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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 .

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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. Heath 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 .

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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.

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Figure 1. Timeline of Ebola Outbreak in Liberia[19]

2014

March 24th

Liberian government announces first suspected Ebola cases in the country, which are confirmed six days later

June 17th

Ebola reaches Liberia's capital, Monrovia

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

August 6th

President Sirleaf declares state of emergency

August 19th

President Sirleaf declares nationwide curfew and orders the West Point neighborhood of Monrovia to be cordoned off

September 16th

US President Barack Obama announces an expanded US role in responding to the outbreak, including the deployment of troops

September 19th

UN Mission for Ebola Emergency Response (UNMEER) is established

September 28th

Ebola outbreak peaks in Liberia

October 29th

WHO reports the rate of infections in Liberia has slowed

November 13th

President Sirleaf lifts state of emergency

2015

January 24th

Just five confirmed and twenty-one suspected Ebola cases are reported across Liberia

February 16th

Schools reopen in Liberia

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 .

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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-ebo/ .

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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.

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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 international 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.

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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/ .

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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 then 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 .

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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.

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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 sociocultural 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.

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