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Falling through the Cracks: The Mounting Health Crisis amid Situations of Precarious Stability

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MEDECINS SANS FRONTIERES

On behalf of Médecins Sans Frontières (MSF), I would like to thank the President of the Economic and Social Council for the opportunity to speak on the important topic of "health challenges in post-crisis situations."

When talking about post-conflict, we should neither presume that the humanitarian crisis is over, nor should we consider that patients no longer suffer life-threatening health problems. In most places where our organization has provided emergency medical assistance over the past 10 years, from Haiti to Sierra Leone, and from Burundi to the Democratic Republic of Congo or Central African Republic, the situation remains fragile after the war, if not tense in some parts of the countries. Even as the guns fall silent, the most vulnerable people who have survived violence still face tremendous economic and health challenges.

As a matter of fact, existing health policies are ill suited to meet ongoing humanitarian challenges: instead of improving the health status of the population, inadequate strategies, that include resorting to widespread fee-for-service health care financing, often cause a deterioration of the health and economic condition of those very individuals in dire need of care.

States and multilateral institutions have a responsibility to improve their understanding of their population's health needs in post-crisis times as well as their ability to respond adequately to these needs, with special attention to the most fragile groups.

Let me now go back to my first point:

Signing a peace agreement does not inaugurate the end of a humanitarian crisis nor does it wash away the health problems of patients. Unfortunately, the post-conflict period does not look as nice as we'd like it to look. Collapsed health systems and dramatic needs coexist in a deadly combination long after the conflict is officially over. In most cases, the political situation

remains fragile as exemplified by the Central African Republic, where regular banditry and localized clashes persist, leading to injuries for the victims that are clinically similar to war-related wounds. Because these tensions and their consequences are not acknowledged by the international actors involved in the peace building process, the humanitarian needs are not properly addressed.

Ironically, the transition from emergency to post-conflict can even precipitate a strange paradox: people's health status and access to health care sometimes deteriorate after the crisis, once humanitarian actors are no longer present to provide free health care to people, especially the most vulnerable. In other circumstances, NGOs cannot simply handover their program as the existing health system is unable to cope with medical needs.

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Just four years ago, MSF came before the UN Security Council to speak out about the incredible violence gripping the Haitian capital, Port-au-Prince. At that time, gunshot and stabbing victims were collapsing at the doorsteps of our hospitals. The city's inhabitants were caught in the middle of an explosive urban conflict. Our wards were overflowing with the victims of this intense violence.

Today, even though a relative calm has prevailed over Port-au-Prince for the past year, our emergency wards are still filled beyond capacity. Despite political stability, MSF is still one of the only providers of free quality emergency health services in a city of 3.5 million people. Just yesterday, though, in the *International Herald Tribune*, Secretary General Ban Ki-moon outlined his priorities for Haiti. Shockingly absent from his essay was any mention of the critical health needs remaining in the country. Instead, the Secretary General is calling upon donor governments and institutions to invest in the country as an emerging economy. This call couldn't be farther from the day-to-day needs of patients coming to MSF medical facilities

MSF's hospital wards are hemorrhaging, not from gunshot victims, but pregnant women suffering from life-threatening complications. Women travel as

far as 120 kilometers to reach the MSF-run Jude Ann hospital. Faced with a massive increase in admissions this past year, pregnant women have been forced to give birth in the hallways or stairwells of the MSF hospital. In Jude Ann, as many as 1,600 deliveries per month occurred in the facility—more than 50 per day at its peak. Since March 2006, MSF has provided obstetric care to more than 25,000 pregnant women in Port-au -Prince. Almost 60% of these cases involved complications, presenting life-threatening consequences for the mother and child. With a maternal mortality rate at 630 deaths per 100,000—the highest in the Western Hemisphere—pregnancy and childbirth for an impoverished woman in Haiti is one of the most dangerous enterprises.

Since 2005, MSF has provided emergency surgical care for trauma-related injuries. More than 14,000 patients were admitted in 2007 and 10,279 since the beginning of 2008. Initially, this program was intended to provide emergency surgery for victims during a time of open conflict between armed groups. Four years later, MSF continues to be *the only provider* of free 24 hour a day, 7 days a week emergency room services for trauma, burn victims, and survivors of sexual violence in the capital.

The absence of emergency services was painfully clear last April, when food riots took hold in the city and MSF treated 160 people for injuries, including 44 gunshot victims, in just four days. And later in the year, when the collapse of a school saw more than 110 schoolchildren transported across the capital to MSF medical facilities.

Without the existing MSF surgical and obstetric programs in Port-au-Prince and MSF's presence in neglected violent areas, residents would have no access to emergency care. Although significant international funding and strategies were meant to improve the public health care system, the majority of Haitians and especially the urban poor, still cannot afford quality lifesaving health care. Instead, they face frequent health worker strikes and the absence of free and quality services.

And that brings me to my second point :

Existing policies fail to meet the health-care needs of the poorest, and therefore the most vulnerable groups. Both inadequate strategy and unpredictable human and financial resources undermine access to quality health care for the most vulnerable.

Haiti is not the only area of intervention where MSF is confronted with critical gaps in nongovernmental or national health services during the transition from war to peace. The MSF experience is one of witnessing acute health needs even as donor policy papers outline so-called development-centered approaches. There is a strong temptation to move quickly to so-called sustainable forms of health financing in the post-crisis periods. But to give into economic dogma comes at incredible expense to the most vulnerable segments of a population.

MSF learned from its own missteps in implementing some of the recommendations of the Bamako initiative in the late 1980s and early 1990s. In Sierra Leone and Burundi, for example, the reintroduction of fee-for-service health-care policies had largely succeeded only in erecting barriers to accessing care. In Burundi, an MSF study in 2004 found that the national cost recovery system was effectively shutting out 20% of the country's entire population from accessing health care. Even the smallest fee amounted to a major obstacle for people trying to access health services.

In Sierra Leone., which is more than eight years removed from conflict, mortality is still four times higher than the average for sub-Saharan Africa, with a significant proportion of deaths caused by malaria. The disease takes a devastating toll on the population in rural areas. However, MSF clinics in Bo, Sierra Leone, saw a radical increase in consultations following the introduction of free care. The number of malaria cases diagnosed and treated doubled

compared to the previous year: 5,535 in June 2004 to 10,451 in June 2005. The trend was confirmed in the following months. The most vulnerable—children—were the greatest benefactors, with the number of treated malaria cases 10 times higher.

First and foremost, health policies should be based on the reality of the population's need and should ensure that medical treatment is available to the most vulnerable regardless of their ability to pay. Experience and field studies have proven that user fees exclude the poorest patients, dissuading them from coming to health centers for treatment.

Furthermore, exemption systems, while looking good on paper, rarely work in practice. In Sierra Leone, no more than 3.5% of children under five, breastfeeding women, and elderly people—all supposedly exempted from payment—actually received an exemption. In Burundi, only 1% of the population was officially exempted, a number far too low considering the country's poverty levels.

These inappropriate strategies have two major consequences: first because it limits access to health care, a user-fee system makes it difficult to assess the real health needs of the population and ultimately leads to inadequate health policies. Second, even modest charges for primary health care risk further impoverishing patients. In Burundi, 4 out of 5 households in the government cost-recovery system had to sell some of their belongings or borrow money in order to pay for health care. Even in the all-inclusive, flat-fee system initiated by MSF in four provinces, where patients paid a fee of 28 cents, 59% of the population still found it impossible to pay the flat fee without going into debt or selling their belongings.

On the other hand, it has been demonstrated that abolishing user fees results in more people seeking health treatment, without leading to an improper or unnecessary use of services.

Conclusion and recommendations:

MSF's experiences in Haiti, Burundi, Central African Republic, and Sierra Leone are emblematic of the dilemmas our medical teams continue to face in the transition from war to peace. The reality on the ground today is that there is a grave gap in quality health-care services for people in these so-called post-crisis situations. Donor funding, based on long-term unrealistic plans, rather than actual needs seen on the ground, lags behind and interrupts services that ironically had been functioning at basic levels during war times. In the end, children, women, and men are dying because their countries have been re-categorized and the very system established on paper to save them is failing them at every turn.

There is an urgent need for all actors to acknowledge the extreme vulnerability of some segments of the population affected by high mortality and widespread poverty, and to adjust health responses accordingly. The contributions patients living in poverty can make to finance their own health care are too small to be considered an essential part of health financing. They will make no difference to the sustainability of health structures, whereas they can significantly contribute to undermining people's coping mechanisms and to worsen patients' health.

Post-crisis environments urgently require a dual track approach which combines rebuilding the health system and dealing with immediate health needs of the population.

Thank you.