

Chapter Eight

CÔTE D'IVOIRE, GUINEA, & SIERRA LEONE

Why Are the Refugees There?

Over the past nine years, civil wars and continuing political instability in Liberia and Sierra Leone have uprooted hundreds of thousands of people, forcing them to live as either refugees or internally displaced persons. Yet at the same time, both countries have also been places of refuge. Liberia has produced one of the largest refugee populations in the world; but it has also provided asylum to some 120,000 Sierra Leoneans escaping their own country's civil war.¹ And although approximately 380,000 people fled Sierra Leone in the past seven years, UNHCR estimates that Sierra Leone is a temporary haven for some 14,000 Liberian refugees. An estimated one million Liberians and 800,000 Sierra Leoneans have been displaced within their national boundaries.² At one point, neighboring Guinea sheltered approximately 650,000 refugees: 400,000 from Liberia and 250,000 from Sierra Leone.³ According to UNHCR, as many as 327,000 Liberians found refuge in Côte d'Ivoire, though that number has now decreased to some 210,000. These refugee populations are extremely fluid, making it nearly impossible to determine precise numbers. As conditions stabilize,

refugees may return home only to flee again if more fighting erupts.

In 1989, fighting broke out between the National Patriotic Front of Liberia, a rebel force led by Charles Taylor, and the army of former Liberian president Samuel Kanyon Doe. Liberians fled to the neighboring countries of Guinea, Sierra Leone and Côte d'Ivoire as the war escalated. After Liberian factions signed a peace treaty on August 19, 1995, plans were made to repatriate the refugees. But in April 1996 intense fighting resumed in the capital, Monrovia, and quashed repatriation plans. Another truce was established four months later. In July 1997, Charles Taylor was elected president. Liberian refugees are cautiously optimistic about the election outcome. Many are waiting to see if real peace takes hold in the country before they decide to return home.

In neighboring Sierra Leone, fighting between the rebel Revolutionary United Front, led by Corporal Foday Sankoh, and the national army raged from 1991 until elections were held in March 1996. The election of a civilian president, Alhaji Ahmad Tejan Kabbah, resulted in a period of calm and optimism—which was shattered in May 1997 when the elected

¹ 1997 *World Refugee Survey*, U.S. Committee for Refugees.

^{2,3} U.S. Committee for Refugees

government was overthrown by a military junta. Thousands more Sierra Leoneans fled to neighboring Guinea. Although President Kabbah returned to office in March 1998, fighting between the Nigerian-led West African Peace Keeping Force, ECOMOG, and the military junta continues throughout the countryside. As a result, Sierra Leoneans are still flowing into Guinea and Liberia.

General Conditions— How Do the Refugees Live?

Côte d'Ivoire

Until 1995 all refugees were integrated into the Ivoirian community in nearby border villages of Danane, Toulepleu, and Guigilo. A rebel incursion in the Tai area in June that year prompted the Ivoirian police to try to dislodge Liberian refugees in the region. The police often used violence, including rape and murder, to do so. Refugees fled in fear to the Red Cross warehouse where they remained until Peace Town, the only refugee camp in the country, was established. By February 1997, some 5,000 to 7,000 refugees were living in Peace Town, although official registration numbers are believed to be much higher than the actual number of inhabitants. The rest of the refugees remain well-integrated in Ivoirian communities.

There is a general feeling that living conditions for the refugees are worse now than noted in the 1994 RHR Report. It has become more difficult to obtain land and farms, and there are few other economic opportunities. Liberians work for other farmers or, if they have skills, they work on contract. Inflation has increased, and so have rents. Some refugees in and around Guigilo were forced to relocate after their

houses were razed in an effort to rehabilitate the area. Food rations have been cut to all except vulnerable refugees. Refugees often used these rations as a source of income as well as a source of nourishment.

Guinea

Guinea is home to approximately 650,000 refugees. Unlike Côte d'Ivoire, refugees in Guinea live in camps ranging in size from under 1,000 to 35,000 people. There are numerous camps spread throughout the Forest Region and interspersed among Guinean villages. In the Gueckedou region, there are as many, if not more, refugees as Guinean citizens. Many camps house both Liberians and Sierra Leonean refugees. As in Côte d'Ivoire, some refugees have lived in Guinea for as long as eight years. Food rations in Guinea are also now available only to those deemed vulnerable. Some refugees earn food and income by farming and cultivating gardens; others by harvesting crops or cleaning houses on contract. Nearly all work long hours for little pay.

Although conditions are difficult, there have been some improvements in the past few years, including an increase in some services. Business training and literacy classes are offered at some camps; and the American Refugee Committee (ARC) and UNHCR provide loans for small start-up businesses. The International Rescue Committee (IRC) runs 47 schools with 300-400 refugee children enrolled in each school.

Sierra Leone

UNHCR estimates that some 17,000 Liberians live in Sierra Leone. Approximately 800,000 Sierra Leoneans, displaced from their homes during the civil war, are living in camps in their own country. Until recently, refugees and displaced persons received nearly iden-



The Marie Stopes Society of Sierra Leone was the first to be on the ground providing RH services to refugees in Sierra Leone. When its own civil war broke out, the MSSSL began providing RH services to displaced Sierra Leoneans.

tical services. However, shortly before the RHR Consortium team's visit in March 1997, the government cut funding and services to displaced persons in an effort to encourage them to return to their homes. The coup in May 1997 dashed any hopes for a mass repatriation.

Which Agencies Are Providing Health Services to the Refugees?

The Ivoirian government health system is the main source of medical care for the refugees in Côte d'Ivoire. As of late 1997, Africare was the only NGO allowed to provide clinical services to the refugees.

In Guinea, refugees are dependent on the Guinean government health system and, for clinical services, Médecins Sans Frontières (MSF)/Belgium in the N'Z-

erekore region or GTZ in the Gueckedou region. IRC and the Regional Working Group are two of the NGOs providing health education to refugees. The Association Guinéenne pour le Bien-Etre Familial (AGBEF) and Population Services International (PSI) are both present in the Forest Region and serve some of the refugees living in the area. Each Département Prefectoral de la Santé (DPS) of the seven prefectures in the Forest Region is responsible for all health activities in the area, including coordination of the NGOs.

At the time of the RHR Consortium team's visit, the Adventist Development and Relief Agency, MSF/Belgium, Concern Worldwide, The Marie Stopes Society of Sierra Leone (MSSSL), and the Planned Parenthood Society of Sierra Leone were the primary organizations providing clinical services to refugees and internally displaced persons, in addition to the Sierra Leonean government health system.

General and Reproductive Health Care and Services

Côte d'Ivoire

Refugees have two options for receiving "Western" medical services: they can go to the Africare clinic at the camp, or to an Ivoirian clinic/doctor. The Africare clinic boasts a doctor and a midwife who dispense contraceptives, including pills, injectables, condoms, spermicides and IUDs. They also provide treatment for STDs as well as deliver babies and offer pre- and postnatal care. Emergency obstetric cases are referred to the hospital in Dalaoa. In the past, Africare provided both consultations and medications free of charge to the refugees. But due to budget constraints, refugees are now expected to pay for medicine. A lack of reliable and affordable transportation makes it

difficult for those refugees living outside the camp to use the clinic. Africare recognizes that the RH component of its services has been limited within the demands of providing comprehensive health care.

There appears to be a wariness about using the Ivorian health system. Refugees say they do not speak the same language as the Ivorian health care providers, they are mistreated at government clinics, and the services are expensive. Many refugees, then, wait until their health deteriorates significantly before seeking care. The Ivorian government does not allow Liberian health care workers to practice in the country because it does not believe there is a need for parallel services and because, they argue, there would be no way to ascertain that the service providers were trained and certified. An underground network of Liberian health care workers may exist; but Liberian

physicians, nurses and midwives fear incarceration if they are discovered treating patients.

In the past two years, there have been some improvements in the RH services available to refugees, but few refugees in Côte d'Ivoire have access to comprehensive and affordable RH services. IRC continues to offer RH education classes in which thousands of men, women, and adolescents have participated. The RH curriculum consists of seven sessions and includes information about family planning, the dangers of unsafe abortion, and STDs/HIV. To increase access and attendance, IRC health workers conduct the classes at times and locations convenient for the participants.

However, a Liberian nurse-midwife and IRC health worker, says that since food rations were decreased, people have been struggling to find food for their

WOMEN'S RIGHTS INTERNATIONAL/WOMEN'S HEALTH AND DEVELOPMENT PROGRAM

A small organization is helping Liberian women confront the issue of sexual and gender-based violence and encouraging them to work together to try to prevent it. Founded by an American physician, collaborating with a Liberian institution, and composed of six Liberian staff members, the Women's Health and Development Program first targets traditional midwives, healers, and other influential women in the community and explains the goal of the project. If the women are interested, they are asked to organize a group of participants and locate a site in which to hold meetings. Using an innovative curriculum/discussion guide they developed themselves, staff members meet with the group for ten sessions, building trust at each meeting. The women are encouraged to meet among themselves after the official sessions are over. One group in Liberia has grown from 10 original participants to more than 350. When fighting broke out in Monrovia in April 1996, the organization's six staff members fled the country. But they subsequently established a base in Man, Côte d'Ivoire, and are working with Liberian female refugees in that country.

Staff members noted the gradual change in attitude among participants. Over the course of the sessions, women who initially said violence is a way of life, and nothing can be done started asking: what *can* be done? The women have also learned the importance and value of group discussions. Says one staff member: "Strength is drawn out of unity and being together."

families. Consequently, people do not have time to attend classes as frequently. But preventive efforts, such as the IRC health classes, she says, have had a positive impact on the community. More people know about family planning and where to

get it. The nurse-midwife says she does not hear about incidences of unsafe abortion as often as she used to. IRC continues to sell low-cost contraceptives to refugees, and, when necessary, will help a refugee obtain a prescription from an Ivoirian or Africare doctor. But many refugees are deterred from using contraceptives if they have to pay for them.

Guinea

When asked about local health services, refugees routinely reply: "chloroquine and aspirin". No matter what the symptoms, when refugees go to Guinean hospitals or clinics they are given chloroquine or aspirin. As in Côte d'Ivoire, refugee medical personnel are restricted from practicing.

In theory, refugees in Guinea have access to RH care. In practice, that access is severely limited. Family planning and other RH services were more accessible in Liberia, so the dearth of RH services in Guinea is especially apparent. Many refugee women say it is more difficult to obtain contraceptives in Guinea than it was in Liberia. Out of approximately 30 refugee women in an adult literacy class at Zarabaga

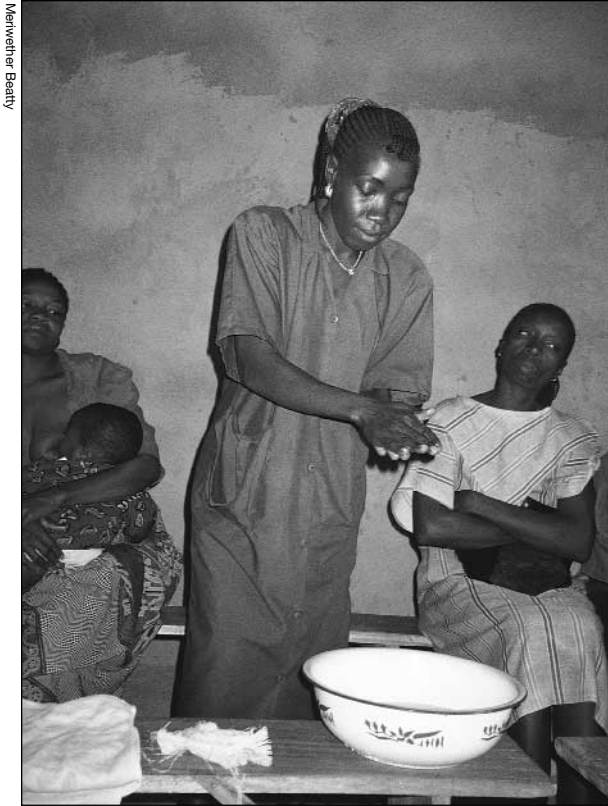


A group of refugee students outside of an IRC school in Macenta, Guinea. It is essential that young people be given an opportunity to continue their education while displaced.

Menwether Beatty

Camp outside of Gueckedou town, only two were using family planning. One was using an IUD which was inserted in Liberia seven years earlier, the other was using oral contraceptive pills. The second woman had to walk an hour and a half to the clinic each month to get one cycle of pills. Sometimes she would make the trek only to discover the clinic was out of stock. In group discussions, women revealed that, despite the difficulty in obtaining contraceptives, the two most common reasons for not using family planning were that the woman's husband or boyfriend did not approve, and that family planning was too expensive.

There is no reliable data on the percentage of pregnancies that are unintended or on the incidence of abortion. One woman said she uses natural family planning and abortion to space her children. Although abortions are illegal, safe abortions are apparently available if one can afford them (about \$US 50); but \$US 5-10 dollars can buy a less safe abortion. We were told that a refugee girl died from an unsafe abortion a week before our visit to the area. While refugees with money can buy good health



MarieWeber Beatty

TBA training for refugees in Macenta, Guinea. TBAs play an important role in many refugee camps, serving as a vital link to health services.

care, most refugees in Guinea do not have that luxury. As one UNHCR official notes: "The truth is that people have to pay at the hospital, and it is reasonably expensive."

Although access to clinical RH care for refugees is limited, over the past three years there has been an increase in preventive education and awareness-building programs. In 1994, IRC established a preventive health education program that addresses refugees' health concerns, including family planning and STD/HIV prevention. There is no data on the prevalence of HIV in the refugee community; but other STDs are believed to be common. Induced abortion by untrained individuals is also believed to be a problem among sexually active refugee students.

According to Jacob Lawuobahsumo, IRC's Senior Health Specialist, three refugee students at IRC schools died from complications related to unsafe abortions last year. In an effort to disseminate RH messages into the community, IRC has formed health clubs within the well-developed refugee school system. The agency also organized Young Women's Social Clubs, designed to offer female high school students a comfortable forum in which to discuss reproductive health and other important issues. IRC has also begun selling condoms in the schools. Both male and female students at each junior and senior high school are selected and trained to be RH peer educators and condom salespeople. PSI also has a social marketing program in the Forest Region, and PSI condoms are sold in bars, hotels and restaurants throughout the area.

Though refugee health personnel are barred from practicing in Guinea, some refugees are working hard within the legal framework to improve the reproductive health of displaced persons. The Regional Working Group was founded in 1994 by two refugee men. They saw that many refugee women, with no source of regular income, turned to prostitution, and thus risked their health, and potentially their lives, on unsafe sex practices. Believing the entire refugee community could benefit from health education, they submitted a proposal to GTZ. Following a successful five-month trial, the program devised by the Regional Working Group was awarded funding for four years. With overhead consisting of two motor-bikes, a pickup truck, and one computer, the Regional Working Group has recruited and trained 133 facilitators to educate refugees about family planning, STDs and HIV/AIDS, hygiene, sanitation, and maternal and child health. The Group gathers refugees together to identify their problems and agree on a solution. All

the facilitators are women, many of whom have a post-graduate certificate and experience in community health. All participate in general training and then divide into groups for more specialized training on particular topics. The facilitators operate in 17 camps, as well as in the towns of Gueckedou and Kissidougou. Family planning facilitators are trained in community-based distribution and they dispense condoms. The Guinean DPS has approved the employment of 24 refugee nurses at health posts. The facilitators refer people to these nurses for other family planning methods as well as for treatment of STDs. The facilitators also encourage all pregnant women to obtain prenatal and postnatal care. The Regional Working Group has registered in Liberia; and members hope to continue their work after they return to Liberia.

The American Refugee Committee, the newest member of the RHR Consortium, gave a grant to 39 refugee midwives to obtain certification from the Guinean Government to practice their mid-wifery skills in the camps. The certi-

fication process was sanctioned by the DPS to provide refugees more access to pre- and post-pregnancy care. The primary goal of the project was to provide refugee health care workers a source of income. ARC hopes to expand this program with the Guinean authorities. ARC also recently completed an RH needs assessment among Liberian refugees living in Guinea. ARC, JSI Research and Training Institute and World Education plan to collaborate on a literacy/RH project in the Gueckedou area.

“An often-repeated request made by women (especially those of urban origin) in the district is for family planning advice and contraceptives.”⁴

Sierra Leone

Sierra Leone provides an excellent example of how to use local resources to ensure that refugees have access to RH care at the beginning of their displacement. MSSSL has been providing RH services to Liberian refugees since July 1991. When fighting in Sierra Leone uprooted people from their homes, MSSSL began providing RH services to internally displaced persons, as well. The Planned Parenthood Association of Sierra Leone is also providing RH services to some internally displaced people. MSSSL runs RH clinics in Jui refugee camp, as well as in the Clay Factory and Waterloo camps for displaced Sierra Leoneans. The agency collaborates with other organizations, such as ADRA and MSF, in providing primary health care at the camps. MSSSL offers prenatal care,

deliveries, family planning and STD counseling and/or treatment; and the organization will refer a patient to its main clinic in Freetown for emergency obstetrics, infertility, sterilization or IUD insertion. (Since the time of the RHR Consortium team's

visit, the coup has disrupted services. At one point, MSSSL was having difficulty obtaining contraceptive supplies due to an embargo.) MSSSL provides ambulance service twice a week to its Freetown clinic. Although RH services were accessible to those refugees and internally displaced Sierra Leoneans living in the Freetown area, we were told it was much more difficult for those living up-country to obtain services.

⁴Assessment of Liberian refugee women, children, and vulnerable groups situation in Sierra Leone. 14 November- 5 December 1990: PTSS Mission Report, UNHCR.

Sierra Leone has some of the worst population and health indicators in the world. According to UNFPA data, Sierra Leone has a maternal mortality rate of 1,800 per 100,000 live births and a total fertility rate of 6.3.⁵ Obstetric emergencies are said to be common among the displaced; and STD re-infection was frequently mentioned by health workers when asked about common RH problems.

Female genital mutilation is common in Sierra Leone; according to some estimates, as much as 99 percent of the female population has been circumcised. Circumcision is part of the broader coming-of-age initiation rite of the secret societies in which girls are sent to "bush schools" to learn certain skills as they enter womanhood. Though war has disrupted some traditional initiation rites, female genital mutilation still occurs in the displaced camps. In January 1997, mass ceremonies were held in Grafton and Clay Factory displaced camps during which, it is believed, more than 3,000 girls were circumcised. MSF sent a nurse, who is a member of the secret society, into the bush to give tetanus vaccinations and antibiotics to many

of the girls. However, several girls turned up at MSF clinics in the weeks following the mass ritual suffering from complications.

The Next Step

The RHR Consortium team heard repeatedly that the best way to improve RH services for refugees was to involve Liberian and Sierra Leonean health personnel and include refugees in training sessions. This would not only benefit refugees living in Guinea, but it would provide a substantial asset to Liberia, Côte d'Ivoire and Sierra Leone once the refugees repatriate. UNHCR recently identified more than 500 trained medical personnel who are refugees in the Gueckedou region. If they lose their skills during their displacement, a valuable tool for the reconstruction of their countries will be lost, too.

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⁵ *Resource Requirements for Population & Reproductive Health Programs - Country Profiles for Population Assistance*, UNFPA, 1996.