

Governance and Health in Post-Conflict Countries: The Ebola Outbreak in Liberia and Sierra Leone

EDITED BY MAUREEN QUINN



Cover Photo: A burial team carries the body of a suspected Ebola victim to a grave in a new cemetery at Disco Hill, Liberia, January 26, 2015. UN Photo/ Martine Perret.

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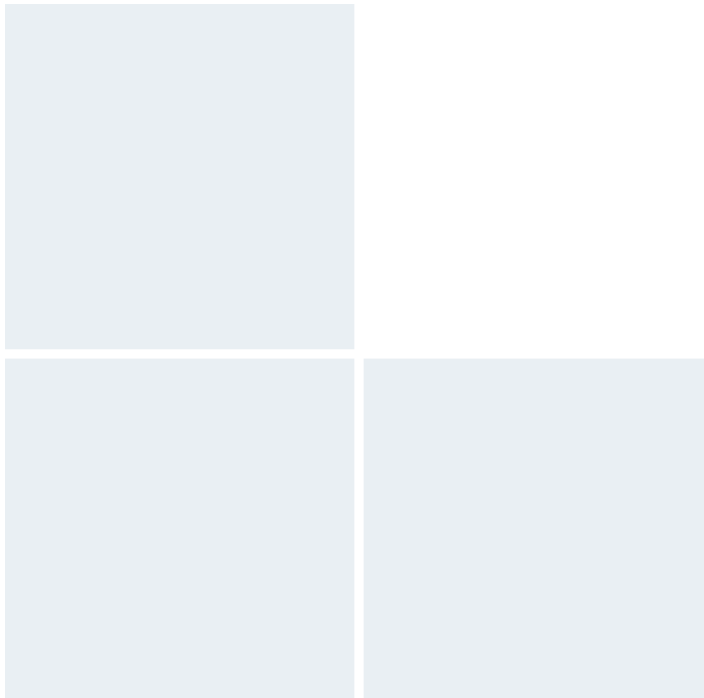
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Executive Summary

The outbreak of the Ebola virus disease in West Africa from 2014 to 2015 underscored the fragility of public health services in countries emerging from protracted conflict. In both Sierra Leone and Liberia, the war had destroyed health infrastructure, swelled the population of cities, and driven members of the professional classes out of the country. As a result, the health sector was chronically shorthanded and undersupplied, particularly in rural areas. Ebola arrived as the large-scale postwar international presence was downsizing and the responsibility for healthcare was shifting to the governments. Both governments had developed comprehensive health policies and plans, including devolution of health service delivery, but these were not fully implemented in practice.

In this context, both countries were unprepared for the Ebola outbreak, and their response underscored the important link between healthcare and governance, particularly when both had been weakened by conflict. The authors identify a number of lessons emerging from the response to the crisis in both countries:

- **Local engagement is critical:** In both countries, the initial response suffered from a lack of communication and coordination at the local level. The involvement of local actors who understood the local context and were trusted by their communities was crucial to eventually containing the outbreak.
- **Emergency measures can be effective but can also have negative consequences:** Both governments resorted to bold containment measures to curb the outbreak, including quarantines.

Although these measures helped contain Ebola, they could have been implemented in a way that would have led to fewer negative consequences.

- **Top-down approaches are insufficient, and inclusivity is necessary:** Both countries initially took a top-down approach in responding to the outbreak, partly because they had not effectively devolved management of the healthcare sector. Over time, the response came to involve more state and non-state actors, including civil society groups and traditional leaders, which facilitated prevention, control, and containment.

Building on these lessons, the authors offer a number of recommendations, including to:

- Implement existing national health policies and plans;
- Build national capacities to detect and respond quickly to health emergencies;
- Improve governance and leadership at the national and local levels;
- Strengthen community engagement in planning and managing health services;
- Rebuild trust in state institutions, including through dialogue with non-state actors;
- Ensure adequate budgetary allocations to the health sector;
- Improve oversight of health service delivery at the national and local levels;
- Build personnel capacity, particularly in rural areas; and
- Coordinate national efforts with regional and international efforts.

Introduction

*Maureen Quinn**

Instability and insecurity make people and communities more vulnerable to disease and prevent people from living healthy and productive lives. Conversely, stability and peace foster an environment conducive to public and private delivery of health services and the provision of humanitarian and development assistance. Violent conflict, even if its root causes are political, is linked to other areas of individual and social life, affecting humanitarian, development, and health issues. Deteriorating healthcare feeds into the challenges of conflict resolution by exacerbating human suffering and diminishing the potential for sustainable solutions and can have spillover effects in neighboring countries.

In 2014 and 2015, the International Peace Institute (IPI) undertook research and convened events on contemporary conflict dynamics and their impact on stability, governance, and development in Africa, particularly the Sahel-Saharan region. This led to two reports on political participation and governance: “Building Peace and Development in the Sahel: Enhancing the Political Participation of Women and Youth” and “Effective Governance in Challenging Environments.” In 2015, IPI turned its focus to the delivery of, and improved access to, health services, using the lens of health service delivery to assess the link among health investments, social and economic development, and social cohesion and peacebuilding. IPI’s research sought to better understand the links between peace, security, and health and to generate policy support to reduce vulnerability, mitigate risks, and increase the resilience of communities and state institutions to threats and instability.

Given that the Ebola virus disease emerged in West Africa during the first stage of this research project, IPI decided to focus specifically on the challenges of health service delivery in Liberia and Sierra Leone, two post-conflict countries. The

outbreak of the Ebola virus disease in West Africa from 2014 to 2015 underscored the fragility of public health services in countries emerging from protracted conflict. Weak institutional conditions and poor governance practices blocked optimal delivery of health services and contributed to health emergencies.¹ This report shares insights from two African researchers who aim to demonstrate the inherent nexus between health and governance and highlight recommendations for reform. The authors draw on interviews, focus groups, and government policy documents as the foundation of each case study.

In both Sierra Leone and Liberia, war had destroyed health infrastructure, swelled the population of cities through rural-urban migration, and driven members of the professional classes out of the country, with many yet to return. Moreover, while postwar policy guidance called for decentralization, including in the health sector, limited resources and lack of capacity outside the capitals hobbled implementation.

As a result, the health sector was chronically shorthanded and undersupplied, particularly in rural areas. In both countries, Ebola also arrived as the large-scale postwar international presence was downsizing and responsibility for healthcare was shifting to the government. But the governments of Sierra Leone and Liberia were not led, equipped, organized, or funded to undertake this new responsibility. They had both developed comprehensive health policies and plans, including devolution of health service delivery, but these were not fully implemented in practice. Governance of the health sector also suffered from mismanagement and corruption.

When the Ebola outbreak hit, both governments were reactive, not proactive. Containment strategies involving the military were mistrusted, and communication was confusing and inadequate. In

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1 United Nations Development Programme, World Bank, European Union, and African Development Bank, “Recovering from the Ebola Crisis,” 2015, available at www.undp.org/content/undp/en/home/librarypage/crisis-prevention-and-recovery/recovering-from-the-ebola-crisis---full-report.html.

Governance and Health in Liberia

*Edward Mulbah**

Introduction

When Liberia was hit by the Ebola virus disease in March 2014, it affected the fabric of the entire society, including its social, political, and economic conditions. The impact of the Ebola outbreak further demonstrated the fragility of the state, including its public health services, as it emerged from fourteen years of civil war (1989–2003), which came to an end through the 2003 Accra Comprehensive Peace Agreement (CPA).

The overall goal of this case study is to assess present and past governance and accountability in health service delivery and to consolidate key findings related to health and governance. It assesses Liberia's institutional frameworks, capacities, challenges, and lessons learned. Interviews were conducted with regional, national, and local officials, as well as medical professionals and both national and international nongovernmental organizations (NGOs). Desk research of key literature, documents, and reports related to governance and the Ebola crisis was also carried out.

Framework for Health Governance before the Outbreak

EFFECT OF THE WAR ON HEALTHCARE

Liberia's health system was seriously affected by the country's fourteen-year civil war. Hospitals and clinics were looted of medical equipment and drugs, and many were burned down or vandalized. By the time the war ended, only 354 of the 550

health facilities that had previously existed were operational, with the vast majority managed by NGOs. The headquarters of the Ministry of Health and Social Welfare (MOHSW) had become a temporary shelter for refugees and internally displaced persons (IDPs). Nine out of ten medical doctors had left the country in search of safe havens, the system for training medical personnel had collapsed, and only 168 physicians remained in the country, mostly in Monrovia.¹

HEALTH POLICY AND DECENTRALIZATION

Before the outbreak, Liberia's MOHSW developed a National Health and Social Welfare Policy and Plan for 2011–2021. The plan's overarching goal was to increase access to healthcare, make healthcare more responsive to people's needs, and make affordable healthcare available to all Liberians. In relation to governance, the plan aimed to shift functions, authority, and resources for healthcare to the local level; restructure the MOHSW; establish a framework to support the decentralization process; and strengthen local government structures.²

A number of additional policy frameworks also aimed to facilitate development and enhance capacity in the health sector. The Agenda for Transformation, a five-year development framework (2012–2017), emphasized that the government will build and operate responsive democratic institutions at the national and local levels and strengthen good governance and peacebuilding. It also provided for decentralization, beginning with deconcentration of essential government services, including healthcare, to each of the fifteen counties.

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1 Richard Downie, "The Road to Recovery: Rebuilding Liberia's Health System," Center for Strategic and International Studies, August 2012.

2 Ministry of Health and Social Welfare, "National Health and Social Welfare Policy and Plan 2011–2021," 2011, available at www.mohsw.gov.lr/documents/Final%20NHPP%20%28high%20res%29.pdf.

This aimed to strengthen the role of local organizations and leaders in making decisions and monitoring interventions.³

The Agenda for Transformation built on Liberia's decentralization and local governance policy, which included Guidelines for National Decentralization developed by the MOHSW in 2008. These guidelines provided for building capacity to manage health services at the county and district levels.⁴ Implementation of this policy has been slow, as the MOHSW's decentralized units had insufficient capacity to coordinate and manage services. Based on an analysis of the ministry's needs conducted in 2012, the Agenda for Transformation recommended strengthening county and district health systems to support operationalization of the decentralization policy.⁵

In addition to these health policy frameworks, the government developed a Strategic Roadmap for National Healing, Peacebuilding and Reconciliation (2013–2030) consistent with the government's Vision 2030, which was launched in December 2012.⁶ While the National Health Plan focuses directly on building capacity in the health sector, the roadmap, like the Agenda for Transformation, is broad in focus. It complements and supports efforts to achieve equitable access to basic social services, including health, education, and agriculture, that enable overall peace and human security. These policy frameworks were expected to mutually reinforce each other in helping government institutions to prepare for, mitigate, and respond to emergencies.

Although relatively good health regulations were in place, these regulations were inadequately enforced. At the time of the outbreak, Liberia was still struggling to implement the 2005 International Health Regulations, compared to other countries in the subregion. Health policies and regulations were

weakened by lack of adequate technical and institutional capacities, which was exacerbated by corruption and politics, including appointments based on political patronage. For example, inexperienced medical students were sometimes assigned to manage critical divisions of the health sector due to corruption.⁷ Setta Fofana Saah, the national coordinator of Liberia's National Traditional Council, remarked that "implementation of health regulations and policies was a big problem because of weak systems and processes, and so citizens suffered the consequences."⁸ Implementation of policies, regulations, and laws in the health sector required greater human and technical resources.

FINANCING HEALTHCARE DELIVERY

As Liberia moved away from direct humanitarian aid to recovery and development, medical charitable institutions and organizations began phasing out, and medical assistance was transitioned to indirect support to the national budget. The health component of the budget, with aid and direct budgetary support constituting 65 percent, grew strongly between 2012 and 2014, from \$38 to \$60 million.⁹ This budget covered a free universal healthcare system for basic services, such as maternal healthcare, at major government facilities, including the John F. Kennedy Medical Center and Jackson F. Doe Memorial Regional Referral Hospital. Other facilities, including the Redemption Hospital and clinics and hospitals in rural areas, were fee-for-service, with subsidies from the government with the support of donors and NGOs.¹⁰

This transition required the government to take over employment of nurses and doctors previously employed by international NGOs and philanthropic organizations. A scale was created in 2007 to standardize the salaries of health workers and top up civil service salaries.¹¹ But nonetheless,

3 Ministry of Planning and Economic Affairs, "Republic of Liberia Agenda for Transformation: Steps for Liberia Rising 2030," 2012, available at www.lr.undp.org/content/liberia/en/home/ourwork/library/liberia-agenda-for-transformation.html.

4 Ministry of Health and Social Welfare, "Guidelines for National Decentralization," 2008, available at www.basics.org/documents/Decentralization-Guidelines_Liberia.pdf.

5 Ministry of Planning and Economic Affairs, "Agenda for Transformation."

6 Peacebuilding Office, "Strategic Roadmap for National Healing, Peacebuilding and Reconciliation in Liberia (2013–2030)," 2012.

7 Interview with representative of Search for Common Ground, Monrovia, Liberia, November 17, 2015.

8 Interview with Setta Fofana Saah, Monrovia, Liberia, October 20, 2015.

9 International Crisis Group, "The Politics behind the Ebola Crisis," October 2015, p. 5, available at www.crisisgroup.org/en/regions/africa/west-africa/232-the-politics-behind-the-ebola-crisis.aspx.

10 Interview with Dr. Nowiah Gorpudolo, women's health specialist at Redemption Hospital, April 20, 2016.

11 Ministry of Health and Social Welfare, "Annual Report of the Health Sector Pool Fund: July 1, 2014, through June 30, 2015," 2015, available at www.mohsw.gov.lr/documents/HSPF_AR_2015_lr.pdf.

health workers employed by international organizations enjoyed higher salaries and better incentives. Moreover, the government only hired 3,500 of the 8,500 workers international organizations had employed, which sparked protests and violence.¹² The transition thus resulted in fewer, less motivated health workers.

Financing of public service delivery in Liberia has historically been centralized, under the direct control of various government ministries and agencies. The government attempted to decentralize financing by creating a County Development Fund in 2005 and a Social Development Fund in 2009 to devolve public infrastructure spending to the county and district levels. This, for the first time, allowed local officials to use their discretion in managing funds, but it also exhibited management problems.¹³

INSTITUTIONAL CAPACITY

At the time of the outbreak, health infrastructure in Liberia was inadequate, and drugs and needed equipment were in short supply, despite financial support received over the years from both the national government and donors. There were insufficient trained health professionals, with reports of one medical doctor to more than 200 patients in hospitals.¹⁴ Health professionals sometimes focused their attention on demanding better wages and benefits rather than on health issues. Moreover, the MOHSW's vital statistics system was underdeveloped, with a low rate of birth and death registration. A 2010 health survey established that surveillance and early-warning systems were extremely weak, with limited capacity to detect and respond appropriately to events such as the Ebola outbreak.¹⁵

This weak institutional capacity contributed to the rapid spread of Ebola. According to the suspended secretary general of the National Health

Workers Association, demotivation and low morale of health workers, coupled with shortage of drugs, low wages, and absence of personal protective equipment, all contributed to the spread of Ebola.¹⁶

Responding to the Ebola Outbreak

EMERGENCY MEASURES

The national government was slow to respond to the health emergency with proactive measures. According to one Liberian, "Our government did not act fast so as to save lives."¹⁷ The first Ebola cases in Liberia were reported in March 2014, but the government did not close its borders with neighboring countries and quarantine the worst-affected neighborhoods until July. The president declared a ninety-day state of emergency on August 6th, due to incidences of insecurity, and the government cordoned off the neighborhood of West Point in Monrovia on August 19th (see Figure 1).

When the government did finally respond to the outbreak, its measures sometimes exacerbated the crisis.¹⁸ The government mobilized the military to enforce the cordoning off of West Point in August 2014, leading to the death of a young boy and several injuries, as well as a strongly negative reaction from the community. There were many risks involved in using the Liberian military to quarantine West Point and other communities. Previous regimes had used the military to repress citizens, so its use in response to Ebola created fear. Many citizens felt provoked and thought it an overly harsh measure. According to one former government official, "We challenged the military [instead] to use the weapons of brooms, shovels, and diggers to clean the community and invest in

12 International Crisis Group, "The Politics behind the Ebola Crisis."

13 United Nations Capital Development Fund, "Final Evaluation: Liberia Decentralization and Local Development Programme," 2013, available at www.uncdf.org/sites/default/files/Documents/liberia_ldld_final_0913_eng_0.pdf.

14 Interview with the secretary general of the National Health Workers Association of Liberia, November 7, 2015.

15 Ministry of Health and Social Welfare, Liberia Health System Assessment, 2015. This assessment covered Liberia's fifteen counties and 159 health facilities and involved thirty focus group discussions and sixty key informant interviews. It lasted for two months (February–March) and focused on leadership and governance, health financing, essential medicines, supplies and supply chain, health financing, human resources for health, health infrastructure, health services, and health information systems and surveillance. The overall objective of the assessment was to generate evidence for the formulation of the post-Ebola health sector investment plan.

16 Interview with the secretary general of the National Health Workers Association of Liberia, November 6, 2014. He was suspended by the MOHSW for inciting health workers to go on strike for almost a week in 2013.

17 Interview, Jallah town, October 27, 2015.

18 Interview with youth leader, Banjor, Liberia, September 5, 2015.

Figure 1. Timeline of Ebola Outbreak in Liberia¹⁹

2014	September 28th
March 24th Liberian government announces first suspected Ebola cases in the country, which are confirmed six days later	Ebola outbreak peaks in Liberia
June 17th Ebola reaches Liberia's capital, Monrovia	October 29th WHO reports the rate of infections in Liberia has slowed
July 27th President Ellen Johnson Sirleaf closes Liberia's borders, bans football events, closes schools and universities, places some areas under quarantine, and establishes a National Ebola Task Force, which she chairs The military is deployed to enforce quarantines three days later	November 13th President Sirleaf lifts state of emergency
August 6th President Sirleaf declares state of emergency	2015
August 19th President Sirleaf declares nationwide curfew and orders the West Point neighborhood of Monrovia to be cordoned off	January 24th Just five confirmed and twenty-one suspected Ebola cases are reported across Liberia
September 16th US President Barack Obama announces an expanded US role in responding to the outbreak, including the deployment of troops	February 16th Schools reopen in Liberia
September 19th UN Mission for Ebola Emergency Response (UNMEER) is established	February 22nd President Sirleaf lifts curfews and reopens the borders
	March 5th Last confirmed Ebola patient in Liberia is released
	May 9th Liberia is declared Ebola-free, although several subsequent cases are confirmed
	July 31st UNMEER is closed, having officially achieved its core objectives of scaling up the response

¹⁹ Global Ebola Response, "Timeline," available at <https://ebolaresponse.un.org/timeline>.

relationships with the community that will help to change negative perceptions of vulnerable citizens about the government.”²⁰ Given some citizens’ negative perceptions of the government—that it was insensitive to the needs of the majority of the population, and that the favored few were enjoying the wealth of the country—these government actions had the potential to create political unrest.

Moreover, when state authorities quarantined communities and restricted movement, they did not provide adequate information on the process and procedures in advance, out of concern that advance warning might create panic and cause residents to flee to unaffected communities. Restrictions on movement, especially in populated areas like West Point and Dolo Town, also limited access to food, basic medications, and other necessities. According to one resident of West Point, government relief aid did not adequately compensate for these restrictions.²¹ Tensions ensued between the government and citizens in quarantined communities, which may have undermined the state’s efforts to control and contain the epidemic by reducing cooperation on the part of the citizens.

CITIZEN TRUST AND PARTICIPATION

A confluence of factors—the use of the Liberian military to constrain movement and spearhead a heavily centralized response, the mixed messaging of public information campaigns, limited community involvement, worsening state-society relations, deteriorating health services, and the escalating Ebola death toll—created mistrust in the healthcare and governance systems.²² The citizens did not trust the government when it pronounced the Ebola outbreak in March 2014. This mistrust was exacerbated by rumors that the president of Liberia had received funds from the US government to conduct a trial test of the Ebola virus. Many people did not believe the virus even existed, perceiving that the government wanted to make money out of the crisis.²³ West Point and Dolo Town, among other communities, refused

access to government workers carrying out public information and awareness campaigns. This initial reaction to information about the virus may have stemmed from previous experiences in the 1990s, when the government abandoned its citizens to fend for themselves against rebel and government forces. General mistrust reduced awareness of Ebola by health practitioners, local traditional leaders, and civil society organizations.

The lack of participatory governance, especially in the design and implementation of the Ebola response, also fueled mistrust. There was general consensus among national and international partners on the post-Ebola recovery plan, undertaken by the United Nations Development Programme (UNDP) in conjunction with other international organizations in early 2015. Critics, however, believed it was not developed transparently and did not benefit from the contributions and aspirations of critical stakeholders, such as women’s and youth groups, traditional leaders, and victims of Ebola. Critics also accused the government of excluding certain populations from development interventions and public services, particularly slum communities in southwest Monrovia, such as West Point, Banjor, and Doe.

The Ebola response was eventually successful due to the increased role of local actors deeply rooted in their communities. As part of the response strategy, the government set up task forces at the national, county, and district levels, with parallel interventions by civil society organizations and indigenous community groups below the district level. The task forces increased awareness and provided education on Ebola prevention, control, and management. These task forces made it possible for ordinary people to participate in containing and reversing the spread of Ebola. Involvement of local groups and communities, such as the Peacebuilding Office’s county and district peace committees and the Community Health Education and Social Services (CHESS), helped build trust.²⁴ Communities welcomed and trusted local groups,

20 Interview with former Minister of Public Works Kofi Wood, July 26, 2015.

21 Interview with resident of West Point, Monrovia, Liberia, August 19, 2015.

22 Erin McCandless, Nicolas Bouchet, et al., “Tackling and Preventing Ebola while Building Peace and Societal Resilience: Lessons and Priorities for Action from Civil Society in Ebola-Affected New Deal Countries,” Civil Society Platform for Peacebuilding and Statebuilding, 2015, available at www.cspps.org/documents/130616042/130793247/CSPPS+Ebola+Report.pdf/33092e41-bd4a-4ccf-8ddf-4464e5c6ce37.

23 Interview with health worker, Monrovia, Liberia, October 7, 2015.

24 Geneva Global, “Meet Jzohn, a Local Leader in the Fight against Ebola,” *Global Citizen*, March 11, 2015, available at www.globalcitizen.org/en/content/meet-jzohn-a-local-leader-in-the-fight-against-ebol/.

even at the height of fear and distrust in the hardest-hit villages.

DELIVERY OF HEALTH SERVICES

Ebola exposed the weaknesses of health service delivery in Liberia. At the outset, nurses and doctors did not use gloves and protective gear, and hospitals were not equipped with emergency response capabilities. Shortages of ambulances, medical practitioners fully knowledgeable about Ebola, and adequate space for proper burial of Ebola victims overwhelmed the health sector and the government.²⁵

The government established a burial team in late August 2014 to collect dead bodies from homes and communities. But the capacity of the team was overstretched due to inadequate logistics and limited manpower, which was recruited from among willing young people in the communities. In some locations, bodies of Ebola victims remained in homes and in the streets for many days before the burial team properly disposed of them.

The National Drugs Service, the government's custodian of medical supplies and equipment, underperformed at the county and district levels due to poor warehousing facilities that lacked an uninterrupted power supply. Not even one of Liberia's fifteen counties had adequate cold-storage facilities for efficient supply-chain management. In most cases, hospital facilities, already overburdened, were used to store drugs.²⁶ Lack of basic communications capacity was also a major challenge to emergency responders in rural communities.²⁷

When the Ebola outbreak started, the government lacked the needed logistical capacity. In response, the government directed all ministries and agencies to redirect their vehicles and motorbikes to use by health personnel and those directly involved in Ebola containment and prevention activities.²⁸ The General Services

Agency, the government's procurement arm, took responsibility for managing the Ebola fleet. The government also lacked needed medical supplies. Personal protective equipment was not in stock, which put health workers at risk of contracting the virus from infected persons seeking treatment from hospitals and health posts. This contributed to the reported infection of 378 health workers, of whom about 192 died.²⁹

October to December 2014 was the most critical period in the Ebola response, and significant improvement was demonstrated by mid-December.³⁰ County health teams, which had been established in all fifteen counties in 2003, were strengthened to work in partnership with local authorities and communities to deliver Ebola response services across the country. By the end of December, the county health teams had recorded 1,400 Ebola survivors and held regular meetings with an established survivor network based in Monrovia, with plans to open chapters at the county level. By this time, the logistics hub was located at the main football stadium, the Samuel Kanyon Doe Sports Complex, with five additional forwarding bases with improved access to land, sea, and air transportation for response personnel and cargo. Additional utility vehicles, motorcycles, and ambulances had been procured.³¹

During the outbreak, the government and its partners considered restoring essential health services as a top priority. In 2014, several funding mechanisms were established in an attempt to restore services, including the World Bank Ebola Recovery and Reconstruction Trust Fund and the National Ebola Trust Fund, which was managed by both the government and international partners.³² The World Bank fund, for example, aimed to support diagnostic services, procurement of drugs and medical supplies, and hazard pay for health workers. Efforts were also undertaken to make the health system more people-centered and resilient

25 Ministry of Health and Social Welfare, "Annual Report of the Health Sector Pool Fund," 2015, p. 10.

26 "Poor Management at the National Drug Service," *Daily Observer*, October 19, 2015.

27 Frank Schott, "Ebola Lessons Learned: Context, Coordination Are Key to Addressing Crises," 1776.vc, February 20, 2015, available at www.1776.vc/insights/ebola-lessons-learned-context-coordination-are-key-to-addressing-crises/.

28 Ministry of State, Circular no. 34, 2014.

29 Ministry of Health and Social Welfare, "Annual Report of the Health Sector Pool Fund," 2015.

30 Ministry of Health and Social Welfare, "Quarterly Report of the Health Sector Pool Fund, 2015: October 1, 2014, through December 31, 2014," p. 9, available at http://reliefweb.int/sites/reliefweb.int/files/resources/HSPF_AR_2015_Q2_final_lr.pdf.

31 *Ibid.*, p. 10.

32 *Ibid.*

by increasing the role of local communities in every aspect of health planning through consultations, constant community engagement, and decision making.³³ All these initiatives were intended to address the country's weak health system.

PUBLIC INFORMATION CAMPAIGNS

At the outset, public sensitization by the government on state radio was confusing and contradictory. At one point, the government advised that eating bats, monkeys, and bush meat, as well as fruits eaten by bats, was forbidden, as they could transmit Ebola, but at another point it encouraged people to properly cook these meats before eating.³⁴ In addition, information mostly reached those who had access to state and community radio stations, at the expense of the rural majority without access to radio. The radio station of the UN Mission in Liberia (UNMIL) complemented state radio, but all information was in English, which many Liberians do not speak or understand.³⁵

Later in the response, public information campaigns were conducted with radio messages in Liberia's sixteen local languages, as well as with billboards and newspapers, all repeating crucial prevention and control tactics, including washing hands, reporting Ebola cases, and not touching sick or dead bodies.³⁶ These campaigns were vital in the fight against Ebola. The government also requested mobile phone companies to provide hotlines to an Incident Management System, with the numbers available to the public.

By August and September 2014, local communities had organized and gotten involved in the public information campaigns, extending them to the community level.³⁷ With the support of the county administrations, teams were formed in various communities for monitoring, surveillance, and contact tracing. These teams included interna-

tional NGOs, such as the Carter Center, Global Community, and Save the Children, as well as existing community organizations and networks, including county and district football teams.³⁸ Local NGOs also formed networks, including the Civil Society Organizations Ebola Response Taskforce.³⁹ These groups undertook a combination of preventive work, by helping ensure that information campaigns reached as many people as possible, and direct response, such as by encouraging infected people and their families to seek help rather than hiding infected relatives at home.⁴⁰

INTERNATIONAL RESPONSE

Not only the government but also the international community was slow to act.⁴¹ The international response to the crisis only became serious when, in August 2014, international medical professionals got infected and were flown to Europe and the US.⁴² The roadmap for containing the virus was made available almost two months after the WHO declared the crisis to be a Public Health Emergency of International Concern on August 9, 2014. The US government announced it would deploy troops to Liberia to help construct Ebola treatment centers and provide logistical support on September 16th, and the UN Security Council declared that the Ebola epidemic was a threat to international peace and security on September 18th (see Figure 1).⁴³

Considering Liberia was still suffering from the effects of its brutal fourteen-year civil war, the international community's slow response further increased the fragility of healthcare governance.⁴⁴ Because the WHO, in particular, was slow to respond to the initial health emergency, and because what began as a health crisis quickly evolved into a humanitarian and security crisis, the UN Security Council was compelled to establish a new body to coordinate the response, the UN

33 Interview with Lancedell Mathews, director of New Africa Research and Development Agency (NARDA), October 21, 2015.

34 Liberia Broadcasting System (LBS), January–June 2014.

35 Mercy Corp Community Radio Program, "Listening Survey," 2004.

36 Philippa Atkinson, et al., "Social and Economic Impact of Ebola, Jallah Town and Banjor Community," September 21, 2015.

37 Interview with Pewu Flomoku, Carter Center Chief of Party, October 17, 2015.

38 Incident Management System, "Ebola Update," September 24, 2014.

39 Interview with Christopher Toe, Executive Director of the National Civil Society Council of Liberia, October 16, 2015.

40 Peacebuilding Office, "National Volunteer Program to Combat Ebola: July, August, and September Reports," 2014.

41 Atkinson, et al., "Social and Economic Impact of Ebola, Jallah Town and Banjor Community."

42 Interview with Wilfred Gray-Johnson, Director of Peacebuilding Office, November 16, 2015.

43 Security Council Resolution 2177 (September 18, 2014), UN Doc. S/RES/2177.

44 Interview with community leader, Jallah Town, Liberia, September 23, 2015.

Mission for Ebola Emergency Response (UNMEER).⁴⁵ Due to the international community's failure to respond more quickly and effectively to prevent the increased rate of infection and death, seven out of ten Liberians believed the international community should provide some form of reparations to Liberia.⁴⁶

INTERNATIONAL, NATIONAL, AND LOCAL COORDINATION

Coordination among response agencies at the international, national, and local levels was initially weak, undermining resource management and response systems.⁴⁷ County, district, and community interventions were not well coordinated until late 2014, with many parallel efforts and initiatives that further weakened community engagement in the Ebola response.⁴⁸

The government established a National Ebola Task Force headed by the president and co-chaired by the minister of internal affairs in March 2014 to coordinate the response, but it suffered from a lack of capacity. The government subsequently replaced the task force with a national Incident Management System and Emergency Operations Center to coordinate the Ebola response at various levels. A Sub-Regional Ebola Operations and Coordination Centre was established on July 24, 2014, following a meeting in Accra, Ghana, as a platform for UN agencies and governments to work together as partners in responding to the outbreak.

However, it was not until three months later, at the height of the response, that the government coordinated the responses of the international organizations flooding the country and moving into rural areas with those of county and district administrations. The minister of internal affairs, former co-chair of the National Ebola Task Force, advised all superintendents to coordinate the Ebola response in the various counties at the district and community levels.⁴⁹ These superintendents, with

support from international organizations such as the World Food Programme (WFP), UNDP, and UN Children's Emergency Fund (UNICEF), worked with the Incident Management System in August 2014 to decentralize and coordinate the response. The government encouraged international organizations to assess progress and coordinate all activities through the superintendents, as well as to recruit service providers locally.⁵⁰

The MOHSW also established County Health Teams, which were decentralized into district and community health teams. The teams and international partners were organized into four sectors to facilitate and strengthen a coordinated approach and encourage communities to take responsibility for their own safety. Cross-sectoral coordination helped to reduce duplication of activities, improve response efforts, and increase performance in areas of overlap.⁵¹ In addition, government agencies, including the Ministry of Internal Affairs and Ministry of Youth and Sports, and other institutions recruited and trained volunteers to work at Ebola Treatment Units, increase awareness, and carry out contact tracing. The contributions of these volunteers were crucial to the fight against the virus.

CORRUPTION AND ACCOUNTABILITY

There were repeated reports of systematic corruption and pillaging of healthcare funds, which had long undermined the postwar transition from relief to recovery and which the government did little or nothing to address. Health workers sometimes imposed unnecessary bottlenecks just to get more money from patients. Health posts, clinics, and hospitals with drugs and medical supplies provided by the National Drugs Service are required to give these to patients for free, but they usually gave only medical prescriptions, requiring patients to purchase drugs from privately owned clinics.⁵² According to one health worker in Monrovia, "Health administrators stockpiled their clinics and

45 International Crisis Group, "The Politics behind the Ebola Crisis," p. 2

46 "Weak Health Sector," *New Democrat*, February 12, 2015.

47 Interview with Fong Zuagele, Superintendent of Nimba County, October 2014.

48 Interview with John Buway, Superintendent of Margibi County, August 2014.

49 Interview with Morris Dukuly, former Minister of Internal Affairs, November 28, 2015.

50 Interview with Thierry Cordier-Lassalle, WHO, Liberia, August 2014.

51 World Health Organization, "Liberia Succeeds in Fighting Ebola with Local, Sector Response," April 2015, available at www.who.int/features/2015/ebola-sector-approach/en/.

drugs stores with drugs provided by donors.”⁵³ In other instances, drugs were not delivered to the facilities.⁵⁴ Monitoring of the health sector was also weak, and health professionals often offered preferential treatment to those they knew.⁵⁵

International NGOs provided drugs and incentives to support the health sector, but the MOHSW was reported not to have provided these in full to health workers. This caused the ministry, in the last few months of 2014, to experience strikes from health workers demanding payment of arrears, including the Ebola risks benefits entitled to former workers of the Ebola Treatment Units. These former workers mounted roadblocks in October 2015 at the central office of the MOHSW in Congo Town, Monrovia.

ROLE OF TRADITIONAL LEADERS

At the outset of the Ebola response, traditional leaders were not involved. On the contrary, traditional practices, such as burial rights and handshakes, were criticized for spreading the virus. The government and international partners insisted that people stop these practices, causing anger, withdrawal, and ignorance that, to an extent, may have caused more deaths and infections. The chairman of the National Traditional Council of Liberia remarked on state radio on August 17th that “the government did not respect our culture, and this make me feel bad.”

Stronger partnerships between traditional leaders and county and district administrations eventually contributed to reducing the rate of transmission. The chairman of the National Traditional Council of Liberia called on all chiefs to participate in education and awareness campaigns. The chiefs went to villages and towns and held radio talk shows, speaking in their respective vernaculars to ensure the message would be understood by Liberia’s sixteen tribes. For example, at a workshop organized by the Carter Center in June 2014 in Gbarnga, Bong County, citizens listened to traditional leaders as they advised on the

prevention and control of Ebola, and this was replicated in several districts. “People listen to the traditional leaders, at times even more than the government,” noted a coordinator with the National Traditional Council.⁵⁶ The council also helped to ease the tensions resulting from disagreements among citizens who believed in the government’s pronouncement of the virus and those who did not, which could have created ethnic rifts.

Lessons Learned

LOCAL ENGAGEMENT IS CRUCIAL

Once the epidemic hit, the national government, at best, failed to adequately communicate and engage with communities and, at worst, stifled local cooperation with disease control efforts, including the quarantine. Moreover, the Ebola outbreak exacerbated competition among national-level government ministries and agencies over authority and resources, as well as between the government and NGOs over donor funding. The government’s messaging on the prevention, control, and containment of the virus was inconsistent and unconvincing. Poor communication and mistrust of the government meant that citizens were hesitant to believe information that could have saved lives.⁵⁷

Active communication and coordination at the county and district levels were crucial to eventually containing the outbreak. County and district officials improved coordination among responders, communicated effectively and regularly with the county and district health teams, provided logistical support for rapid response and referrals, enforced guidelines about the transportation of Ebola patients, and sensitized people. Constant public reminders to wash hands, establishment of isolation centers, and use of proper burial processes also had a positive effect. The involvement of local actors in this process was significant, as these actors understood the local context, were able to develop trust and confidence with the communities, were

53 Interview with NGO health worker, Monrovia, Liberia, September 13, 2015.

54 For example, on September 21, 2015, Liberia’s Drugs Enforcement Agency stopped and confiscated a truckload of medical drugs on its way to Guinea. Many of these were discovered to be essential drugs, and further investigation uncovered drugs missing from UNICEF warehouses. The Drugs Enforcement Agency investigated the National Drugs Service for attempted theft of essential drugs and medical supplies.

55 Interview with Samuel Wilson, Community Liaison Officer for the UNICEF/Peacebuilding Support Office Social Cohesion Project, August 13, 2014.

56 Interview with coordinator of National Traditional Council, October 25, 2015.

57 Edward Mulbah, Lesley Connolly, and Nontobeko Gcabashe Zondi, “Picking Up the Pieces: Liberia’s Peacebuilding Efforts Post-Ebola,” African Centre for the Constructive Resolution of Disputes, August 2015, p. 4, available at <http://lab.isn.ethz.ch/service/streamtest.php?id=193353>.

easily accessible, and understood and spoke the local language.

EMERGENCY MEASURES CAN BE EFFECTIVE BUT CAN ALSO HAVE NEGATIVE CONSEQUENCES

At the onset of the epidemic, Liberia's health system was unprepared, and the government implemented only limited preventive measures to arrest the outbreak. The government was therefore left with no alternative but to take a number of bold decisions, including declaring a ninety-day state of emergency, putting nonessential civil servants on sixty-day compulsory leave (initially thirty days), closing schools and markets, and imposing quarantines. These control and preventive measures angered some citizens, who perceived them as violating their rights, and had some negative economic and social consequences.⁵⁸ Nonetheless, these measures, particularly the quarantining of heavily-infected communities and restrictions on mobility of people across borders, helped contain Ebola.

TECHNICAL RESPONSES ARE MORE EFFECTIVE

The government initially set up a National Ebola Task Force chaired by the president and co-chaired by the minister of internal affairs, and the minister of information, tourism and cultural affairs was required to provide daily briefings to the public on the scale of the disease. At times, information provided was inaccurate and misleading. Because of these technical inadequacies, the government quickly dissolved the National Task Force and replaced it with the Incident Management System, which was chaired by a public health specialist and co-chaired by two other health professionals. This shift from treating the epidemic as a national political issue to treating it as a technical issue improved the effectiveness of the response.

INCLUSIVITY IS NECESSARY

Liberia's health system is centralized, with major decision-making and planning processes following a top-down approach. Despite the creation of health districts and decentralization of health services in theory, Liberia lacked subnational

health structures and systems to implement the Ebola response in practice. The recovery plan has also followed a top-down approach, driven by the international community but with national authorities made to believe they are in charge.

In line with this top-down approach, the government's initial response to Ebola was not inclusive and collective. It was not until late 2014 that civil society organizations and traditional and local leaders became involved. The absence of collective engagement and inclusive participation of both state and non-state actors, especially local chiefs and youth groups, made prevention, control, and containment of the virus difficult. The eventual involvement of these actors contributed to reducing the infection rate and keeping it low. These actors, which have a significant role to play as part of good governance practices in general, should also be engaged in finding solutions to challenges during emergencies.

The different groups involved in the fight against Ebola each had different comparative advantages. For example, local and traditional leaders played an important role in encouraging people to take steps necessary to prevent, control, and manage the Ebola outbreak, such as by not eating bush meat and avoiding traditional burial practices. Civil society organizations carried out advocacy to encourage the government and international organizations to support the fight against the outbreak. They also provided relevant information and data on affected communities to policymakers and carried out public information campaigns using community radio stations and traditional channels of communication, such as town criers.⁵⁹

Moreover, while Liberia's post-Ebola recovery and development processes call for inclusivity in building sustainable peace, women and youth tend to be left out in the design and implementation of policy frameworks.⁶⁰ The government's health policy frameworks lack robust analysis of efforts to promote women and youth participation in designing and executing these frameworks and to ensure women and youth have access to quality services.⁶¹

⁵⁸ Ibid.

⁵⁹ Town criers are local people who provide information to the communities on important issues of collective interest and concern.

⁶⁰ Ministry of Health and Social Welfare, Liberia Health System Assessment, 2015.

⁶¹ Ibid.

CRISES CAN SERVE AS A LAUNCHING PAD FOR IMPROVED REGIONAL COOPERATION

The Ebola crisis highlighted the need for more regional cooperation in the health sector. Regional bodies like the Economic Community of West African States (ECOWAS), African Union (AU), and Mano River Union, provided support in the fight against Ebola and formed partnerships around key preventive and curative issues. Establishing a regional platform for information sharing and knowledge transfer would build on and strengthen these partnerships, as well as increase interaction and engagement, not only for emergency response but also for illegal cross-border activities (e.g., smuggling, prostitution, small arms and light weapons trafficking). This cooperation could advance the regional Ebola strategy and enhance national capacities for post-Ebola recovery programs and initiatives. Regional institutions, particularly the Mano River Union, will need to redefine and rebrand themselves to become more relevant in meeting contemporary demands of citizens.

Recommendations

As Liberia emerges from the Ebola crisis and moves forward, the following policy recommendations are advanced for consideration. These recommendations are aligned with the government's 2015–2021 Investment Plan for Building a Resilient Health System for Liberia and other important health programs.

- **Implement existing health policies:** The government, in partnership with bilateral and multilateral organizations, should strengthen the country's health system by implementing the National Health and Social Welfare Policy and Plan to remove physical, financial, and sociocul-

tural barriers to healthcare; improve the quality of services and adhere to health standards; and make sure that infection, prevention, and control measures are undertaken in concert with local communities. This could help build a more robust, resilient health system that can withstand future shocks.

- **Build detection and response capacity:** The government should strengthen surveillance and early-warning systems, as well as laboratory and diagnostic systems, all through a decentralized approach. It should also build core national capacities to detect, assess, report, and respond promptly and efficiently to public health risks and emergencies, as required by the WHO's International Health Regulations of 2005.
- **Improve governance and leadership:** The government should strengthen governance and leadership at all levels—national, county, district, and community—to ensure effective delivery of health services and meet targets in the coming years.
- **Strengthen community engagement:** The government should strengthen community engagement in planning and managing health services and bolster community structures to effectively undertake more roles and functions, including promoting health and disease prevention, while ensuring that the private sector is regulated to meet quality standards.
- **Rebuild trust in state institutions:** The government should explore how trust can be (re)built in state institutions. This will include promoting dialogue and communication between state and non-state actors, as well as developing an institutionalized approach to community engagement that complements efforts undertaken in other priority areas set forth by the government and the MOHSW.

Governance and Health in Sierra Leone

Charles Silver*

Introduction

The goal of this report is to highlight the link between health governance and health service delivery in Sierra Leone prior to the outbreak of the Ebola virus disease, as well as how this affected the country's ability to respond to the outbreak and the subsequent outlook. It also presents the lessons learned and makes suggestions for dealing with public health emergencies in the future.

This research was conducted using both primary and secondary sources. Primary data include in-depth personal interviews with key stakeholders, including public health officials, civil servants, and traditional leaders, as well as focus group discussions. Interviews were conducted in Moyamba, Bo, Freetown, and Kailahun, and two focus group sessions were organized in Freetown and Makeni. Focus group participants and interviewees were selected based on their experience in health governance, the war, and health service delivery in Sierra Leone.¹ Secondary data derive from relevant scholarly works on healthcare delivery and governance, local and international policy documents, and databases on health service delivery.

Framework for Health Governance before the Outbreak

EFFECT OF THE WAR ON HEALTHCARE

Sierra Leone's eleven-year armed conflict (1991–2002) caused untold damage to almost all sectors of the country, including the health sector. The war affected the health sector in two major ways. First, the intensification of the war, particularly in rural

areas, not only destroyed existing health facilities but also forced health workers and residents of rural communities to flee to urban safe havens. Second, many medical personnel, especially doctors, fled the country. Even though the war ended in 2002, some of these personnel have yet to return. Moreover, postwar governments did not prioritize public health in the reconstruction process.

Participants in a focus group discussion with health workers at the Connaught Hospital in Freetown unanimously pointed to the war as a major reason for the apparently insurmountable public health crisis in the country. One of the participants stated that overcrowding in the capital, Freetown, was a major reason for the alarming spread of Ebola in the city. She described living in a three-room house with fifteen people and needing to get up at 5:00am every morning to have a bath. This overcrowding makes it difficult to deal with a public health emergency. At the same time, one participant disclosed that health workers, as well as ordinary citizens, remain reluctant to return to the communities where they lived before the war, largely due to deplorable socioeconomic conditions and health facilities in those communities. These factors related to the civil war made it difficult for the nation and the health sector to combat the outbreak.²

HEALTH GOVERNANCE BEFORE THE OUTBREAK

Sierra Leone's 2010–2015 National Health Sectors Strategic Plan (NHSSP) was the blueprint for health sector governance and service delivery in Sierra Leone before the outbreak. According to the NHSSP, "Governance in health addresses the actors involved in governing the health sector (MoHS [Ministry of Health and Sanitation] and

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1 In order to provide an enabling environment for participants to freely express their views, special sessions were organized for health workers, members of the public, and civil society, respectively. Questions raised during the focus group sessions included: What was the state of the health sector in Sierra Leone before the Ebola outbreak? Was the government's response to the outbreak appropriate? What do you think the government and its partners should do to forestall future health emergencies?

2 Focus group discussion, Freetown, November 22, 2015.

stakeholders), what needs to be governed and, to a limited extent, how it will be done.” The NHSSP conferred multiple responsibilities on the MoHS, including formulating policy, setting standards and regulations, collaborating and building coalitions, and monitoring and overseeing resource mobilization. The MoHS was expected to provide leadership and coordinate the efforts of all healthcare providers and financiers at all levels. This enhanced role required the MoHS to develop capacity at both the local and national levels, especially considering the ongoing process of devolving health service delivery to Sierra Leone’s nineteen local councils, which began in 2008.³

But no matter the degree of innovation in a strategic plan, its implementation depends on adequate budgetary allocations (coupled with the actual disbursement of resources), availability of trained and qualified personnel, logistical support, and, above all, effective and efficient governance structures. Did the NHSSP and devolution process lead to any practical progress in health service delivery on the ground?

A former councillor in Bo city in southern Sierra Leone described the devolution process as not yielding the desired dividends. She pointed out that devolution of the health sector, like many other

sectors in the country, was not accompanied by adequate and regular financial and logistical transfers. Hospitals and clinics faced shortages in drug supplies and personnel. Transfer of responsibility was not followed by transfer of resources, which is necessary to implement devolution in practice.⁴

Inadequate budgetary allocations to the MoHS constrained it in meeting its core objective of delivering accessible and affordable healthcare to the citizenry. According to the 2013 National Health Accounts, the sector remained heavily reliant on donor support and out-of-pocket payments from patients (see Table 1). This led to unmitigated shortfalls in service personnel across the sector. A public health officer in Moyamba town in southern Sierra Leone intimated that one of the major problems confronting the health sector in Sierra Leone, even before the Ebola outbreak, was lack of adequate funding and personnel to operate the various health units in the country: “There are only two of us in the whole district. I am the only public health officer in this town. Hence, once I go out of town, there is no one to fill the gap.”⁵

Research carried out by the Institute for Governance Reform, a Sierra Leonean research

Table 1: Health expenditures in Sierra Leone (2013)⁶

Financing Source	Amount (SLL)	Amount (USD)	Percent of Total
Government of Sierra Leone	171,690,064,040	\$40,142,638	6.8%
Donors	614,220,929,261	\$143,610,224	24.4%
Nonprofit organizations	180,615,391,664	\$42,229,458	7.2%
Out-of-pocket payments	1,551,096,883,189	\$362,660,015	61.6%
Total	2,517,623,268,154	\$588,642,335	100%

3 Ministry of Health and Sanitation, “National Health Sector Strategic Plan 2010–2015,” 2009, available at www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Sierra_Leone/NationalHealthSectorStrategicPlan_2010-15.pdf.

4 Interview with former councillor, Bo city, November 27, 2015.

5 Interview with public health officer, Moyamba, November 20, 2015.

6 Ministry of Health and Sanitation, “Sierra Leone National Health Accounts,” 2013, available at www.mamaye.org/sites/default/files/evidence/MoHS%20SL_2015_Sierra%20Leone%20NHA%202013.pdf.

institute, indicate that people trained in health and education were reluctant to work in rural communities.⁷ This could be attributed to the ever-growing socioeconomic disparities between urban and rural communities in the country. A nurse in Freetown blamed health workers' reluctance to go to rural areas on the poor working conditions there. Another focus group participant claimed that, until the government of Sierra Leone and its partners make a genuine effort to improve working conditions of health workers, especially in remote parts of the country, as well as to ensure adequate and regular supplies, it will be difficult to attract health workers to rural communities.⁸ Unfortunately, these efforts fell short, and Sierra Leone's limited health facilities and personnel remained concentrated in urban areas.

The NHSSP did not include any specific provisions on the needs of women and young people. The government did, however, introduce a Free Healthcare Initiative for pregnant women, lactating mothers, and children under five in 2010.⁹ At the outset, this initiative was relatively effective, but the situation deteriorated over time. There were allegations that, despite the Free Healthcare Initiative, fees were often charged for services that should be free.¹⁰ A lactating mother in Makeni city in northern Sierra Leone aptly described the situation:

Initially, the free healthcare was very effective. Throughout my pregnancy, I did not spend anything on drugs up to the time I delivered my child. Unfortunately, things have changed. Even before the Ebola outbreak, it was extremely difficult to access the free health service. You go to the hospital today, the nurses will tell you we do not have drugs. You go there the other day, no nurse is available. This has been the trend until the Ebola outbreak collapsed the entire system.¹¹

The problems associated with health service delivery in Sierra Leone were further compounded

by high-level mismanagement and corruption in the health sector. Government services in Sierra Leone, including health services, are associated with making money, and in extreme cases, health services are sometimes denied until payment. While Sierra Leone does not have a system of free universal healthcare, its health services, like other public services, are not intended to be profit-making; the ultimate goal is to maximize public interest, including through judicious and accountable use of limited resources. But this has often not been the case in Sierra Leone, as in 2013, when allegations of high-level fraud saw donors suspend funds to the MoHS.¹²

One health worker lamented that, due to this high level of corruption and mismanagement, many medical doctors preferred administrative positions in the ministry, where money gravitates. Almost all major projects in the MoHS were spearheaded by medical doctors, which exacerbated their shortage. This situation also arose because the general working conditions for health workers, including doctors, were unsatisfactory, leading many to prefer the administrative side of the sector, where they could write and manage projects. Moreover, monitoring mechanisms in the health sector were very weak, particularly for doctors. One health worker in Makeni city posited that medical doctors are free to do whatever they choose and that, recently, many have come to pay little attention to their profession.¹³

Due to these factors, there is a mismatch between policy and practice in Sierra Leone's health sector. The NHSSP's strategic goal—"to reduce inequalities and improve the health of the people, especially mothers and children, through strengthening national health systems to enhance health related outcomes and impact indicators"—remains unfulfilled.

7 Institute for Governance Reform, "Service Delivery Index in Health, Education, Sanitation and Water," 2015.

8 Focus group discussion, Freetown, November 18, 2015.

9 The Free Healthcare Initiative was part of the government's policy reforms under the auspices of the Global Health Initiative for the country.

10 Amnesty International, "At a Crossroads: Sierra Leone's Free Health Care Policy," 2011, available at www.amnestyusa.org/sites/default/files/pdfs/sierral_maternaltrpt_0.pdf.

11 Focus group discussion, Makeni, November 27, 2015.

12 GAVI, "GAVI Review of Health System Strengthening in Sierra Leone," April 11, 2013, available at www.gavi.org/library/news/statements/2013/gavi-review-of-health-system-strengthening-in-sierra-leone/.

13 Focus group discussion, Makeni, November 27, 2015.

Figure 1. Timeline of Ebola Outbreak in Sierra Leone.¹⁴

2014	2015
May 25th World Health Organization (WHO) reports the first Ebola cases in Sierra Leone	January 23rd President Koroma lifts movements restrictions
June 11th Sierra Leone closes its borders with Liberia and Guinea and closes a number of schools	February 13th Hundreds of homes in Freetown are placed under quarantine for twenty-one days
July 15th Sierra Leone's Ministry of Health and Sanitation (MoHS) establishes an Emergency Operations Centre (EOC) in Freetown	February 18th Door-to-door search for Ebola patients is launched in Freetown
July 31st President Ernest Bai Koroma declares a state of emergency and sets up a presidential task force	February 28th Surge of cases in Sierra Leone prompts reintroduction of some restrictions
September 19th Three-day national lockdown begins	March 27th Three-day national lockdown begins
October 26th Ebola outbreak peaks in Sierra Leone	June 16th Operation is launched to eradicate Ebola from two northern districts
	July 31st UNMEER is closed, having officially achieved its core objectives of scaling up the response
	November 7th Sierra Leone is declared Ebola-free

Responding to the Ebola Outbreak

NATIONAL RESPONSE

Sierra Leone's health sector was not financially, logistically, or technically equipped to respond to the Ebola outbreak. The first Ebola case was confirmed in Sierra Leone on May 25, 2014 (see Figure 1). The government's response to the outbreak was largely reactive, at least at the early stages. This reactive response could be attributed in

part to the deplorable condition of the health sector on the eve of the outbreak, which prevented the government from quickly addressing the situation. One senior civil servant in the MoHS described the outbreak as not only a public health emergency but a painful exposure of the deplorable and neglected condition of the health sector over the years:

As a ministry, we are in a quandary. In addition to lack of adequate financial and logistical support needed to combat the disease, we do not have [the] requisite staff, [not to mention] the expertise required to deal with such a volatile disease. We are

14 Global Ebola Response, "Timeline," available at <https://ebolaresponse.un.org/timeline>.

constrained in all areas. We have only twelve ambulances to serve the entire country. Unless outsiders come to our aid, the situation remains precarious.¹⁵

Upon confirming the outbreak, the first measure by the government was to invoke a public health emergency, based on a provision in Sierra Leone's 1991 constitution. The Ministry of Education, Science and Technology immediately announced the closure of all learning institutions in the affected eastern districts of Kenema and Kailahun and, later, of all learning institutions nationwide. The government also set up a National Ebola Response Centre (NERC), with its headquarters in the Office of the President and branches in all regions and districts.

The NERC served as the coordinating unit for all information relating to Ebola. By decentralizing its activities to branches across the country, the NERC helped to collect and collate information on the outbreak at the chiefdom, district, and regional levels. The information gathered provided the basis for interventions by the government and international partners. The decentralization of the NERC's activities also helped the government and international partners identify the similarities and differences in public perceptions about and attitudes to the outbreak. This may have guarded against a one-size-fits-all approach to dealing with Ebola.

The health emergency included a ban on inter-district, inter-chiefdom, and inter-village visits until the Ebola outbreak subsided. A paramount chief in Kailahun District revealed that one of his wives died of Ebola and that one of her relatives attempting to visit from Freetown was decisively stopped from entering the township. According to the chief, "Some of us consider such measures as appropriate as of now, since we are dealing with a public health crisis and, more importantly, an enemy no one can readily identify."¹⁶

Some, however, expressed reservations about the lockdowns, arguing that they could worsen the situation. One local NGO cited the "poor training"

of the volunteers enforcing the lockdowns, and many Sierra Leoneans suffered from widespread food shortages and lost income.¹⁷ Médecins Sans Frontières (MSF) likewise observed that the nationwide lockdown imposed by the government could exacerbate an already precarious situation by "driving people underground and jeopardizing the trust between people and health providers."¹⁸

LOCAL RESPONSE

In the wake of the outbreak, information about the disease was not only scant but scary. The initial message from the government and the NERC was that Ebola was a killer without remedy. This description of the virus instilled enormous fear in people, who eventually considered visits to health centers, even for other illnesses, to be suicidal.

The situation changed dramatically, however, when, after setting up the NERC, President Ernest Bai Koroma called on traditional leaders, parliamentarians, faith-based organizations, civil society and community-based organizations, and local artists to come on board to fight the Ebola outbreak. This gave momentum to massive local sensitization campaigns to educate the populace on the virus and suggest precautionary measures to prevent infection. Despite acute financial and logistical constraints prior to the outbreak, the overwhelming support and cooperation the government received from these groups contributed immensely to containing Ebola in Sierra Leone.

For example, during the lockdown from September 19th to 21st, about 30,000 volunteers, with support from the police and army, embarked on a house-to-house search for people infected or suspected of being infected with Ebola. The home-visit teams were also tasked with educating the population about the disease and how to prevent it. In addition, some private businesses, mining companies, learning institutions, and individuals supported the government's efforts to fight the virus through cash donations.¹⁹

15 Interview with civil servant, Freetown, November 23, 2015.

16 Interview with chief, Kailahun District.

17 Sarah Roache et al., "Lessons from the West African Ebola Epidemic: Towards a Legacy of Strong Health Systems," O'Neill Institute for National and Global Health Law, briefing paper no. 10, October 2, 2014.

18 Umaru Fofama and David Lewis, "Sierra Leone Lockdown Will Not Help Halt Ebola: MSF," *Reuters*, September 8, 2014.

19 For example, the University of Sierra Leone presented the sum of 50 million leones (\$10,000) to the national fight against Ebola.

REGIONAL AND INTERNATIONAL RESPONSE

Despite pronouncements in international fora that the Ebola outbreak in West Africa was unprecedented and posed security threats to affected nations, a robust international response came late. The World Health Organization (WHO), which was expected to take the lead in mobilizing external support to contain the disease, only declared it a Public Health Emergency of International Concern on August 8, 2014, and released a response roadmap on August 28th.²⁰

Some health workers interviewed noted that donor funds were neither controlled nor coordinated by the MoHS. Nonetheless, subregional, regional, and international intergovernmental organizations and the donor community made significant contributions to implementation of the NHSSP before the Ebola outbreak under the Global Health Initiative Strategy for Sierra Leone, which was spearheaded by the US Embassy in Freetown.²¹ The core objective of these organizations was to complement the role of the government in implementing the NHSSP.²²

This lack of national ownership also characterized the international response to the Ebola outbreak. One health worker pointed to the health sector's overdependence on external assistance as rendering the country powerless to respond to the outbreak promptly: "Whilst we were eagerly waiting for international response, the virus was ravaging our people. As a nation, we have learned a bitter lesson."²³

Lessons Learned

LOCAL ENGAGEMENT IS CRITICAL

One lesson learned from the Ebola outbreak was that local ownership is instrumental in dealing with public health emergencies. Initial government messaging was counterproductive, and it was not until local groups became involved in sensitizing the public about the outbreak that efforts to

contain Ebola were successful. The strength of local actors in combating the Ebola outbreak lay partly in the fact that they belonged to and lived in their respective communities and were thus already familiar with their customs, traditions, norms, and taboos. This allowed them to readily interact with those communities. The pivotal role of local involvement in the fight against the outbreak was demonstrated in the dramatic subsiding of the disease in the Kenema and Kailahun districts where the outbreak began. These two districts were among the first in the country to record forty-two days without new Ebola infections, in part due to the efforts of local actors.

EMERGENCY MEASURES CAN BE EFFECTIVE BUT CAN ALSO HAVE NEGATIVE CONSEQUENCES

The invocation of the public health emergency teaches Sierra Leoneans, the government, and partners an important lesson about dealing with crises. Despite local and international efforts, very little could have been achieved had it not been for individual and collective support and cooperation by Sierra Leoneans during the emergency. The lockdowns and house-by-house surveillance initiated by the government contributed tremendously to local strategies to break transmission of Ebola. Nonetheless, lockdowns need to be either preceded or accompanied by the provision of essential commodities such as food and water in order to ensure compliance. Moreover, precautions have to be taken to avoid isolating communities and local healthcare workers.

OVERRELIANCE ON THE INTERNATIONAL COMMUNITY CAN UNDERMINE RESPONSE CAPACITIES

The Ebola outbreak in Sierra Leone is a clear testimony to the fact that overreliance on international assistance, particularly in times of health emergencies, can sometimes have devastating consequences. If workable processes and systems had been in place in Sierra Leone prior to the outbreak, a quicker initial response could have

20 Lawrence O. Gostin, "Ebola: Towards an International Health Systems Fund," *The Lancet* 384, no. 9951 (2014).

21 US Embassy Freetown, "Global Health Initiative Strategy for Sierra Leone," 2011, available at www.ghi.gov/wherewework/docs/SierraLeoneStrategy.pdf.

22 Notable organizations involved in health service delivery in Sierra Leone prior to the outbreak included: the US Agency for International Development (USAID); UK Department for International Development (DFID); World Health Organization (WHO); UN Children's Emergency Fund (UNICEF); UN Population Fund (UNFPA); European Union; Japanese International Cooperation Agency (JICA); Global Fund to Fight AIDS, Tuberculosis and Malaria; and West African Health Organization.

23 Focus group discussion, Ministry of Health and Sanitation, Freetown, December 29, 2015.

mitigated the consequences. In the case of Nigeria, for example, no sooner had a case of Ebola been confirmed than an Emergency Operations Centre was established, and communications and data sharing between urban areas helped to contain the outbreak. Adequate preparation can help ensure a coordinated and effective response should a future outbreak occur.²⁴

Recommendations

Based on the lessons learned emerging from the study, the following recommendations are proffered:

- **Ensure adequate budgetary allocations:** The government of Sierra Leone should not only prioritize healthcare in terms of policy initiatives but should also make adequate budgetary allocations to the health sector to translate policy into tangible results. This could include setting up a national health trust fund as part of the post-Ebola recovery strategy. The country already has a National Road Maintenance Fund and a National Social Security and Insurance Trust, to which all public and private sector workers contribute. These could be replicated in the health sector, with funding from sources such as a certain percentage of proceeds from the country's mining sector. This fund could complement government allocations and reduce the country's reliance on external assistance.
- **Improve oversight:** The government should establish oversight committees at both the national and local levels to monitor health service delivery and ensure compliance and accountability. These oversight committees should not rely only on national institutions but should also have support from international donors. This move could help reduce corruption, ensure adequate and sustainable progress toward meeting benchmarks, and, most importantly, encourage coordination within and among the various organs of the health sector.
- **Build personnel capacity:** The government and its partners should build capacity within the health sector to address alarming personnel shortfalls. As part of this effort, working conditions of healthcare workers should be improved, with special allowances for those working in remote parts of the country to close the growing disparities between health service delivery in urban centers and rural communities.
- **Coordinate with regional and international efforts:** To enhance the capacity of countries to deal with public health emergencies in the future, international support to health service delivery in Africa should be in line with the 2007–2015 Africa Health Strategy, which puts a premium on areas such as development of human resources in the health sector, information and communication technology to foster data collection and dissemination, transportation, facilities, and medicines and supplies.²⁵ There is also a need for robust coordination of donor agencies involved in health service delivery in Sierra Leone and elsewhere in Africa.

24 Faisal Shuaib et al., "Ebola Virus Disease Outbreak: Nigeria, July–September 2014," Centers for Disease Control and Prevention, October 3, 2014, available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6339a5.htm.

25 African Union, *African Health Strategy: 2007–2015*, 2007, available at www.who.int/workforcealliance/knowledge/resources/africahealthstrategy/en/.

Conclusion

Maureen Quinn

The authors of these two cases assess the national health policy frameworks of Sierra Leone and Liberia as adequate. Yet both critique the lack of resources—financial, physical, and human—allocated to the sector, as well as poor oversight and insufficient implementation, which hobble public health service delivery. The national health infrastructure does not reach into rural communities, and health service delivery is not effectively devolved to local actors. Moreover, national health leaders usually turn to international actors for external assistance, such as the UNDP, the World Bank, and bilateral donors, rather than collaborating at the regional level.

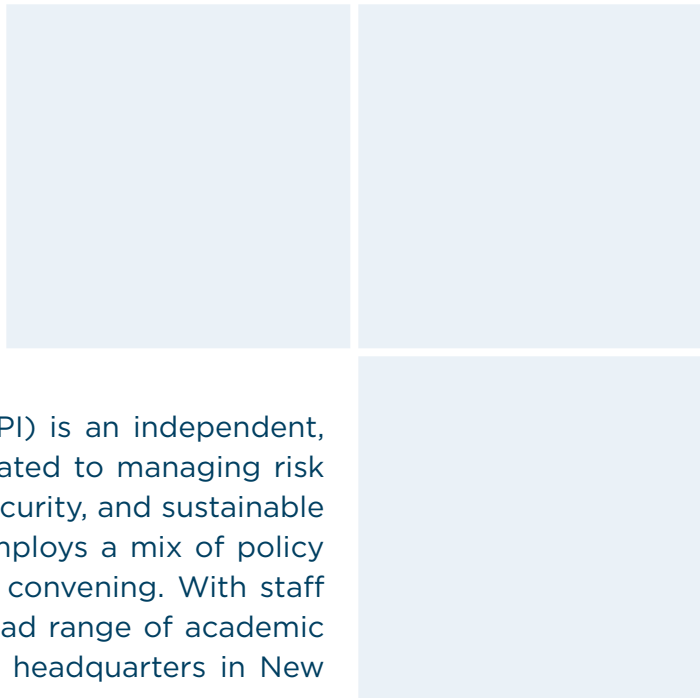
Ebola left a path of disease, suffering, and death in its wake over the course of 2014 and into 2015. Local, national, and international authorities were not adequately prepared and did not have effective preventive measures in place, despite longstanding international health regulations, requirements, and policy commitments. When the international community stepped in to address the Ebola outbreak as an “international threat to peace and security,” its response was late and externally driven. The crisis did not come under control until internal and external actors cooperated. Through this cooperation, external actors brought expertise and resources (including military forces and capabilities), traditional and community leaders were engaged in outreach and messaging, and traditional burial practices were challenged and safe practices adopted through joint efforts.

Lessons learned from the perspectives of both authors in these post-conflict settings center on community engagement and the need to address

the different health service needs in urban and rural settings. Tapping traditional leaders and communicating in local languages were also essential to reaching the population. Both authors mention the role of the military (national and non-national) in the emergency response. Directly and indirectly, the authors question the role of the military but acknowledge that quarantines and controls, while unwanted, were essential to bring the outbreak under control.

For the governments of Sierra Leone and Liberia, the Ebola crisis offers an opportunity to assume leadership in preventing and preparing for the next epidemic. To create a networked approach to health service delivery that can contain the next epidemic or manage the next health crisis, they will need effective leaders at multiple levels who take the initiative to work in conjunction with the UN, WHO, and major NGOs. In neither Liberia nor Sierra Leone did international partners and local actors work to address the crisis while simultaneously building sustainable capacity to manage health emergencies.

Drawing upon the lessons from this painful experience, national leaders should initiate reforms to prepare and strengthen the health sector. Commitments have been made to invest in the future of the health sector as the crisis abates, and policies and programs are now available to strengthen the health sector. This is a rare moment for national leaders to engage the international community and commit to strengthening governance and specific health management practices.



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