hospital were linked to chronic illnesses or high blood pressure problems that MSF is not used to treating in conflict situations. In late 2005, the Liberian desk team decided to focus on reducing mortality in the hospital's medical department (which had the highest mortality rate). The idea was to "set up tools providing a more accurate diagnosis of the situation and be able to identify the curable and treatable diseases with the highest mortality rates" and, where necessary, to introduce suitable treatments (Presentation to operations in December 2005 and Interview with the MSF-F Desk Head, December 2008).

126. The project documents clearly show this change. In 2004 and 2005, the MPH's secondary goal was still "to be capable of taking care of the wounded in the event of renewed armed conflict or violence in the city of Monrovia". In 2005 and 2006, this goal disappears to be replaced by ten or so more medically-oriented objectives ("Set up external consultations for monitoring patients with chronic pathologies", "Take care of patients with AIDS and introduce ARV", "Take care of patients with tuberculosis", "Continue to train hospital teams", etc.). The goal changed from preparing for a fresh outbreak of war to innovating in the sphere of hospital care in a precarious context.

the legitimacy of MSF's presence in a post-conflict country: "The discussion took time to get going in 2004, we were lacking in coordination. As of 2005, spurred on by the new Head of Mission, we began to reflect…. How far should we go, how long should we stay in such a context? It is very difficult to answer these questions. Everyone has a different opinion."[127]

Consequently, the structure's future was under debate: should activities be extended, concentrate on specific care categories, or should it be closed? While recognising that the structure provided many services to the city's residents, some were of the view that it was not part of MSF's "*raison d'être*".[128] In May 2006, for instance, the medical coordinator wrote to the desk team: "we should not increase the level of healthcare activities at the hospital, because that would actually mean creating a 'JFK' [Monrovia's main secondary healthcare hospital], which Monrovia no doubt needs, but I don't think that it is up to MSF." She urged the desk team to plan on closing the hospital in 2006. Other team members advised recentring MSF-F activities on primary care in disadvantaged neighbourhoods or on surgery. In-the-field discussions on the project's future went hand in hand with heated debate at head office over the strategic choices open to MSF. The operations management was then pushing for MSF projects to refocus on the "direct victims of violence." Some people found this view too restrictive or felt that it offered little opportunity for innovative projects. In late 2006, the project was examined twice in the space of three months during Operations meetings. It was decided to maintain the MPH and concentrate on two departments (medical and surgical) and closing two others (obstetrics and paediatrics). The goal was clearly focused on improving MSF's hospital care expertise. The choice to be present in Monrovia, rather than somewhere else, continued to be justified by the lack of secondary care services (and high mortality rates in the MPH medical department), and the addition of a new goal: to reach the most vulnerable populations in *Central Monrovia*. However, globally the "new formula" MPH reflected the goal of improving medical techniques (hospital techniques, in this case) rather than a reflection on MSF's positioning within post-war health development policies. MSF gave itself two years to launch and then assess the project to reconfigure MPH.

However, a year later, a new Operations meeting decided to close down the MPH following some very tense discussions. There are differing versions of the role played by the various people involved. The turnaround can no doubt be

127. Interview with the medical coordinator, MSF-F Liberia.

128. The expression that crops up most often in reports and interviews is that the MPH "does not lie within MSF's mandate."

explained by the combination of several elements: the idea supported by the Operations management that MSF did not have a role to play in the post-conflict period was a key factor in the decision, but not the only factor. There was also a certain hostility towards major hospital projects, the balance of power between certain head office managers, and considerable lassitude towards the recurrent problems the Liberian mission encountered (particularly the multiplication of legal disputes). The decision was take to close the MPH in mid- 2007.

During the December 2006 discussions, the desk team, convinced that they should remain in Liberia, proposed a last project focused on urban violence. The proposal highlighted the fact that MSF already ran a similar project in Haiti. The Operations management was not convinced by the validity of the comparison, but decided to assess the problem in the first half of 2007. This was a last effort to look at the issue of specific Liberian post-war dynamics. Despite the attention paid to this question by the last Heads of Mission, the study did not result in a concrete proposal: they seemed to have had trouble finding an operational and, especially, medical solution to what was essentially a political and social problem. An inter-section MSF study carried out at on healthcare services in Monrovia in late 2004 had also concluded that, from a health standpoint, urban populations were better off than people in rural areas.[129] The pro-closure approach won the day. Following a failure to try and hand over to the Indian government, owner of the premises, the MPH closed down in May 2007. And with it ended MSF's seventeen-year presence in Liberia.

What can we learn from this closure? Firstly, the fact that, contrary to its reputation as "first to arrive, first to leave", MSF-F took its time to come up with an answer to the question of its presence in post-Taylor Liberia. Not only did MSF-F remain in Liberia five years after the end of hostilities, it also hesitated over the options to take and debated extensively on the how to adapt its operations to the new context.

In the end, the idea that prevailed was that MSF did not have a specific role to play in post-Taylor Liberia and, in particular, was not tasked with taking part in health reconstruction policies. This decision reflected both a certain balance of power (at head office and in the field) and the influence of a certain perception of the organisation's "core business", i.e. "intervention during a conflict period." This position contrast with that of the other sections we are looking at.

* * *

129. A conclusion we feel to be too hasty and overly general (see final section).

2.2.2. MSF-CH activities: reconstruction in disguise?

A mission that continued to extend

A larger range of healthcare services was being offered at the Saclepea clinic: between 2003 and 2004, the health centre was based on an IPD/OPD, maternity ward and feeding unit. The next two years saw the addition of a tuberculosis programme, AIDS programme, paediatrics service and Sexual and Gender-Based Violence programme (SGBV, rebaptised Women's Health Unit in March 2006). Starting in the late 1990s, this last issue took on increasing priority within the MSF movement, and more broadly, in the humanitarian aid world. In Geneva, it was driven by several influential figures at the operational centre, including Françoise Duroch[130].

The Swiss section maintained its mobile clinic activity (particularly near the Ivorian border, which was "under surveillance) and stepped up work on supporting health units in southern Nimba: a total of eight health units were built or rehabilitated between 2003 and 2008. In 2005 and 2006, MSF-CH also launched a series of exploratory missions in the south east of the country. Once the financial crisis that had forced it to hand over Benson to MSF-E, MSF-CH was seeking to open a second Liberian project. As in 2003, it was trying to push out the geographical boundaries of its deployment out a little further. In the wake of disarmament, new NGOs set up in Nimba, some of them operating in the health sector. In contrast, the country's more enclosed areas, like the south east, remained empty of structures and organisations. MSF-CH felt that it was important to go to areas where no other organization was going. "The South East region of Liberia is poorly covered by existing health infrastructure and the humanitarian needs in the region are still quite large and mainly unmet"[131] Exploratory missions were also justified by proximity to the Ivorian border: "The Counties in the South-East corner (Grand Gedeh, River Gee, and Maryland) are also located along the border with Ivory Coast and may face future influxes of refugee populations or other emergency needs if the situation in Ivory Coast remains unstable or explodes with renewed fighting."[132] A geopolitical justification of the exploratory missions was provided, as if the lack of health equipment could not justify the extension of the teams' work alone. In the end, although the exploratory mission reports confirmed the absence or extreme fragility of health structures, the initiative did not result in any concrete deci-

130. See the May 2004 report "Women". Liberia was at that point one of six countries where the Swiss section organised SGBV activities, including treatment and different forms of psychological and legal support.
131. MSF-CH, 2006 POA.
132. Idem.

sions. And in 2006, the legitimacy of the Swiss presence in Liberia came under question.

Confused goals

As the Nimba project continued to evolve (see box on the Saclepea project), the reasons underpinning MSF's presence in the area and Liberia in general started to become confused. In February 2006, the 2006-2007 operational plan defined the situation in Liberia as "post-emergency", where the main priority was to rebuild a functioning primary care system. The same report underlined the total absence of the Liberian Ministry of Health's capacity in Lower Nimba: in the light of these conditions, MSF sought to guarantee the region's population access to primary and secondary care. One of the main projects launched that year was construction of a permanent 50-bed hospital in Saclepea. However, the way the project's goals were formulated was ambiguous: reconstruction of the Liberian healthcare system was the stated priority, and MSF was embarking on building a permanent hospital, but nothing pointed to a MSF goal of taking part in national reconstruction plans. It is possible that this was not so much an oversight or lack of detail but the fact that the question had not been settled. In the second half of 2006, head office did however take the decision to halt the medical activities in Nimba planned for 2008 (following completion of work at Saclepea and handover of all MSF-managed health structures). This decision was partly linked to a broader discussion at head office on the need to improve MSF's ability to close down projects once the crisis is over: the MSF-CH 2004-2006 Operational Project deplored the fact that "too often we try to identify uncovered needs in order to stay on leading to difficulties in controlling growth. But crisis situations do come to an end and objectives as initially defined may be reached. In this respect, we should start thinking about exit when starting a given project."[133]

Along the same lines, the 2006-2007 activity report raised the question of closure in Liberia due to a "stabilised context" and the "economic interests" the country was attracting. Nevertheless, in November 2007, the end of mission report by the MSF-CH medical coordinator defines a totally different goal for the mission. He felt that it hinged on "working with other healthcare actors, particularly the MOH, to develop a quality healthcare system for the people of Lower Nimba." The section's goals varied with each different report, from preparation for closure, provision of healthcare to a population in need in the post-emergency situation,

133. Operational Project, 2004-2006, draft version, MSF-CH, November 2003.

or implementation of the national health plan drawn up by the authorities. In 2008, the Nimba project was still running. Work on Saclepea Hospital was completed in December 2007, but the mission had found a temporary new raison d'être with a study on ASAQ[134] in agreement with the Liberian ministry.

MSF-CH and the reconstruction process: discreet participation

Without openly adhering to reconstruction objectives, in effect the Swiss section followed the same route as other medical NGOs (IMC, Médecins du Monde, Africare) involved in rehabilitating the healthcare system. It did however differ from these organisations due to its decision-making autonomy and habitual substitution role.[135] MSF-CH felt that, in 2006, the Ministry of Health was still not functioning properly in the field:

"Although there has been some development in the past two years, the overall health infrastructure is still completely inadequate for the general population. The only improvements in the health structure are due to NGOs and their ability to spread further into the countryside to develop more programs. The Ministry of Health does not function at all as an implementing agency. They have not yet begun to implement a real health strategy or have a real presence within the health care system in Liberia. They have no resources and very little staff – almost 100% supported and supplies through NGOs" (MSF-CH, 2006 POA).

MSF-CH thus became involved in "reconstruction" while aiming to maintain independent decision-making. For instance, like the other MSF sections, it only took part in the UN health cluster as an observer. Locally, the health authorities were informed and consulted, but MSF-CH kept control over its operations. Due to MSF's wide-reaching role in the Lower Nimba health district, this sometimes caused major misunderstandings: the County Health Team was only informed at a very late stage of the Saclepea permanent hospital project. On the other hand, the MSF teams only found out about the existence of another public structure in Saclepea supported by Mercy, a Liberian NGO, after work had started. The public health authorities had a problem with the very format of the new MSF unit: firstly, because there was no secondary care unit in Saclepea before the war (the referral hospital was an hour away in Ganta), and secondly because the MSF structure, even reduced to 32 beds, had no equivalent in the Liberian

134. One of the therapeutic combinations developed by the DnDI (Drugs for Neglected Diseases Initiative) and recommended by the WHO to combat malaria in Africa.

135. For NGOs like MDM, substitution was something of a frightening prospect, and it tended to be used only as a last resort. Their goal was to systematically work in partnership with the Ministry of Health (Interview with the MDM Liberia desk, Paris, December 2007).

system—no basic health unit or referral hospital—to integrate with, as required. The Liberian public health resources plan therefore had to be modified to incorporate the MSF structure. When the structure was officially inaugurated in December 2007, it kept the name MSF had given it: CHC (Comprehensive Health Center).

The changing face of the MSF-CH Saclepea project

The question of moving from a temporary tent-based structure to a permanent structure had been raised since 2005. During field visit, head office managers were concerned about the "village of tents" built by MSF in Nimba, or made fun of it. For health reasons and to rationalise space, the coordination team therefore decided to change to a permanent structure more suited to hosting medical activities. After spending some time exploring the possibility of transferring hospital activities to the Tapeta hospital, the Swiss finally decided to begin building a permanent structure in Saclepea itself. The project started out ambitiously, planning for 80 to 90 beds, and was then moderated to take into account he possibility of being taken over by the Liberian public health authorities, ending up with 32 beds. When the building work was finished, the Saclepea CHC triggered some debate at head office: some people felt is was a real technological success and concrete contribution to rebuilding the Liberian health system, whereas others made fun of the "referrals monster" that, if it did not empty out after the section left, would encumber the local government's management capacity.

MSF-CH's relationship with the reconstruction process was fairly disconcerting. There did not appear to be any real discussion of the challenges and limits of its involvement at head office. Furthermore, MSF-CH's degree of participation in rebuilding the healthcare system in southern Nimba contrasted with the relative timidity of their political commitment to the issue. In contrast with MSF-B or an organisation like MDM, MSF-CH had not undertaken any major lobbying of government or donors to influence or support reconstruction of the public health system and formulation of new public health policies in post-war Liberia. And yet, in the field, MSF-CH was a key actor in the Nimba region. In

addition, the 2005 POA revealed a desire to draw attention to "medical deserts" ("on the medical 'deserts' in countries coming out of crisis (Angola, Liberia)"). In the absence of any real discussion of a notion that needed careful handling, the action was essentially limited to a handful of press releases asking for the fate of Liberian people not to be forgotten.
MSF-CH did not join in the campaign led by MSF-B and Save the Children UK to support free healthcare in Liberia. On the other hand, in 2008, it organised a public conference on the treatment of sexual violence. In the wake of the conference, MSF-CH also asked for sexual violence to be recognised as a "national priority" and recommended a "decentralised approach with integrated structures throughout the country" along with the introduction of special training (modelled on the Saclepea Women's Health Unit).
The history of MSF-CH's Nimba project thus conjures up a low-key participation in the reconstruction process, discreet, in disguise even. When the mission finally ended in late 2009, the results were far from negative. However, it would not be wrong to ask if the section would have done better by discussing its relationship to post-conflict reconstruction more openly.

Epilogue
As the Liberia mission was ending, the 2008-2011 Operational Plan stressed that "our organization is suffering from a 'this is not MSF' syndrome which tends to restrict initiative, progress and to favour the implementation of standard rules without an understanding of their raison d'être and their natural need to evolve with time. Anything can become an MSF practice from the moment it is relevant to the people we assist". This appeal to deliberation possibly came too late to trigger discussions o n MSF-CH's role in the post-Taylor Liberian reconstruction process.

2.2.3. MSF-B: RECONSTRUCTION VIA LOBBYING

As regards MSF-B, we can recall that 2005 was meant to usher in a massive reduction in activities, or even a forthcoming closure, for the Liberian mission. However, this opinion was reversed during the year, re-energising MSF-B's mission.

Renewed energy starting in 2006
While projects were being successfully handed over, the Liberian mission received a number of visits from head office, particularly the AAU/Analysis and Advocacy Unit. This unit was exploring the operational impact of free healthcare: having supported cost recovery in the 1990s, in 2003 MSF-B committed

to a contrasting policy of lobbying for free healthcare.[136] Post-conflict situations seemed favourable to promoting messages of this kind. People were still fragile and impoverished, and the free care standpoint could draw on the idea of a necessary transitional period during which payment of care by patients should be suspended, or not reintroduced. MSF-B had supported this policy in other post-conflict context, like Burundi and Sierra Leone. There were those who pushed for this action to be extended to Liberia. In August 2005, a visit from the AAU led to the production report recommending strong action against the temptation to reintroduce cost recovery in Liberia.[137] In September 2005, an AAU manager circulated a text within MSF criticising "the isolationist attitude" of certain MSF missions, and recommending that links be established with other actors to influence public health policies at certain decisive moments[138]. The next month, the AAU produced a similar text for the La Mancha discussions. This text cites post-crisis situations like Burundi and Liberia where MSF still had a role to play thanks to its political influence and knowledge of health issues.[139] It was particularly important to protect local populations in post-conflict situations from too sudden a return to development processes based on cost recovery.[140]

These ideas on MSF's reforming role in the post-war and reconstruction contexts were passed on by operational department heads and re-energised MSF-B's Liberian mission. The lobbying action meant that MSF had to know how to identify the different actors and their policies, to be able to establish links with them, and to manage to influence their decisions while continuing to head operations in the countries concerned. MSF-B also had to proof itself capable of producing information that could back up its recommendations regarding health policies. While making sure that it maintained its independence of action, MSF-B become involved, to a greater degree than the other sections, in a series of discussions with other aid actors, and particularly with the Ministry of Health and its

136. It is difficult to accurately date this reversal, but it was partially linked to a wide-reaching survey on access to healthcare that MSF-B carried out in Burundi in late 2003 (cf. Mit Philips, Inma Vazquez and Armand Sprecher, "Good donorship in practice: the case of Burundi", *Humanitarian Exchange Magazine*, no. 29, march 2005).

137. Suspended since September 2003.

138. "Action unique, parole unique, pensée unique: à un pas du contrôle de la pensée et de la Complaisance. MSF et les gardiens de la pensée unique de l'humanitaire », Mit Philips, September 2005.

139. "MSF and access to healthcare: in-the-field experience in lobbying for a change of policy", Mit Philips, October 2005.

140. This position was also supported by other participants, such as Egbert Sondorp (former MSF-H board member and lecturer at the London School of Hygiene and Tropical Medicine) who advanced the idea of a transitional post-crisis space wherein MSF still had a major role to play. He explicitly referred to Liberia in a text written for La Mancha (Sondorp, "Creating 'transitional space'", *My sweet La Mancha*, MSF, December 2005, p.288-290).

donors. This is why a liaison officer in charge of Liberian and Sierra Leonean questions was sent to the field in 2006.

Other actors, however, stressed that this lobbying action was not the only reason behind MSF-B's continuing presence in Liberia beyond 2006. Firstly, from an operational standpoint, 2006 saw a growing investment in Island Hospital. Having attempted to hand it over to the Ministry of Health, the Belgian section finally decided to take entire responsibility for the hospital, which specialised in paediatrics. The number of beds continued to rise: 50 in 2002, 65 in 2003, 122 in 2006 and 187 in 2008. Secondly, MSF-B's presence can be explained by the teams' uneasiness when faced with the difficulties caused by closing down projects and the question of handing over activities. Some opinions had it that maintaining the mission was linked less to the desire to influence the general direction of post-war health policies and more to the difficulties of finding satisfactory exit strategies.[141] We can well ask whether development of the Island Hospital project was not directly linked with the tensions caused by the difficult way that the Redemption project ended (tensions with the authorities and the staff as well as the teams' discomfort with withdrawal that sometimes made them feel they were abandoning the population). An internal MSF-B document specified the line to take in response to questions from the press and Liberian authorities:

"*Did you make the wrong decision by leaving Redemption? No. It made it possible to intensify the work at Island Hospital and to help many that we were not able to help while we were working at Redemption. I do regret that Redemption is not functioning well. The responsibility of the problems at Redemption is a collective responsibility and is shared by international donors, MSF and the government of Liberia*"[142].

Following a series of handovers in 2005 and 2006, MSF-B operations found a new raison d'être by focusing on an entirely private hospital structure and a group identified as particularly vulnerable in the post-war period: children. This new impetus has several causes: the difficulty in closing existing projects and the choice of concentrating on a paediatrics hospital combined with the action of lobbying for free healthcare to revitalize the Liberian mission.

From free healthcare to closure (2007-2010)

The Belgian section made a special lobbying effort during the international donors conferences that met in Washington in February 2007 to discuss Liberia. To coincide with the conference, the Belgian section published a report entitled

141. Interview with the MSF-B Head of Mission, Monrovia, February 2009.
142. "Redemption handover. Main messages", undated, unsigned. MSF-B Liberian Mission archives.

"No cheap solution for health care in Liberia: From emergency relief to development" (9 February 2007). MSF-B alerted donors to the difficult transition between emergency operations and development phase. As humanitarian actors that substituted the public authorities withdrew, MSF-B felt that a major investment effort was needed in the health sector. The report also supported maintaining free healthcare, citing the example of Redemption Hospital where the partial reintroduction of cost recovery led to a significant drop in attendance after MSF's departure.

It is difficult to assess the impact of MSF-B's lobbying policies in this area. Free healthcare has been maintained in Liberia until the present day. The Belgian section's efforts certainly helped, although other actors also supported the same position (ECHO). In addition, a UNICEF report underlined that the Liberian government did not have much in the way of other options that maintaining free healthcare in view of the population's poverty.

The Belgian section found it more difficult to call donors' attention to the need to support paediatrics hospitals in Monrovia. The Belgian and Spanish sections together covered 80% of this form of care in 2008. This meant that donors were basically participating in reconstruction of the primary care system within the country and the introduction of a Basic Package of Health Services (BPHS), a policy the ministry adopted in 2008.

After the relative success of 2007's lobbying activities, the Belgian section again raised the question of closing down its projects in Liberia. In 2008, a new plan to close activities was put in place, with a schedule reaching until late 2009. The teams' biggest concern was Island Hospital. The structure had undergone rapid growth that the teams felt was necessary due to the lack of equivalent structure in the country (Island grew from 50 to 187 beds between 2002 and 2008). In 2009, the ECHO representative believed that its size was a serious obstacle to being taken over by the Ministry of Health. MSF-B finally handed the structure over to the Ministry of Health in June 2010, without, as far as we know, having found any international donors to support the structure. It is still too soon to know what will happen to the hospital in the years to come.

2.3 CONCLUSION

Comparing the operations led by the three MSF sections in Liberia reveals both strong areas of convergence and deep-reaching differences over the analysis of post-conflict humanitarian aid.

In the immediate post-war period, the three sections set up fairly similar operations, tackling the Liberian situation with interpretative mechanisms inherited from wartime. As peace became established, these mechanisms for analysis lost their relevance, questions arose on the legitimacy of MSF's presence and operational policies began to vary from one section to the next. MSF-F spent some time hesitating between several options for its urban hospital, but after a heated debate finally decided it did not have a role to play in a country that was in the hands of the "developers". It was thus the first to leave. In late 2005, MSF-B was preparing to leave when a broader current of thought, mainly initiated by head office, reinvigorated the mission: it set itself the goal of influencing reconstruction policies and better managed its own exit strategies. The results of this choice are not yet known, and are only outlined here. MSF-CH also remained longer than MSF-F and became involved in a process to rehabilitate a health district. MSF-CH was no doubt the section that took the greatest role in the process to rebuild the health system—the process as perceived by the aid system. However, the Swiss section did not acknowledge this reconstructive role and, in contrast with MSF-B, hardly discussed its specific goals in this area. In the end, despite their differences, the three sections closed down their projects and left the country in a fairly short space of time (2007-2010).[143]

Aside from the actual policies, it is interesting to note the extent to which post-Taylor Liberia triggered debate, in the field and at head office, on MSF's intervention contexts and the possible roles the organisation might or might not choose to play. There were those who felt that post-Taylor Liberia represented a risk of drifting off course and possibly getting bogged down in development approaches that did not correspond to MSF's "core business". Other rejected this notion of "core business" and called on MSF to be less isolationist, more innovative and more responsible in the difficult situations of post-conflict transition. This study's purpose is not to sanction any particular opinion. However, it is interesting to note that most deliberations at that time took the Reconstruction issue seriously. Both those who believed that MSF had no place in the post-war period and their opponents all ended up accepting the terms of debate as laid out by the key aid players' dominant view (see part 1). To some extent, the terms of the debate triggered by the post-conflict situation were not questioned, but taken as read: post-conflict humanitarian issues did in fact merge with reconstruction issues; the choice was to participate or not participate. In

143. MSF-B did however maintain a reduced presence in 2010 in Liberia, and MSF-F sent an exploratory mission there, although it did not lead to a decision to open a mission.

the following section, we will try to highlight the political choices underpinning the Reconstruction message and stress the value in questioning humanitarian post-conflict issues with analysis perspectives other than transition, reconstruction and development.

3. ALTERNATIVE ANALYSES: A DIFFERENT POST-CONFLICT CONTEXT, DIFFERENT HUMANITARIAN ISSUES?

The dominant views, based on rebuilding a failed State, the URD continuum and the New Liberia, influenced all actors in the aid world. Even for those who chose to remain outside the systems that produced them, these views continued to model the analysis perspectives used to understand the dynamics of post-conflict Liberia.

3.1. REVISITING THE FACTS: A PEOPLE ON ITS KNEES IN A DEVASTATED POST-WAR COUNTRY?

To say that a country is devastated by war and that its people come out of the conflict on their knees is nothing out of the ordinary. Post-Taylor Liberia was no exception, especially since the violent fighting with its succession of men in wigs and child soldiers made an impression on the international media. In response to the tales of destruction, "reconstruction" naturally emerged as the dominant theme, particularly in the healthcare domain. However, the relationship between the war and the health situation in Liberia is more complicated than it first appears. Reports that began to appear in 2003 to assess the health situation in Liberia testified to an extremely worrying situation. These figures justified the idea of a necessary and massive investment in rebuilding the health system. However, in the absence of quantitative data, difficult to produce in the immediate post-war period, most reports were based on figures dating from the 1990s, or even the period before the war. In 2007, the DHS (Demographic and Health Survey), carried out in line with international standards, was meant to provide decision-makers with health indicators and simultaneously report on the worrying condition of the people.[144] Although the survey revealed a far from positive situation,

144. LISGIS, MOHSW & Macro International Inc., *Liberia Demographic and Health Survey 2007* (June 2008).

it also reported some surprising figures. For instance, the improving health and life expectancy among some segments of the population during the war. According to the DHS, child mortality, one of the most widely used indicators after the war, had been dropping steadily since the 1980s, including during the war. Other surveys also revealed somewhat surprising situations: for example, many observers expected a high HIV-positive incidence among the Liberian population after the war and the accompanying sexual violence.[145] However, the incidence seemed relatively low (1.5%[146]), equivalent to Guinea and Sierra Leone and lower than their Ivorian neighbours (4.7% in 2005[147]) and Ghana (2.2% in 2003). Another example is the survey produced by the ACF organisation in February 2008 on the nutritional conditions in the urban environment, which revealed more worrying figures than in inland rural areas even though they had been declared underserved and were thus a priority for food and nutritional aid.

We can of course choose to ignore some of these results, as the fruit of surveys using dubious methodology. This applies to the 2007 DHS: many observers agree in saying that it was based on faulty or totally out of date demographic data. But we could also consider that these fragmentary and sometimes questionable data encourage us to revise hasty judgements on the links between war and health.

Prior to the war, the main healthcare provided in Liberia came from the private sector, often missionaries or linked to concessionary companies, a sector inaccessible to most people. With the war, hundreds of thousands of people, particularly very young people, took refuge in a succession of camps in Liberia or abroad, where they benefited from relatively unprecedented access to curative and preventive medicine (particularly vaccinations). It is not unreasonable to think that, paradoxically, the health conditions of certain age categories improved because of their forced exodus to the camps.

We are not saying that the war was a positive phenomenon for Liberians' health. But we need to qualify the idea of total destruction of the health economy and uniformly severe downward trend in health indicators. The situation was far more complex: for certain populations, fleeing their homes paradoxically resulted in improved access to healthcare. For some other groups, the war brought damage to healthcare structures and their ensuing inaccessibility. It is thus possible that

145. As far as we know, this link between an increase in the HIV epidemic and rape has not been proven. However, it is often confirmed by aid actors in the conflict situations.

146. *Liberia Demographic and Health Survey 2007*.

147. The Ministry of Health's "Survey on AIDS Indicators"

the mother-child health indicators, closely monitored by international NGOs, improved while the condition of other groups deteriorated. The MSF-F Desk adopted the same analysis at Mamba Point Hospital when they refocused treatment on uncared for groups: "Adult men were the ones whose health has been neglected."[148] We do not wish to deny the impact the conflict had on the Liberian population's health. What we do want is to put an end to the perception of post-Taylor Liberia as a *tabula* rasa where everything needed rebuilding. We would also like to qualify our analyses and understand health situations that were more nuanced than the perspective rooted in the shadow State and barbaric wars would allow.

3.2. RECONSTRUCTING THE POLITICAL DIMENSION OF THE RECONSTRUCTION PROCESS: AID WHERE PEOPLE ARE/AID TO WHERE WE'D LIKE THEM TO BE

The notion of "reconstruction" of a failing State was purportedly grounded in the international community's generosity and solidarity with the Liberian people. Above all, it gave the impression of being based on facts and common sense: in the wake of a war, the next step was clearly reconstruction. And yet, the words and actions relating to rebuilding the New Liberia also encompassed political stakes linked primarily to rebuilding law and order, a concern shared by the new regime and key international players (see first section). One of the major questions arising in the aid world just after the war was how to manage displaced populations, representing over a third of the Liberian population. To kick-start Liberia, its State and its economy and ensure law and order, the various national and international authorities wanted to return all displaced people to their homes. The refugee displaced persons camps were seen to be areas lacking in law and order and a potential source of trouble. Monrovia's poor and overpopulated neighbourhoods were seen as a breeding ground for crime and opposition (several riots broke out in Monrovia, all blamed on "ex-fighters"). Aid actors were roped in to contain this "threat" in the guise of participating in "reconstruction". The UN agencies, particularly the HCR and its implementing partners, were in charge of taking Liberians back to their "native region", sometimes with the support of UNMIL soldiers or the Liberian police to calm down the streets of Monrovia and "encourage" IDPs to leave.[149]

148. Interview with the head of the MSF-F Liberia Desk, December 2008.
149. See Michel Agier's analysis in *Vacarmes*, no. 40, 2007.

The imperatives of political management of the people had a direct impact on humanitarian organisations and the choices they were encouraged to make in distributing aid. The question was, where should aid in post-Taylor Liberia be directed? Should it be distributed where the people were, and thus focus on Monrovia, which was home to 40 or 50% percent of inhabitants? Or should it be allocated to the place the population were meant to return to[150] and get back to work (rural areas, particularly plantations and mining areas in the north)? International actors and the new Liberian government made a pretty clear decision: aid would go to useful areas (rural zones) and not to support the "useless" and "dangerous" people still massed in the ghettos of Grand Monrovia. The argument was never expressed in such direct terms, but was suggested far more subtly: the war in Liberia was described as the fruit of an historical imbalance between the "natives", the people living inland, and the Americo-Liberian elite, primarily urban. So as not to repeat the mistakes of the past, it was therefore necessary to invest in underserved areas (to use the terminology in vogue among texts produce by the World Bank and United Nations in Liberia), i.e. rural areas. Aid was thus directed at rural areas in the name of the poor and vulnerable. Another stated rationale was the necessary levelling out of an historical imbalance linked to the very origins of the Liberian republic. The argument was not lacking in logic—apart from the fact that many of the underserved were then gathered in the urban areas that were no longer reserved for the Congo elites alone.[151]

These decisions in the geographical distribution of aid were fairly clear to see in the National Health Plan and the priority it gave to primary care structure in rural areas with the least services. Monrovia and the health needs of its million and a half inhabitants were pushed into the background. However, it is not MSF's place to judge these policies; in their concern for law and order and, doubtlessly, as a matter of conviction, the government and its international support felt that the return of people to rural areas was the best guarantee of an enduring return to stability; all efforts were concentrated on that purpose, and thus the aid machine too. However, it is important to understand this policy and the consequences for vulnerable populations. They had a difficult choice: return to the rural areas they came from to receive aid, or remain in the camps and squats and manage by themselves. In deconstructing the reconstruction messages and policies, it is possible to come up with other possibilities for humanitarian intervention.

150. The place it was supposed they wanted to return to.

151. We use the term to mean the descendants of the Afro-American colonisers who made up the political and social elite of the Liberian republic from the outset. See Stephen Ellis, *The Mask of Anarchy*, 1999.

3.3. OTHER POSSIBILITIES: FROM IDPS TO THE DISPOSSESSED IN THE NEW LIBERIA

When we shift from the question of humanitarian organisations' role in reconstruction to the effects of the political choices tied to reconstruction, other figures emerge and open the door to other operational projects.

In the months following Johnson-Sirleaf's election, the Liberian authorities endeavoured to reconquer the spaces occupied by squatters, such as plantations, mines and, especially, Monrovia's urban areas. Useable urban space was relatively rare and land prices soared with the arrival of a huge wave of international actors. In just a few months, thousands of inhabitants were encouraged or forced to leave their homes. Rehousing solutions were wholly inadequate. Some of these former squatters no doubt returned to the rural areas they had come from, for want of a better solution, but many stayed in the capital and crammed into the poorest and most insalubrious outlying neighbourhoods of Grand Monrovia.

These are the "dispossessed", a traditional figure in West African urban history, but totally absent from the traditional categories used for humanitarian intervention. The MSF-F and MSF-B teams took some interest in them by investigating the ghettos, but without identifying a convincing operational intervention format. The MSF International Office survey conducted in Liberia in 2006 also asked the teams to think about "collateral victims" of Reconstruction policies[152].

Like the IDPs, the dispossessed were running away, although not from the same thing: fighting in one case, the law and the police in the other. They differed in every other respect. In Liberia, IDPs were a central figure, greatly in evidence, familiar to the humanitarian systems. The dispossessed, on the other hand, were newcomers living on the margins of society and hard to pin down in two ways: they did not exist as a legitimate intervention category, and unlike IDPs, they tended to be dispersed rather than concentrated by their flight. However, if we retrace some of their journeys, we might find that many of these "dispossessed" were themselves former IDPs who arrived in Monrovia at different periods of

152. "Several factors strongly suggest that the clusters in Liberia will define common strategies to be imposed on all participants. These include the already high level of UN integration, the proliferation of coordination structures adopting common positions (e.g. MSG), historical experiences of politicization such as the IDP return and the potential for fusion between the clusters and the LRDC's four-pillars process. One key humanitarian actor expressed concern that such common positioning risks 'collateral damage' of populations not covered by assistance, such as non-returning IDPs. The question is if and how an independent actor like MSF should meet the needs of populations neglected in the UN or World-Bank led processes." (Katharine Derderian, *Liberia and the Humanitarian Reform*, MSF, International Office, October 2006).

the war. Did the displacement caused by war create more health needs than post-war evictions? The answer is unclear: the rate of malnutrition in urban areas reported by ACF in post-Taylor Monrovia and the recurrent cholera episodes that MSF treated indicate that the area has major health needs, which could possibly be linked to this new generation of displaced people, those still on the run after the war. Getting a better understanding of this issue would entail tackling health problems in Monrovia from a different angle: not from the overly diffuse perspective of urban development, which discourages or paralyses some MSF sections, but from the viewpoint of aiding a very specific population, a displaced population who are in danger, exhausted from successively fleeing the armed militia then the new power's forces of order. A post-conflict intervention outside the province of reconstruction is one possible solution among others; such a solution arises once we consider the post-conflict situation otherwise than solely in the light of the Reconstruction paradigm.

List of Abbreviations

ACF	Action Against Hunger
ANR	Congolese National Security Agency
CGR	Congolese Commissariat General for Professional Reintegration
CIAT	International Committee in Support of the Transition
FAC	Congolese Armed Forces
FARDC	DRC Armed Forces
EDF	European Development Fund
FONAMES	National Medical & Health Fund
IRC	International Rescue Committee
LRRD	Linking Relief, Rehabilitation and Development
MONUC	United Nations Organization Mission in the DRC
MSF	Médecins Sans Frontières
MSF-B	Médecins Sans Frontières – Belgian section
MSF-F	Médecins Sans Frontières – French section
MSF-CH	Médecins Sans Frontières – Swiss section
MSF-E	Médecins Sans Frontières – Spanish section
NFI	Non Food Items
WFP	World Food Programme
HSRSP	Health Sector Rehabilitation Support Project
PATS	Transition Support Programme
CPA	Complementary Package of Activities
EIP	Expanded Immunisation Programme
MPA	Minimum Package of Activities
EMRRP	Emergency Multisector Rehabilitation and Reconstruction Project
PUC	Congo Emergency Team
RCD	Congolese Rally for Democracy
SRSS	Health System Strengthening Strategy
TB	Tuberculosis
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs